Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Welcome to Nightintales. This podcast was created during the international year of the nurse and nurse midwife, and what a year that was. This podcast is dedicated to telling stories of nurses from across our profession. Our goal is to introduce you to the seemingly infinite possibilities in nursing and encourage you to find your true passion within this work. I'm your host, Jessica Spruit, and I'm so glad you're here. Thank you for joining us for another episode of Nightintales. I'm glad you guys are here and I'm glad to introduce our guest to you today. We have Dr. Margaret Campbell, she is a professor at Wayne State University's College of Nursing. And she's joining us today to tell us about her journey in nursing and the unique path that took her to becoming a nurse researcher and actually someone who has developed a really widely used tool and a critical tool when caring for adults at the end of life. And we'll spend some time talking about that, but Dr. Campbell, thank you so much for joining us today and spending your afternoon with us.

Margaret Campbell, PhD, RN, FPCN:

Oh, thank you, Dr. Spruit, it's always a pleasure to have an opportunity to encourage some of our students or new nurses to think about research as a career.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

I think it is an important opportunity, I think, as you say that it makes a lot of sense because probably not a lot of people going into the profession of nursing, think, I'm going to fill this knowledge gap, I'm going to develop a tool or conduct this research that generates new knowledge, yet it's critical. When you think about the evolving healthcare climate and the environment that we are in, it's critical that new knowledge continues to be generated. So I'm excited for you to tell us a little bit about your background and what took you to the development of the RDOS, which we'll be talking about throughout this episode. So if you don't mind, tell us how you started in nursing, if you have always dreamt of becoming a nurse researcher or maybe instead the path that took you there.

Margaret Campbell, PhD, RN, FPCN:

Well, I've been a nurse for quite a long time and I started thinking about nursing when I was 12 and broke my ankle. And back then, this was in the 60s, they kept you in the hospital nowadays, they would put you in a cast and send you home. But back then I was in the hospital for four days, I had a lot of pain and I remember this amazing nurse and she took care of me every day and I just thought she walked on water. And that's when it snapped for me that I want to be like her. And so I chose nursing and went to the Henry Ford Hospital School of Nursing and got a diploma. So that school of nursing doesn't exist anymore and most diploma nursing programs have also been eliminated because nursing is a complex field and generally more degree time is needed to enter the field.

Margaret Campbell, PhD, RN, FPCN:

So with my diploma in nursing, my first jobs were in the intensive care unit. And I liked the autonomy that I had as critical care nurse, but I also knew I needed more stimulation, after a while everything became same old and I needed to continue my education and to continue to advance my career in nursing, because apparently I have a short attention span and I get bored. For a while I was a nurse educator and I was definitely bored with that job, teaching blood gas interpretation over and over and over, oh my God. But it was a great, flexible job for me to have while I worked on a master's in nursing that led me to be a acute care nurse practitioner and that became more exciting because it wasn't same old, every case taught me something, every case I could make a difference. And I was one of the earliest acute care nurse practitioners to begin a new field of nursing, which was palliative care. Back in the middle 80s, Detroit Receiving Hospital was the first in the country to have an inpatient palliative care service led by a nurse practitioner.

Margaret Campbell, PhD, RN, FPCN:

And doing that work led me towards knowing that there were research gaps because I was a critical care nurse practitioner and now I was doing acute care palliative care and had no training in that. So I went to the literature and all the literature was hospice cancer home based. Well, how would that help me with a patient dying from stroke in the intensive care unit on a ventilator? So I created some of the knowledge base using a method called trial and error. And that means that sometimes I made wrong choices because we didn't have an evidence base. And the longer I did that work and the more excited I became at what I was learning that I could publish and share with others who were starting palliative care programs, that led me to realize that I really needed to not just care for patients one at a time, but to inform care of patients collectively. And that led me to getting a PhD and doing research.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Wow. Yeah, that is such a natural progression although not one that we necessarily think of often, but when you are in practice and identifying, one, your own desire for change, and then two, the lack of evidence to support your next moves and the interventions that you're offering patients and their families, it really does make a lot of sense. Although, like I said, not something that we immediately think of when we think of this journey. So you, then were a master's prepared, acute care nurse practitioner, and then you went to pursue a PhD because you recognized, it sounds like that there was a knowledge gap and truly a need for generation of new information. Can you tell us a little bit about that PhD program and what your journey through that education meant or looked like for you?

Margaret Campbell, PhD, RN, FPCN:

Sure. I did my PhD study at the University of Michigan in the College of Nursing and I got there thinking I knew what I was going to study. The gaps in symptom research for people who were at the end of life were huge, we knew a lot about pain, but not all people at the end of life have pain. Everything still was driven, all the evidence at that time was still driven by cancer and cancer patients often do have pain, but patients with COPD, patients with stroke, patients with dementia, who have pneumonia at the end of life, they suffer from shortness of breath, also known as dyspnea and we had a big evidence gap. So I got to the U of M and in that first course, the faculty asked all of the new cohort of students, there were 12 of us, what we were going to study. And I said, "Well, I'm going to study dyspnea at the end of life." And the professor pushed me, "Well, what about dyspnea at the end of life?" I said, "Well, about dyspnea, treating it. And she said, "Well, what about treating it?"

Margaret Campbell, PhD, RN, FPCN:

And she kept pushing me and pushing me and pushing me and finally, I was able to focus my research as a student on how to assess dyspnea when a dying person isn't able to tell you that they're short of breath, because I knew from my practice that that was a gap. I knew as an expert practitioner, that I could walk into a patient's room and conclude that they were short of breath by observing them. But the nurse at the bedside might have been at my hand saying, I don't see that the patient is short of breath. So it was a gap in practice that I recognized as the person prescribing care, I would prescribe treatment for shortness of breath and then go home for the night and come back in the next morning, and my patient was in distress because the night nurse didn't recognize what I recognized. And so that led me to focus my PhD study and my subsequent career on assessing shortness of breath using behavioral signs, because many patients get to the end of life and lose the ability to tell us what symptoms they're feeling.

Margaret Campbell, PhD, RN, FPCN:

I was lucky that I had professors that helped me hone my research question, take the right courses, develop the right methods to graduate and have that be the beginning of my program of research.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Yes. It sounds like that initial conversation, which it sounds like had been very early in that program, but was really formative when it comes to, as you said, the rest of your career and what you're currently doing. I think this also is such a nice illustration, Dr. Campbell of the role of a PhD in someone who has a very strong clinical background. And I think we don't always think about that transition from a strong clinician in advanced practice to pursuing the PhD. But I think this is a really nice illustration of the opportunity that exists when someone elects to do that.

Margaret Campbell, PhD, RN, FPCN:

Agreed. And as we are starting to see more people finishing their bachelor's in nursing and continuing on towards the PhD, one of my reservations has been, will that nurse student who's now a PhD student, have enough of a clinical background to inform clinical research? And my advice to people thinking about PhD study right out of a bachelor's in nursing is maybe give yourself a year to really polish your nursing skills, define the area of nursing that excites you and makes you passionate and then consider PhD study. So I do believe that because nursing is a practice field and nursing research is also aimed at improving practice, improving the care of patients. And so if you don't have a strong foundation as a nurse, my bias, and there may be others that would disagree with me, my bias is that you do need some confidence as a nurse that you don't have as a new grad. It may take as much as a year to really hone your confidence then to make you a credible PhD student in nursing.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure. I think that that makes sense and hopefully will resonate with some listeners, especially if they don't have that idea in their head. It sounds like you came to your PhD program with real determination to help people at the end of life who had lost their voice and their ability to describe their symptoms. And I think that as you said, identifying that passion and solidifying that desire, not that you have to know exactly what your project will be, but that that would be really valuable. I'd like to keep talking about the tool that you developed, it's now as we know it, the RDOS, and it's been translated to several different languages and it's widely used. And I was sharing before we started the recording of this podcast that I attended a conference just a couple of weeks ago, that repeatedly referred to Dr. Campbell and the development of her tool and the utilization of this actually in day to day practice, as they were caring for patients who were critically ill and experiencing dyspnea at the end of life.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

And so I think that this is just a great opportunity to highlight how impactful and meaningful something that you do in your doctoral work and a tool that you developed such as this can really impact patients and their families.

Margaret Campbell, PhD, RN, FPCN:

Well, the RDOS stands for respiratory distress observation scale. So it's a simple label and it's exactly what it is. When a person has dyspnea, there are behaviors that we associate with their verbal report that they're short of breath, and those behaviors can be operationalized into a scale. So the RDOS has eight variables and each of the eight variables is scored zero if it's normal, one or two points, and then the points are summed. So the scale has a total score ranging from zero to 16, the higher the score, the more severe the distress. And in the early development of the scale, the psychometric testing are the first steps when a new instrument is developed, is it reliable? Is it valid? Will two nurses use the scale and get the same score? Will the score represent what the patient says is happening? And so all of that testing was done over a period of a few years.

Margaret Campbell, PhD, RN, FPCN:

The scale then was released for use, and as users started to use it, I was starting to get queries, well, what does the score mean? What is the cut point? When is a score between zero and 16, mild, moderate, or severe distress? I hadn't even thought about doing a cut point study. So sometimes there's a give and take between the researcher, then the clinical user, then back to the researcher. And so then I did two studies to determine the cut points for the RDOS. Now, once I had the RDOS, my long term goal was to identify treatments that do and don't help respiratory distress, but I couldn't develop those treatments because there was no way to measure. And so the RDOS was not the goal of my research, it became my legacy, but it wasn't my goal, my goal was to look at the best way to treat respiratory distress in dying patients.

Margaret Campbell, PhD, RN, FPCN:

So after I developed the RDOS, then I was able to do a study that showed that routine oxygen, that is a standard of care isn't needed when the person is close to passing if they're not in distress, in fact, it might actually prolong their dying. And so that study was an intervention study. Another study I did was to show that death rattle, which is a sound that dying people make when they are retaining pharyngeal secretions, because they're so close to passing that they don't have the strength to cough or swallow. And it's generally believed that there's no patient distress from this naturally occurring sound, yet a number of studies have been done looking at pharmacologic measures like a scopolamine patch to reduce the sound, but drugs have side effects and if the patient's in no distress, then the drugs aren't needed. And so I did the first and only study that demonstrated that patients with death rattle are not in respiratory distress.

Margaret Campbell, PhD, RN, FPCN:

Now, translating research into practice means somebody has to take my results from my study and say, let's do something different with our patients instead of putting them on a scopolamine patch. So translating research into practice becomes the goal of the advanced practice nurse, even the staff nurse in a hospice setting who reads the research and says, oh, why are we doing this routinely? Let's translate this evidence into practice. And so when a clinical scientist such as myself, does this work, it still has to be translated into practice. And that's where getting it into the clinical literature quickly, after doing a study that has important findings, but hoping that nurses in practice will pick up those findings and translate them into routine care.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

If you were talking to someone, you were advising someone who was doing work such as this and wanted to quickly translate this into the literature and then help nurses embrace this and translate it into their practice. What tips or tricks did you think were helpful? Was there anything in particular that made that possible for you or any strategies that you think were more or less effective?

Margaret Campbell, PhD, RN, FPCN:

Well, in my early years as a nurse scientist, I was still in practice, for the first four or five years, maybe six years after I finished my PhD, I stayed in practice as an acute care NP who now had a PhD and I was able to hire a nurse practitioner to work with me, to give me some release time, to continue my research. And so for a while, I could do that translation into practice in the setting where I was working, but I was making change in one site, one hospital, one health system. And that wasn't satisfactory to me, that only the place where I worked was going to have the translation of research into practice. So the opportunity to translate research into practice comes from dissemination. When a researcher presents at a meeting, presents at a conference, publishes the work you're careful to publish where it's going to get to the end user. So I publish in the critical care literature, I publish in the palliative care literature. And I present my research at palliative care meetings and that disseminates it more broadly.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure. And with great intention, it sounds like, with that targeted audience in mind, with great intention of sharing this tool and this resource to the people who may actually be able to utilize it.

Margaret Campbell, PhD, RN, FPCN:

Yeah. I'm really proud of the fact that over time, I'm aware that my RDOS has been put into practice in more than 60 sites in the United States. And some of those are acute care settings, some of those are hospice settings because the application can be in any setting where somebody breathes, this is about shortness of breath at the end of life and there are many settings where people pass away. So having that kind of representation is pretty exciting to me, but what was even more exciting was the international appeal. My RDOS is in place in 11 countries and has been translated into seven languages, and that's pretty cool.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Oh, it truly is. It's a global legacy. And when you think of those patient who clinicians can better recognize when to intervene, how most appropriately to intervene, now that this is so developed and those thresholds are in place, what an amazing legacy. I think that that is the ultimate demonstration of nursing and caring for people, and you're empowering people all over the world now, to be able to do that. And I think that that is such a cool opportunity, such a special thing that we don't, like I said, we don't always think of that. We don't always imagine our legacy and especially not one that's so big, but certainly you've articulated how it's possible and how, with a good foundation in nursing and a good awareness of where the needs are, that there are opportunities such as this, even if you didn't go to school, dreaming of them.

Margaret Campbell, PhD, RN, FPCN:

Yeah. Who knew back when I was a nursing student, that this is where my career would end up. I would've had no idea. The only regret that I have is that I was having such a rewarding career as a palliative care nurse practitioner, that it took me a very long time between finishing my master's and starting PhD study. And I wish I had done that a little bit earlier, for the same reason that I hope some of our younger nurses who are just finishing their bachelors, think about PhD study. Don't wait until you're 40 years old, think about it earlier so that by the time you develop a program of research and then are able to seek federal funding, which is the pinnacle of research funding, you need to develop your program of research. You can't do it right out of your PhD program, you can't get that kind of funding as a junior investigator.

Margaret Campbell, PhD, RN, FPCN:

And so the time gap from how much I can contribute as a scientist is going to be shorter because I was mid-career before I went back for my PhD. So hindsight says, I wish I'd gone back sooner, because I'm really enjoying where I am in my field now and I wish I had done that a little bit earlier.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure. I think that that's great advice. I think that's a great tip and it does bring us to current day. If you don't mind, could you tell us about what your life, currently your work life, as a nurse researcher looks like? We know that you work at the Wayne State University College of Nursing, but day to day or week to week or month to month, I know that you are really involved in obviously the dissemination of this work and the mentoring of students, in editing textbooks and really applicable resources. But what are your days and weeks look like Dr. Campbell?

Margaret Campbell, PhD, RN, FPCN:

Well, it varies. The thing about being in academic is we make our own hours and we make our own schedule and we're outcome driven rather than punch a clock driven. So as long as I meet my goals, which are scholarship, continuing my program of research and there's a number of steps involved in that, there's proposal writing to get funding for new studies, there's keeping a study team functioning while we're enrolling and analyzing data, there's dissemination for studies that are done. But then there are other areas of scholarship because I'm a leader in my field, an expert in my field of study, I get invitations to review manuscripts by other investigators who are studying dyspnea. And so there's manuscript review. I got invited to lead a guidelines task force as a co-chair person for the American Society of Clinical Oncology. So I'm collaborating with a dyspnea researcher from MD Anderson in Houston. He and I are the co-chairs for a dyspnea advanced cancer guidelines panel.

Margaret Campbell, PhD, RN, FPCN:

So those kinds of activities are part of my university scholarship that informs based on my area of research. So on a given day, I might have a meeting with a student that I'm mentoring, I might have a university meeting because I'm on university committees, I might be at my desk reviewing a manuscript that has been sent to me to comment about, I might be writing a paper or a chapter, I might be inviting a colleague like Dr. Spruit to write a chapter in a book series I'm editing that she agreed to do. So every day I'm not bored, every day there's something interesting that I'm doing.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure. I think that that represents the great variety of being in academic nursing. And I think the flexibility that it presents, and I don't know about you Dr. Campbell, but I know some days I might really feel like writing and other days I might really feel like reviewing papers or something or meeting with students or doing different things. And I think that that flexibility is really afforded to you when you are in academic nursing, as we are.

Margaret Campbell, PhD, RN, FPCN:

Yeah. I agree. There are days where I can't put two words together and that's not a day I'm going to write, but that might be a day that I'm going to read something. I've always got a stack on my desk and when I print them because I'm old school, when I'm reviewing something, I need to see it on paper and I need to pull out a pad and make notes in the margins, but I keep a stack on my desk and it's in chronological order in the upper right hand corner, when is this due? So right now I have a stack with 1011, 1013, 1019 and today I don't feel like writing, but I can grab one of these papers and do a review. And you're absolutely right, don't just screw it. It's the flexibility that's very attractive to having an academic position.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

So I think if you are considering an academic career or if this is of interest to you, you should know that you don't have to sit down at your computer every day and write papers. There's a lot of variety in the kind of work that we do. And I think certainly, the clinical applicability of this work is illustrated by Dr. Campbell's career and her trajectory so far. Dr. Campbell, we can get close to wrapping up here, but I was just curious if you didn't mind, from your perspective, what kind of student do you think, or what kind of nurse should consider a PhD? What qualities might they observe in themselves? What kinds of questions might they be asking, where if you were to meet with them, you would say, this aligns well with earning a PhD or looking at nursing research?

Margaret Campbell, PhD, RN, FPCN:

Curiosity, recognizing that we don't have all the answers, being passionate about a domain of practice that excites you as a clinical nurse, but that has opportunities for new knowledge. So I think passion and curiosity would be two attributes that I'd be looking for.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Sure.

Margaret Campbell, PhD, RN, FPCN:

And perhaps what we do when we're considering the next cohort of PhD applicants, what we're looking for is that that nurse can articulate a nursing research phenomena. So for example, many students come thinking world peace, world hunger, premature babies, we're going to resolve premature babies. Well, what about premature babies? So the same kind of probing my faculty did with me when I was a new student, this is what we do with applicants. It's like, so what about premature babies? Bring that broad question down to a narrow gap in evidence. And if you can articulate that when you're thinking about PhD study, remember that you don't have to have it all figured out first semester, we'll help you bring that world peace question down to something measurable.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

So that eventually you can achieve world peace, right?

Margaret Campbell, PhD, RN, FPCN:

Yeah, right.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

It gets bigger though. I mean, I think that it's important to remember that that's the launching point, not the ending point. And so your long term, very big goals will become increasingly achievable as you move through the program and get the guidance and mentorship of your faculty who become your colleagues. Dr. Campbell, I think this was so helpful and I personally love hearing about this trajectory, the journey that you've taken. And I really, more than anything, just love imagining how much it empowers nurses to provide end of life care that truly does relieve symptoms and in an evidence-based way. And so I, certainly as a practitioner, thank you for that and thank you for your time today and sharing all of this expertise with us and this really unique perspective that you have.

Margaret Campbell, PhD, RN, FPCN:

Thank you for having me.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Thank you for listening to this episode of Nightintales. As you do, we encourage you to consider the unique nature of each person's journey through this profession. The views shared on this podcast are those of an individual, not the academic institution that they graduated from, their employer or the professional organization that they're active in. The stories of their career path and progression are not intended to suggest that there is a uniform approach to achieving similar accomplishments, but to open your mind to all that is available to you. Each journey in nursing is as unique as each individual that we serve. We hope you'll listen again next time.