March 17, 2015

House Committee on Health

RE: HB2280

Chair Mitch Greenlick and committee members:

My name is Julie McNamara and I am a radiology practitioner assistant (RPA) which is also referred to as a radiology assistant (RA). A fellow RPA, Pat Williams, attended a recent committee meeting in Salem and was asked if there have been any documented cases of harm to patients by PA-C's. I do agree with her statement to the committee regarding it is probably not documented, because errors are often caught before causing harm to the patient by radiology staff. I have had conversations with radiology staff and radiologists in two healthcare systems in Portland and would like to share some comments of errors caught before patient harm, hence no documentation.

1. A resident accompanied his surgical patient to imaging for a pre-op evaluation of a known fistula between the esophagus and right lung. The resident was adamant on requesting Gastrografin for the exam since it was to rule out a leak. The RPA doing the exam questioned the resident and explained the contraindication using that contrast for the exam. He wanted to speak with the radiologist. A radiologist came to the room and informed the resident the patient could go into respiratory arrest and possibly die with that contrast, and said we can use some thin barium. This is a good example of well-educated people in their respective fields specializing in additional knowledge of imaging standards that stopped patient harm from occurring.

2. A PA-C placed an order for a CT scan and in the comment section stated to use "non-ionic" contrast due to patient's iodine allergy. The PA was called and informed we cannot do this exam without premedication. The PA was confused and did not realize "non-ionic" still has iodine. Although, the PA was very apologetic and clearly unaware of the contrast issue, this is another example of leave imaging to qualified staff with experience in imaging and contraindications to all types of contrast used in our field.

3. A gastrointestinal doctor who has taken the standard hospital test on radiation for a non-radiology physician has been overexposing patients. He was allowed to run the fluoroscopy pedal on his own by taking this "test". The staff had so many concerns with the high amounts of dose in the room; they stayed in the control area. After informing the physician he can use pulse fluoroscopy, which decreases the dose 30-50%, he did not understand why to use it and said he could see so much better on full dose. He only needed the fluoro to check his tube placement and can easily do it with pulse. He also did not cone the image down causing increased exposure

to the patient, himself, and staff with scatter radiation. After conversations with the physician, he now follows the suggestions of the radiology department. This is an example of a non-radiology physician overexposing and not understanding why they were. He even passed the fluoroscopy test given by the hospital. It is not enough training. Fluoroscopy times on his patients were reaching 45 minutes routinely and now they are around 10-15 minutes.

Although, these are just a few examples of events that could cause harm, it is obvious non-radiology staff do not have sufficient training to recognize potential dangers. There are many more examples like this we see in radiology. In the last example, with the highest dose, the radiation effects could show up weeks, months, or years later. It is too hard to track, unless a radiation burn develops, which has been documented in many articles and why the FDA requires so much radiation safety in our field. It takes a team of experts, in their specialized fields, to work together to help a patient.

These are just a few reasons why we highly suggest and urge your committee to take more time to look into this. Radiation safety is high on the priority list of the federal government and has started to require documentation in patient charts of their dose. This is so it can be traced weeks, months, or years later. WE simply do not have enough data over the years of the possible harm ionizing radiation has caused. It is accumulative. It has been hypothesized by experts over the years that our field of radiology has caused cancer in some patients by overexposure. The standard of care in imaging is stricter because we are seeing results of our standards twenty years ago.

Thank you,

Julie McNamara ARRT(R)(M)(CT) RPA/RA