My name is Nick Widder, and I am the new chair of the AARC’s Adult Acute Care Section. Many of you may recognize my name, not only from the ballots that you filled out when you voted for me, but also from my two years as the Bulletin editor. Currently, I am the staff therapist at a community hospital with a teaching affiliation in Concord, NC, a suburb of Charlotte. As I am not used to winning elections, please bear with me through the following:

I have several people to thank by name. First is John Graybeal, CRT, our retiring chair. I first met John at a Maryland-DC respiratory care conference. Over the years he has become a friend and mentor, and it is he who encouraged me to become involved in the Association on a national level. John has been chair of the section for the last five years, and he leaves me large shoes to fill.

Second is Jeff Whitnack, RRT. Jeff and I have only met via electronic media, but I have always found his opinions and observations both poignant and entertaining. One of the requirements that I had for a Bulletin editor was the ability to raise the awareness of issues that are important to the section. Jeff is quite gifted in that regard, and I am glad that he has agreed to serve as our Bulletin editor.

I would also like to thank two of the managers I have worked for over the past several years. First is my current manager, Susan Hinson, RRT. Susan was thrilled when I decided to run for section chair and has encouraged me ever since. Second is Garry Dukes, RRT, my former manager, who allowed me to work on the section Bulletin while I was in his employ. I know that I could not have succeeded in my endeavors without the assistance I have received from my department managers.

I would also like to thank Susan Blonshine, RRT, RCPT; Ron Sing, DO; Will Miles, MD; Joe Coyle, MD; Dana Oaks, RRT; Dwayne Smith, RRT; Roger Deavers, RRT; John Wieroney, RN, RRT; Tom Striplin, RRT; and Aram Arabian, MD, along with a host of others too numerous to name here, for assisting me in reaching this position.

I come to the position of section chair with a few specific goals. First and foremost, I would like to provide information that is useful to our members, the majority of whom are still working at the bedside. Our Bulletin provides an excellent way for us to network ideas that may not be popular in one locale, but are standards of care in others. I would also like to receive input from you regarding special interests that you would be willing to share with other members through articles in the Bulletin. My contact information is listed on page two of this and every issue.

My second goal is to recommend to the Program Committee the inclusion of lectures at the AARC Congress specifically geared towards those of us still out here in the trenches. By the time this Bulletin reaches you, the deadline for submitting topics and lecturers for the 2001 Congress has passed. I would like to thank the Program Committee for their assistance in this area.

Dues for the AARC are currently $150.00 per year, and include a subscription to the Bulletin and access to the Online Member Services Web site. If you have questions or concerns, please contact the AARC office at 1-800-41-4-SAFE or via email at info@aarc.net.

“Notes from the Chair” continued on page 2
“Notes from the Chair” continued from page 1

program will have passed. But it is not too soon to start thinking about the 2002 program. Again, you can contact me with your thoughts on this regard, or you can come to the business meeting in San Antonio this December and express your opinions there.

Finally, with a membership of 1266, our section will be represented on the AARC Board of Directors. I am pleased to be able to represent those of us at the bedside to these elected officials, as in my rather biased view, we represent the core of the profession. Feel free to contact me with any issues or concerns that you would like to see addressed in that venue.

Notes from the Editor: Respiratory Therapy Has Been Good to Me
by Jeff Whitnack RRT

My name is Jeff Whitnack, and I have been a respiratory therapist since 1982, working mainly in the San Francisco Bay area. Before becoming a respiratory therapist I worked as a garbage man (it’s a long story) and was taking nursing prerequisites. I tried to go from garbage cans to bedpans. But, as John Lennon once said, “Life is what happens to you while you’re busy making other plans.” So instead I went from maggots to mucous.

I currently work at the VA Hospital in Palo Alto, CA, as a clinical supervisor. I am married (yes, to an RN) and have three children who, apparently, have been lucky enough to have inherited my recessive genes. Add one Boxer dog and a Black Throated Monitor Lizard (named “Macho Man” by my five-year-old daughter), and you have my family.

A few years back, during a particularly trying time in the era of hospital redesign, I had a bit of a professional catharsis. Having coincidentally been elected Shop Steward just before the redesign got underway, I found myself sitting at the negotiation table. The redesign efforts were occurring mid-contract, and the hospital administration was meeting with the labor unions (RNs, RTs, service workers, laboratory, etc.) in an attempt to change job descriptions and roles.

So, after working the night shift for about ten years, there I was sitting at the negotiation table when a top RN administrator actually laid out a proposal calling for RTs to become “Clinical Partners 1.” “Clinical Partner 2” was to be the new name for an LVN. Clinical Partner 1 was a certified nursing tech. I can still remember the sense of outrage I had at the time. It was a mix of the incredulous, the indignant, and something else — something I imagine you may feel as a long-term relationship untangles and you realize the depths to which your partner’s respect for you has sunk.

Now before this — which for me was a professionally epochal event — I wasn’t exactly RT chopped liver. But I had somehow let an institution slowly and insidiously influence how I defined my professional identity and boundaries.

Reeling from this insult, I resolved never to be so “ambushed” again, to reassert my professional identity and mindset as a respiratory therapist and not as an employee of Hospital X. I subscribed to more journals, attended more conferences, started including new RT books on my reading list, and took the CPFT, RPFT, and Peds/Neonatal exams. I began to see my hospital duties as having more to do with matching services to actual clinical needs and achieving actual clinical results than just completing the assigned workload in the allotted time.

And a funny thing happened. Clinical life was more fulfilling. Dare I even say more fun? The ever so pervasive fog of burnout and malaise, so prevalent among RTs as we confront sub-optimal wages, respect, and recognition, was lifted. And I was also able to make even more of a difference for my patients.

All this for just intellectual pennies a day!

Anyway, that’s my story. As editor of this Bulletin I hope to help build up the Adult Acute Care Section. I don’t mean to take away from any other

“Notes from the Editor” continued on page 3
The November and December issues of Respiratory Care featured the proceedings of a unique conference convened by the Journal in May of last year. The conference, “Palliative Respiratory Care,” brought together a faculty of internationally-recognized experts to review and discuss aspects of end-of-life care pertaining to the respiratory field.

Among the topics addressed at the conference were: how to assess and treat dyspnea in terminally ill patients, how to talk to families about death and dying in the ICU, the nuts and bolts of withdrawing life support, and the role of respiratory therapists in palliative care. The two Journal issues contain the formal papers presented by the faculty, the often spirited discussions following each presentation, and an insightful conference summary.

According to Dr. David Pierson, Journal editor, “Although almost nothing has previously been published on this specific aspect of palliative care, respiratory care clinicians have long played a vital role in this arena. The material presented in these special issues breaks new ground and is sure to become a valuable and practical reference source for everyone participating in the care of patients with severe respiratory disease.”


47th International Respiratory Congress, Dec. 1-4, 2001, San Antonio, Texas USA

For 46 years the AARC’s International Respiratory Congress has been the gold standard of respiratory care education and trade. For 46 years the AARC’s International Respiratory Congress has delivered the highest quality programs with information that really matters. For 46 years the AARC has plowed its resources back into the profession, expanding the practice and influence of respiratory therapy in the health care system.

Don’t miss out on the largest and most comprehensive respiratory care meeting in the world, coming in 2001 to one of the most entertaining cities in the US, San Antonio. For additional information, please call (972) 243-2272, or e-mail clay@aarc.org.

High Hopes for High Frequency
by Brian Stearns, RRT, Carolinas Medical Center, Charlotte, NC

Chair’s Note: In the following article, Brian Stearns reports the anecdotal experiences at one medical center. Having been involved in this undertaking, I can state that the combination therapy being reported was due to a successful collaboration between the attending physicians and the respiratory care department. In this case, USN and heparin were instituted concurrently and were successful enough that the attending physician staff was unwilling to randomize one or the other therapy; hence the report is not of high scientific value. However, one of the goals of this Bulletin is to share anecdotal experiences so that our patients may gain from the work of others. It is our

“High Frequency” continued on page 4
Meanwhile, I am thinking about some holes that may remain in the patient's picture. While we have had good outcomes with these patients, we have been unable to attribute them to a specific cause. Since we started using the USN and the heparin simultaneously, we have two variables that may be contributing. With time we will quantify and qualify what is working and why. But for now the results will have to speak for themselves.

---

**Book Review**

by Jeff Whitnack RRT

**Cardiopulmonary Interrelationships in Clinical Practice**

Edited by Anthony M. Cosentino, MD, and Richard J. Martin, MD

Copyright 1997

Futura Publishing Company

http://www.futuraco.com/

“Dr. Anthony Cosentino and Dr. Richard Martin have formulated an intriguing textbook on cardiothoracic relations in health and disease, with the major emphasis on the seldom addressed and often under-appreciated influence of chest pressure and lung mechanics on the hemodynamic performance of the heart and pulmonary circulation.”

“It is the purpose of this book to review what is known about cardiothoracic interrelationships, both in normal and disease. The material will be informative and intellectually stimulating for those who manage patients with cardiopulmonary dysfunctions, including physicians in pulmonary, cardiac, and critical care medicine. It should also be of interest to cardiac surgeons and anesthesiologists engaged in ventilator work.”

—From the Preface by Dean T. Mason, MD

Where can I begin to describe this

“Book Review” continued on page 5
book? It’s a real gem. In my opinion, anyone involved in the application of mechanical ventilation, or the treatment and management of diseases such as asthma, COPD, CHF, and ARDS, just to name a few, should be familiar with this book and its information. Or, to put it more bluntly, anyone responsible for slamming pressure into a patient’s lungs should be well-versed in cardiothoracic interrelationships.

Often, at the bedside of a mechanically-ventilated patient, the RN will be assessing cardiac function via the monitor and the various pressures while the RT assesses pulmonary function through various other pressures and measurements. Sure, in the ideal situation the RT is deeply cognizant of cardiac function as well, and the RN is likewise taking note of the pulmonary. But, alas, this is all too often not the case. Typically, we just see the RN staring at the cardiac monitor, with its numbers and its waveforms, and the RT staring at the ventilator, with its numbers and waveforms. Meanwhile, the heart and lungs are working in such an intertwined relationship as to make a mockery of the clinician separation occurring just a meter or two away.

Or, to quote from the opening paragraph in Chapter 4, “Respiratory Considerations in Congestive Heart Failure?” by Haddad, Bailey, and Gray:

“Although the heart and lungs share the thoracic cage and are intimately interconnected, it is common to think of these two systems as separate and independent, a misconception that has been perpetuated by the intense specialization that has occurred in medicine. Clinicians, however, who manage cardiorespiratory diseases, have long identified the need to view these systems together, with the recognition that alterations in one can produce simultaneous changes in the other. . . .The clinical descriptive term ‘cardiac asthma’ for cardiogenic pulmonary edema further epitomizes this close association . . .”

I first heard Dr. Cosentino talk at the 1992 Lake Tahoe conference titled “Cardiothoracic Interrelationships in Clinical Practice.” Attending this conference really piqued my interest in this topic. The conference was dedicated to the recently-deceased John Butler, MD, who died in a glider accident just before the conference. I recall the lectures by Drs. Cosentino, Michael Pinsky, and Solbert Permutt. Just enter the author names of either “Permutt, S.,” or “Pinsky, M.,” into Grateful Med Search for a plethora of interesting abstracts on this issue. Dr. Pinsky described how he constructed a ventilator that was synchronized to cycle to inspiration during early systole. When chest binders were also applied to patients in cardiac failure, the cardiac output was markedly increased.

Here’s a short preview of what’s in this book:
• A dynamite review of physiology relevant to the topic with emphasis on certain applied physiology concepts;  
• Pulmonary vascular resistance;  
• The role of lung volume and PVR in status asthmaticus;  
• The ventilator as an afterload reducer in heart failure;  
• Cor Pulmonale — is it really right heart failure or a hormonal disease of peripheral edema formation and cardiac limitation via lung mechanics?;
• The interrelationship of shunt, cardiac index, and FIO2 on PaO2;  
• Pulmonary edema formation and re-absorption;  
• Mechanical ventilation in asthma and ARDS;  
• And the provocative question — is the proper term, “to wean from the ventilator,” or do we really just “fledge”* them, etc.?

If I have any criticism of this book it’s that I wish there were a chapter describing the physiology of coronary perfusion and how it may be impacted by cardiothoracic interrelationships. There was no mention of the role that an opened foramen ovale may play as another cause of hypoxemia. This may occur in either obstructive sleep apnea or certain vascular and pulmonary pressure derangements. The pages of this book would have also been another opportunity to spread the word about how the “change up/change down” in systolic BP that occurs (or doesn’t) with mechanical VT delivery can be used both for general hemodynamic assessment and to ascertain the impact of mechanical ventilation. This is detailed in Perel and Stock’s book, Handbook of Mechanical Ventilation, and was also the topic of a talk given at the recent Brussels International Symposium on Intensive Care and Emergency Medicine.

All in all, however, I believe this book should be on the shelf of every respiratory therapy department.  
*Fledge: to raise a young bird until it’s ready to fly.

A Call for Articles!
by Jeff Whitnack RRT

This is an open invitation to all section members who would like to write an article on any topic relevant to adult acute care. Please e-mail your articles to me at the address listed on page 2.  

Bulletin articles may be up to 3000 words in length, but generally, 500-1000 will suffice. The Bulletin can include: book or product reviews, stories about how things are going in your institution, informational articles on specific treatments or modalities, articles on section activities, stories.
from the soul of an RT, or anything else of interest to the membership.

Even if you can’t write anything for the next issue, please send me a quick e-mail and list any topics of particular interest that you may be able to cover in future issues. You don’t need to be an accomplished writer to submit to this publication! After all, that’s why editors were created.

Upcoming deadlines are as follows:
- **March-April Issue**: February 1
- **May-June Issue**: April 1
- **July-August Issue**: June 1
- **September-October Issue**: August 1
- **November-December Issue**: October 1

Here are some general topic ideas to get your juices flowing:

- **A review of the new modes on the new vents** (from ATC to ASV and on to fuzzy logic ventilators to beat the lung’s fractal drum). Recently, Branson and Hess wrote a great chapter on “Weaning Modes in Liberation from Mechanical Ventilation II.” Resp. Care Clinics of North America. Perhaps we could highlight a “Mode of the Month”? Given the proliferation of new modes, both weaning and support, and considering the resultant alphabet soup, a regular, brief but succinct description may help keep us all “in touch” with modes we don’t use at our individual hospitals.

- **RN/RT relations** — a tale of mutual cooperation (at times) and mutual antagonism (at other times). Both professions face dwindling enrollments and looming staffing crises at a time when the Baby Boomers are getting ready to swell the need for hospital beds and clinicians. A constant theme of my professional life has been cooperation and competition between RTs and RNs — not to mention that one party I attended where every male RT, save one, was married to an RN. What’s that about? How do RT/RN marriages fare compared to the national average? Does having one’s spouse know the pressures of hospital work and professional responsibility help?

- **What’s going on in South Texas?** I continue to hear stories about how RTs are becoming “extinct” in that area. Is it true that ICU vent management is actually being taken over by nursing? If so, what vents are they overseeing and will ventilator “history” now become “frozen”? Are these RNs able to handle the intubated asthmatic or the patient with ARDS? If not, are the MDs focused, competent, and available for 24/7 ventilator management? Is this happening by design or by default? Is this a local aberration or a harbinger of things to come?

- **Palliative care** — how do RTs become involved in such issues? We at least become involved with issues of dyspnea, oxygenation, secretion clearance, and ventilation, as obscure goals such as “letting nature take its course” meet the already nature-altered reality of the acute care hospital and clinicians with both a different mindset and default action mode. And then there are those Albuterol tx’s . . .

- **Your hospital doesn’t have NO available.** But you do have a vent patient with severe pulmonary hypertension. What are the nuts and bolts of nebulizing Prostacyclin?

- **What’s your hospital’s default ventilator mode — A/C or SIMV?** It seems that some hospitals regularly consider one to be the mode of choice and the other to be the anathema to good ventilator practice. Indeed, the very mention of the unofficially disallowed mode seems to bring on crucifix raising, garlic wearing, and recited incantations (“they overbreathe,” “idiot mode ventilation,” etc.). Let’s get this issue out in the open and “duke it out” in the pages of the Bulletin.

My goal is to eventually make this newsletter interesting enough so that it, alone, will help entice people to join the section — sort of like how folks used to tune into the original Tonight Show with Jack Parr just to see what would be on next. We need our Bulletin to contain articles, information, and perspectives that we usually don’t find elsewhere. Remember: the readers of this Bulletin are already receiving Respiratory Care and AARC Times, and many are no doubt reading other journals as well. So this Bulletin needs to find its niche. Like that old potato chip commercial, it’s got to be “interesting, provocative . . . well seasoned.” I’d like to see the Adult Acute Care Section grow in part because the Bulletin is a unique source of stimulation and information, but I’ll need your help.

Given the onset of the deadline so soon after I took over editorship, it’s perhaps understandable that I have had to write almost this entire issue. And, of course, if in future issues I don’t get enough articles I’ll have to resort to posting even more of my take-offs on popular tunes.

Please don’t let that happen!

---

**AARC Wants to Know Your Top Five Areas of Concern**

The AARC is currently seeking input from section members regarding the top five areas of concern unique to our specialty area. Please mail, email, or fax your top five concerns related specifically to the specialty (not to the AARC or the practice of respiratory care in general) to: Kelli Hagen, 11030 Ables Lane, Dallas, TX 75229, email: hagen@ aarc.org, FAX (972) 484-2720 or (972) 484-6010. The Association will utilize our input in determining priorities for the coming year.
JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the Bulletin.

Accreditation visit you are reporting (choose one):

- Home Care
- Hospital
- Long Term Care
- Pathology & Clinical Laboratory Services

Inspection Date: ________________________________________________

Facility Name: ________________________________________________

Contact: _______________________________________________________
(Please provide name and email address.)

1. What was the surveyors’ focus during your site visit?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

2. What areas were cited as being exemplary?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

3. What suggestions were made by the surveyors?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

4. What changes have you made to improve compliance with the guidelines?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Additional comments:
Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229
FAX (972) 484-2720
Don’t forget to make your nominations for the 2001 Adult Acute Care Specialty Practitioner of the Year. This honor is given to an outstanding practitioner from this section each year at the AARC’s Annual Convention.

The recipient of this award will be determined by the section chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the section.

Use the following form to send in your nominations for this important award:

I would like to nominate ____________________________ for Adult Acute Care Specialty Practitioner of the Year because ______________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Nominee ____________________________

Your Name ____________________________

Hospital ____________________________

Hospital ____________________________

Address ____________________________

Address ____________________________

City ____________________________ State, Zip ____________________________

City ____________________________ State, Zip ____________________________

Phone ____________________________

Phone ____________________________

Mail or FAX your nomination to the section chair at the address/number listed on page 2 of this issue.