I’d like to begin this issue by thanking all of you for honoring me as your 2001 Specialty Practitioner of the Year. I am very sure there are many more RTs out there far more deserving of the award than I. But as I write this column on the eve of my departure for San Antonio, TX, and the AARC International Congress, I am feeling quite blessed to have received the award this year, and am looking forward to meeting many of you at the meeting.

My ten-year-old, however, has been terrified that I’d be flying to San Antonio, and that provided a forum for us both to have a very nice talk. I can certainly understand her fears, given the world we live in today. It seems that during the past month the news has been filled with the war on terrorism and the military matters that go along with it. And in many ways, perhaps our role in critical care and emergency medicine may be likened to soldiers going into battle.

Certainly, when reading Keith Lamb’s article in this issue, I was struck by the resemblance that our jobs have to that of a newly trained soldier getting accustomed to life in combat. Many of us are so used to “life in the trenches” that it is perhaps healthy for us to stop and give ourselves a pat on the back for both surviving the stress we subject ourselves to and the service we provide our patients.

Years ago, a few months after I graduated from RT school, I worked at a facility where we did the intubations, especially during codes. I went through the two weeks in the OR, learning all the fussy proclivities of the anesthesiologists, along with some real tips to help tube that patient lying on the floor in a pool of vomit. I had done a few intubations and was pretty good at it.

Then one night at about 11:30 p.m. I was looking over a chart on a monitored step-down cardiac unit. The unit nurse supervisor came in off-duty in her street clothes to drop off some educational material for the nursing staff. She was a friend of mine, and we said “hi.” Suddenly, one of the patient’s monitors erupted in a display of V-tach with the alarm sounding. “Oh $#%##,” she exclaimed, and trudged into the patient’s room with her platform shoes a cloggin’. I followed suit. The patient was shaking his arm and looked distressed in the extreme. I quickly raised his O2 to 6 l/m. I grabbed the phone to call a code, suddenly realizing I knew not what room number I was in. I almost pulled the phone out of the socket stretching it in order to crane my neck up to look at the room number.

The RN barked out an order: “I’ll get the crash cart, you walk him out of here.” She meant his roommate, of course, but I thought she meant the arresting patient. She said it with such a ring of authority, and I was real green. So I ran up behind him and briefly started to raise him up. In my head were dueling messages (much like the Devil and Angel speaking to Pinto in Animal House during the party) — “that’s ridiculous, to walk him out of here” . . . “but maybe it’s something like a precordial thump?”

All this took place in a matter of seconds. Just then the code team arrived and saw that I had the patient raised up. The patient had just arrested to the point of unconsciousness. One of the code team members smiled appreciatively. She thought I had the patient raised up in order to place the board under him, not as a prelude to a little stroll out in the hallway.

The board was placed, and I intubated the patient with aplomb. But I sometimes wonder what would have transpired had the code team arrived to find an empty bed, then looked down the corridor and seen me, blue patient in tow, exclaiming, “Hey, uh, I don’t think this walking technique is working too well.”

Back to the military . . .

Awhile back I picked up a book sitting out in the discount pile at a local bookstore. The title was Embattled Courage, The Experience of Combat in the American Civil War, by Gerald F. Linderman (The Free Press).

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This book starts out by describing the

“Notes from the Editor” continued on page 2
general conception of battlefield courage during that war. Courage, manliness, and godliness were all tightly interwoven and thought to be guiding beacons for behavior. A person’s word of honor even infringed into the military realm in a manner we would find ludicrous today. From page 12, “Prisoners of war, for example, were often paroled pending exchange. Ulysses Grant released the Vicksburg garrison on parole. Each was liberated solely on the basis of his assurance that he would not return to soldiering until informed that a captive held by his own side had been released, freeing both to return to duty. In the interim the paroled soldier was expected to proceed on the basis of his word of honor — to go home, or, in a few cases where states forbade the return of paroleses, to report to one of the detention camps maintained by his own side.”

Battlefield courage often involved steadfastly marching in formation upon the enemy. In previous wars the musket range was only 100 yards, which meant that often the defenders could only get off one volley before being descended upon. But by the time of the Civil War, the muskets had become rifled. The effective deadly range was now 300-400 yards. The old concept of battlefield courage now became a recipe for massive slaughter, and charges against entrenched positions became recipes for battlefield defeat. Still, the old concepts persisted. It took a man who was a failure in both formal military training (last in his West Point class) and in personal ventures to begin to recognize this shift and change how war was fought. That man was Ulysses Grant.

From page 210, “One of the peculiar results of Grant’s inurement to failure was that it diminished his investment in the system of values others bought to the Civil War and thus provided a detachment making visible and reasonable possibilities hidden or unthinkable to others.”

But remnants of the old concept of battlefield courage continued on into World War I, until as described on page 17, the soldiers, “were likely to feel themselves so subordinated to the destructive processes of war that they came to think of themselves less as actors in war than as victims of war. Men were compelled to concede the limits of individual will and the exhaustibility of courage.”

So, the courage which was to serve them in battle became in itself embattled courage. I find a corollary in today’s health care environment with caring. Many of the caring professions are embattled by a shrinking base for staffing, technology that allows us to keep people technically alive much longer, specialization, professional turf rivalries, and the intrusion of economic models that have little if anything to do with the caring concepts or images of Marcus Welby, MD, or Florence Nightingale.

As I look around I see that today it is caring which is embattled. It’s not that clinicians didn’t start out with every intention of providing quality care for patients. But just as marching into rifled muskets guaranteed a slaughter in 1862, so now in 2002 will believing in the traditional concepts of caring become a recipe for ultimately burning out and feeling betrayed?

I think this is a problem we have to acknowledge. Some of the best have already fallen or deserted. Others are trying to mix caring with new tactics of digging in and flanking. From where will come our General Grant?

2001 Specialty Practitioner of the Year: Jeff Whitnack, RRT, RPFT

The Adult Acute Care Section was proud to honor Jeff Whitnack, RRT, RPFT as its 2001 Specialty Practitioner of the Year during the Awards Ceremony held at the AARC International Congress in San Antonio in December. As most of you know, Jeff is a tireless volunteer for the section, serving in numerous capacities, including editor of this Bulletin, where he has increased submissions from the membership and treated us all to a very entertaining — and enlightening — look at RT through the eyes of health care providers around the world through the CCM Discussion series.

Jeff, who has been a member of the profession since 1982, is currently on the staff at the VA Hospital in Palo Alto, CA, where he has worked hard to increase his professional skills over the years. When a hospital-wide redesign effort took place several years ago and consultants wanted to rename all RTs in the institution “Clinical Partners 1,” Jeff responded by doing all he could to improve his skills and knowledge base, taking the CPFT, RPFT, and Perinatal-Pediatric Specialty exams and devoting more time to professional activities such as reading journals and keeping abreast of the latest developments. These actions, along with those made by his colleagues and their determination not to accept the name change, resulted in the swift demise of the “Clinical Partner 1.”

A Respiratory Student 2.5 Years Later
by Keith D. Lamb, RCP, RRT

I was no doubt the class clown. At 32 years old and just a couple of years out of the Marine Corps, I wasn’t the oldest student in our class, but I was by no stretch the youngest either. I had spent some time as a criminal justice major a while back, so college life wasn’t totally new to me. With the exception of our first pulmonary pathophysiology class and maybe my first chemistry class, most of the subject matter came pretty easy to me. I managed to ace most of my classes, and when I finally did graduate I did so magna cum laude.

But back to being the class clown. I pretty much thought that everyday college life was pretty funny. I actually enjoyed being in class, and like a lot of folks, I could probably have made a career out of being a student if the pay wasn’t so incompatible with life. I liked making jokes and the attention that it sometimes got me. I spent every day Monday through Friday in class and every evening and weekend working for a retail outlet store in a nearby ocean city in Maryland. The drive each way to and from school was about 40 minutes on a good day and almost double that.

“A Respiratory Student” continued on page 3
CCM-L Discussion Part Six: Evolution is a Funny Thing

**Editor’s Note:** The final installment of the CCM discussion takes us full circle, as health care professionals from around the world realize what a respiratory therapist is and how the responsibilities we hold here correlate to those abroad.

New Zealand MD #3: (South African MD #1) tells me he is hurt at being ignored in my list of predictions. Leaving aside the veracity of his assertions and my difficulties at verifying them by email, I predict that RTs are rare in South Africa. Perhaps there are a very few. I wonder if the unique schizoid history of health care in South Africa, coupled with the rising expectations of many of the populace and the difficulties of a cash-strapped government, could lead to an opportunity for RTs to occupy a place in South Africa. (I just don’t think many U.S. RTs would want to work there — unless perhaps they were ex-pats wanting to return home.)
South African MD #1: You are right — they do not exist here in Durban as yet, but we are in the process of building this VERY, VERY fancy new academic hospital in Durban. We are turning people away from dialysis etc., etc., yet we are building the golden cow?! The public service nursing services have not collapsed, but the standard of nursing has changed radically over the last few years. Aside from that there are many nurses who have been trained in my unit and who are now scattered to all four corners of the globe — I can think of four in Australia/New Zealand at this moment. Because of this we have now introduced, with the permission of the authorities, the concept of the “Critical Care Technologist.” As for being regarded as a replacement for doctors, the government in its wisdom has slapped a moratorium on all registered doctors from the UK, NZ, Australia, etc. Now, given the fact that 70% of doctors working in rural areas here are foreign trained, this is disaster. So, I doubt it will be too long before the government recognizes the value of these individuals in replacing various medical and nursing personnel.

Canadian RN #1: I work in a busy invasive coronary intensive care unit in a large teaching hospital in Toronto. Without respiratory therapists we would be lost. I certainly am not proud of this fact; but it is true nonetheless. Our cardiologists, residents, and nurses are often lost when it comes to ventilating and/or weaning patients. The heart seems to be the only organ they know how to deal with.

We frequently deal with patients in our unit who are ventilated, have PA catheters, intra-aortic balloon pumps, inotropes, vasodilators, and CAVHD. Without the input of our skilled RTs many of our patients would either be over-ventilated far too long or inappropriately extubated too early.

I can’t tell you how often ABGs are looked at only for pO2 levels and not for pCO2, pH, and bicarbonate levels. Most of our patients are on Furosemide infusions and have bicarb levels through the roof. Many times our staff cannot appreciate that we need to normalize the pH before attempting to extubate (in a non-COPD patient). They often do not understand that the patient will not have the drive to breathe when we take the “tube” out. We continually chase K+ levels without any thought to alkalosis contributing to the problem.

This is where skilled RTs come into play to offer their suggestions. Ideally, I believe it should be the RN at the bedside or the resident/staff physician looking out for the patient’s ventilatory health. Unfortunately, where I work we give excellent cardiac care and not so great pulmonary care (in my unit). Therefore, RTs will always have a great value in our CICU.

USA RT #7: You have pretty much just made the point I was trying to make — i.e., just because the systems are “different” from each other does not mean one is automatically superior or inferior. I submit that there may be no single “right” system. You do what works for you. And if you don’t need a respiratory therapist because you are totally available 100% of the time you’re on duty, then that’s wonderful. I am sure nobody wants to force a respiratory therapist on you. But, my friend, it isn’t so everywhere in the world. In your specific situation, they may well not be of benefit to you. But, as (USA MD #5) and others have noted, things aren’t the same in everybody’s units. The fact that a respiratory therapist would be unnecessary in YOUR unit doesn’t mean they would be useless EVERYWHERE.

The respiratory therapy profession wasn’t invented by a bunch of folks who just decided on a whim to invent a new profession and push their way into places where they weren’t needed or couldn’t be of use. Respiratory therapists came about to fill a need, and they do fill a need. The absence of that need in your ICU doesn’t do away with the need that may exist in other ICUs. And, of course, the converse of your statement, “just because the system is the way it is in the U.S. doesn’t mean it is the right system,” is just as true as your statement, “just because the system is the way it is in the Netherlands doesn’t mean it is the right system.”

South African MD #2: (New Zealand MD #3) wonders if we have RTs in South Africa. We have clinical technologists who deal with technology and the patient-technology interface. They service ventilators; troubleshoot and change their circuits, etc., when necessary; set-up transducers and monitors; and troubleshoot problems with these, etc.; but they don’t do intubations, administer nebs, and all the other things that an American RT does. Nurses are such a scarce resource here (many of our units caring for the sickest patients have one trained ICU nurse to two or more patients), and the clinical technologists take a lot of these burdens off them.

Clinical technologists? A rose is a rose, by any other name . . .

Evolving technology and economics are bringing us around.

Interesting that respiratory care protocols should be confused with disease pathways and cookbook medicine, that salaried respiratory therapists should be confused with expensive specialty consultants, or that no one has explored the sensitive subject of the draconian MD reimbursement changes which would truly tend to cast us out of the USA health care system.

Lead, follow, or get out of the way.

Pa rum pa pum pum, me and my drum

United Kingdom MD: The fun of it all — the rich tapestry of life. Thanks for all the messages saying what RTs do. (New Zealand MD #3) says, the docs, nurses, and physios do all of that in many places, and that’s why from where I sit I could not imagine what you did. Evolution is a funny thing.
Decoding lung cancer genes

Researchers at Stanford University have uncovered a group of genes that could distinguish between different forms of lung cancer. The finding, published in the November issue of the Proceedings of the National Academy of Sciences, may help predict individual treatment strategies and someday lead to better lung cancer drugs.

Lung tumors are generally categorized into one of four types: small cell, squamous cell, large cell, and adenocarcinoma. When doctors diagnose a small-cell tumor, they can provide a fairly accurate prognosis. But other tumor types, particularly adenocarcinomas, respond very differently to standard treatment.

To find out whether genetic differences exist between lung tumors, they analyzed RNA from 67 lung tumor samples and six normal lung samples. In most cases, samples that had been assigned to the same category by light microscopy also fell into the same genetic grouping. The adenocarcinoma samples, however, fell into three distinct genetic subtypes. Patients within those subtypes had different outcomes. Patients with a subtype 1 tumor had about 40% survival over a five-year period, whereas none of the patients with subtype 3 survived during that same period. All patients with subtype 2 tumors were still alive at the end of the study.

ED good place to spot adverse drug reactions

A new study finds emergency departments are often the best place to identify adverse and potential drug reactions among the elderly. Canadian researchers found that about 10% of 283 emergency department visits of people 65 years and older were directly related to an adverse drug reaction. About 30% of the patients had potential adverse drug interactions.

The five most frequently found potential adverse drug interactions noted in the study involved the following medications:

- Furosemide and digoxin potentially leading to electrolyte disturbances and arrhythmia.
- Salicylic acid interfering with the antihypertensive effect of beta-blockers by inhibiting renal prostaglandins.
- Salicylic acid decreasing insulin requirements.
- Enalapril and potassium supplements predisposing electrolyte imbalances and arrhythmia.
- Acetaminophen increasing the anticoagulant effect of warfarin.

CD-ROM addresses end-of-life issues

A new CD-ROM developed at Michigan State University is helping people with advanced illnesses address the important issues they face as they approach the end of life.

The resource, “Completing a Life,” is divided into three main content areas:

- Taking Charge: staying active in decisions about health care, family, and everyday living.
- Finding Comfort: easing pain and suffering, and living with dignity at this time of life.
- Reaching Closure: coming to terms with the past, present, and future, and exploring the possibilities for spiritual growth.

A Personal Stories section also features the real-life narratives of people who have confronted terminal illness. To find out more about the CD-ROM, go to: http://www.completinglife.msu.edu

HHS invests $50 million to improve patient safety

HHS Secretary Tommy G. Thompson has released $50 million to fund 94 new research grants, contracts, and other projects to reduce medical errors and improve patient safety. The initiative represents the federal government’s largest single investment to address the estimated 44,000 to 98,000 patient deaths related to medical errors each year.

The six major categories of awards include:

- Supporting Demonstration Projects to Report Medical Errors Data: These activities include 24 projects to study different methods of collecting data on errors or analyzing data that are already collected to identify factors that put patients at risk of medical errors.
- Using Computers and Information Technology to Prevent Medical Errors: These activities include 22 projects to develop and test the use of computers and information technology to reduce medical errors, improve patient safety, and improve quality of care.
- Understanding the Impact of Working Conditions on Patient Safety: These activities include eight projects to examine how staffing, fatigue, stress, sleep deprivation, and other factors can lead to errors.
- Developing Innovative Approaches to Improving Patient Safety: These activities include 23 projects to research and develop innovative approaches to improving patient safety at health care facilities and organizations in geographically diverse locations across the country.
- Disseminating Research Results: These activities include seven projects to help educate clinicians and others about the results of patient safety research.
- Additional Patient Safety Research Initiatives: The remaining projects will cover other patient safety research activities, including supporting meetings of state and local officials to advance local patient safety initiatives and assessing the feasibility of implementing a patient safety improvement corps.

Get It on the Web

Want the latest news from the section in the quickest manner possible? Then access the Bulletin on the Internet! If you are a section member and an Internet user, you can get your section newsletter a week and a half to two weeks earlier than you would receive it in the mail by going to your section homepage at: http://www.aarc.org/sections/section_index.html.

You can either read the Bulletin online or print out a copy for later.

The AARC is encouraging all section members who use the Internet to opt for the electronic version of the Bulletin over the mailed version. Not only will you get the newsletter faster, you will be helping to save the AARC money through reduced printing and mailing costs. These funds can then be applied to other important programs and projects, such as ensuring effective representation for RTs on Capitol Hill.

To change your option to the electronic section Bulletin, send an email to: mendoza @aarc.org.