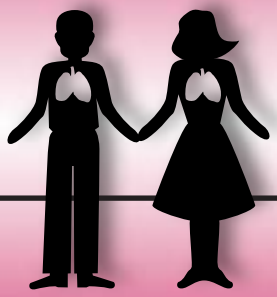

Adult Acute Care Bulletin

Mar./Apr. '01

American Association for Respiratory Care

Notes from the Editor

by Jeff Whitnack RRT

In this issue of the *Bulletin* we are beginning a new series based on a discussion that occurred on the Critical Care Medicine Listserv (CCM-L). CCM-L is an international newsgroup comprised of various critical care participants, including MDs, RNs, RTs, pharmacists, and others. Due to the length of the discussion, we've divided it into several parts and will run one segment in each issue of the *Bulletin* over the course of the year.

The CCM-L web site (http://ccm-l.med.edu/), as well as the CCM-L newsgroup, is hosted by Dr. David Crippen. To get a sense of Dr. Crippen's writing prowess, please visit the web site and click on "Fearless Leader Speaks" to see his collection of extremely entertaining articles. Other archived discussions of interest may be found under headings such as "Classic Cases" and "Clinical Discussions." You can also click on "Subscribe" to sign up to receive the CCM-L newsgroup postings, although I strongly recommend the digest version for email control.

One special note about the discussion: the conversation transcends international boundaries and is perhaps also a bit of a tribute to the legacy of British colonialism. The take-home message for me, and I hope for you as well, is a new appreciation for how much has been placed upon our "table." In many countries, overseeing mechanical ventilation is a task belonging only to the physician — often via a 24-hour intensivist service. Contrary to some popular misconceptions, we are not simply replaced by nurses. To quote one speaker at a seminar I attended, "If you walk into a European ICU at 2 a.m. you will likely see more doctors than nurses." So please keep this in mind as you tune into the discussion and hear the various opinions on how the respiratory therapist can, is, and should figure into the grand scheme of things. ■

Notes from the Chair

by Nick Widder, RRT

If you've just read Jeff Whitnack's "Notes from the Editor," you know that we are launching a new series in this issue of the *Bulletin* based on a discussion that took place on the Critical Care Medicine Listserve (CCM-L) hosted by Dr. David Crippen. The international flavor of the discussion is both refreshing and enlightening. There is indeed a significant difference in the practice of medicine across the Atlantic, where respiratory therapists for the most part don't exist. This difference became readily apparent to me during a recent family trip to Great Britain.

During the trip, I was introduced to a cousin who is a successful ENT surgeon outside London. Through the course of pleasantries that accompany meeting family for the first time, we came to my profession. My cousin had some difficulty understanding my role in the care of the critically ill, since mechanical ventilation tends to lie only under the purview of physicians, with nurses making some of the ventilator manipulations, in Great Britain (In fact, I remember one British nurse who was moving home after being in the States for many years. She was worried that one of her job responsibilities would be to calibrate the Servo 900-Cs between patients.)

As the CCM-L discussion demonstrates, we function as "physician extenders" so that the intensivist's presence is not required at the bedside 24 hours a day. This is a great responsibility, and as those of us who have worked nights and weekends have come to realize, we do function as the eyes and ears of physicians when dealing with their respiratory patients.

This once again demonstrates the need for all of us to maintain a high level of professionalism. I have often noticed that when a new member of the physician staff at our hospital first encounters respiratory therapists from our department, he or she tends to treat them based on the "lowest common denominator"(LCD) among the therapists he or she has dealt with before. The LCD MUST be raised so that we are looked at as an indispensable part of the health care team, not just as an adjunct that allows the American physician to sleep at night. ■

CCM-L Discussion Part One: *Who Needs RTs?*

Editor's Note: The following discussion is being reprinted with permission from the Critical Care Medicine Listserv, and in order to protect the privacy of those involved, all names have been replaced with more generalized identifications. As noted in my "Notes from the Editor," the discussion will be featured in the Bulletin *over the course of the year. Please keep in mind that we enter Part One a bit midstream, when a question about simple protocols soon migrates into a discussion about the validity of even having respiratory therapists at all. I think you'll find the discussion quite interesting and lively. But be forewarned: this thread will not read like a well-organized article! Rather, pretend you are at a party and the conversation is weaving in, out, and around as various participants both enter and leave. And while the initial question leads, in this segment, to some less than vibrant comments as far as RT is concerned, remember that this is just Part One . . .*

USA Surgeon #1: Does anyone have any thoughts, comments, or experiences regarding the benefit (or lack thereof) of clinical protocols for post-operative respiratory therapy, in terms of the frequency of incentive spirometry, percussion therapy, bronchodilators, suctioning, etc.? We are considering standardizing these "interventions" to eliminate the variability and the anecdotal approach.

USA Surgeon #2: Yes, I have some very STRONG thoughts, comments, and experiences relating to clinical protocols, clinical guidelines, practice guidelines, clinical pathways, and all other forms of cookbook medicine. Such lazy and "standardized" habits exist only for the unthinking and those physicians who do not want to exercise any judgment. It is a step backwards to think that all patients are alike and can be treated with a preprinted formula. If such were true, we would be able to practice medicine completely by computer feedback loops.

Every time any of our units revert to such practice guidelines, usually at the insistence of the ICU nursing and quality assurance people, we have some terrible complication or death. The process of discussing such guidelines has great educational value, but when an individual patient is treated, one must use an individual approach . . .

USA RN #1: In graduate school, I was introduced to research-based practice. In bedside nursing, I see a lot of myth-based practice. One of my particular pet peeves is seeing every poor sod who undergoes thoracic surgery subjected to chest physiotherapy. When I try to educate a little about the possible negative side effects of CPT on some patients, I get looks which imply that I really am too lazy to take care of my patients the "correct" way. I have seen patients obviously in bronchospasm being chest PT'd, posturally drained, and encouraged to "cough, cough, cough." As a person with asthma, I become short of breath just watching.

French MD #1: I have NO problem with the process of developing protocols. Even in the evidence-based medical Alice's world, it's better to do something than nothing.

South African MD #1: (Quoting USA RN #1 from a previous post), ". . . Dr. X routinely remembers to order incentive spirometry and appropriate activity levels for his patients, and this is evident in outcomes that are equal to or better than average. Dr. Y, on the other hand, forgets these items (does he think that we perform them automatically, without an order?), and his patients languish in the ICU until they develop pneumonia and end up on the vent, with a prolonged ICU and hospital LOS and higher mortalities."

Why do you need an order to wean the patient? Surely the object of any teamwork is to try and pull together in order to do the best for the patient. It can serve nothing to stand on your dignity and say, "I didn't wean the patient because the order was not written." You, yourself, have said that this failure to wean leads to pneumonia, etc., etc., so in essence you are allowing a situation to develop because you are more worried about "turf" than the patient.

(Quoting USA RN #1), "In these days when we 'ship them in, ship them out,' it is beneficial for the health care team to follow the same general plan. A 'cookbook' approach to patient care is not the answer, but consistent guidelines can be helpful, albeit, protocols, clinical pathways, etc., have their problems and are not cure-alls. If the majority of patients can benefit from them, it seems the focus should be on identifying the outliers and individualizing care for them."

It seems to me that you need a protocol/guideline/cookbook whatever to direct your every reasonable action. What sort of care is that?

(Quoting USA RN #1), "While protocols and the like may be 'lazy' medicine for some, it need not be for all. Practitioners at the bedside are more likely to feel comfortable with evidence-based medicine and the use of appropriate methods for patient care than 'whatever Dr. Z usually does.'"

If Dr Z. was a caring individual, keeping up with the literature as reasonably as possible, giving thought to the problems of the unit, then I suspect everybody would feel comfortable with "whatever he does."

Clearly this is far from the usual case.

South African MD #1: (Quoting a previous USA MD post), "It is no secret as to why they (protocols) work: they cause health care workers to be physically present in the ICU and they push the patient towards extubation."

If that is the reasoning behind the need for a protocol, then I am on (USA Surgeon #2)'s side every time.

(Quoting USA RT), "The residents cannot abandon the weaning process to the respiratory therapist, or they get a good butt whipping."

I'm staggered that they should think that way in the first place!

(Quoting USA RT), "The protocols sim-

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ply emphasize the importance of ventilator management and assure that everyone is on the same page — that page is to move the patient towards extubation. The concept that 5 p.m. is too late in the day to make vent changes has disappeared."

I am astounded and appalled that people should require a protocol to drive these simple issues. That a protocol should be required to keep people in the unit defies description. That a trained physician, who presumably carries ultimate responsibility for the patient, should allow himself to be dictated to by the respiratory technologist is akin to the drummer boy ordering the general to muster his troops.

That a situation existed wherein extubation could not take place after 5 p.m. is astounding.

South African MD #1: (Quoting a previous post by an MD), "No protocol or pathway or whatever you like to call it will replace information collection, thinking, processing, and responding to ever-changing patient conditions and needs. Well-researched protocols will provide guidance for the direct care staff when the intensivist is not there to respond appropriately."

First part, OK. Final lap — nahhh!

Why should the protocol be necessary when the intensivist is away? Does the staff instantly forget what to do just because he/she is away? Do the corporals forget how to do a drill or fire a gun when the sergeant is away? This smacks somewhat of the expression that, "when the cat's away the mice do play." Turning patients should not require an order, and when there is a broken neck the staff should not have to refer to a protocol which says, "if neck broken then log roll."

. . . If I leave, the unit doesn't fall apart.

Indian MD #1: (Quoting a previous USA MD post about protocol use to reduce vent LOS), "Our vent time has been cut in half so far, with decreased length of stay in ICU and in hospital."

I find this intriguing. In my humble opinion, the patient will wean, whatever mode or protocol one uses, once the primary problem necessitating ventilation is adequately reversed. If the vent time is cut in half, would it be reasonable to infer that you were previously ventilating them well beyond the period that mechanical ventilation was really required?

(Quoting from previous USA MD posting), "Reintubation rate is slightly down. Mortality the same. I have not looked at pneumonias yet. Data is going to be presented at upcoming respiratory therapy meetings and our state surgical meeting." Why do you think that that reintubation rate is actually less? Is it just a patient selection bias, or does increased vent time actually create pulmonary problems that necessitate reintubation? We are in the process of analyzing our actual reintubation rates and consequences. We plan to do this for 1000 consecutive patients. Currently, of 700 patients, 23 have been reintubated. Is this about average? Was it more or less in your series?

(Quoting from previous USA MD posting regarding protocols), "It is no secret as to why they work: they cause health care workers to be physically present in the ICU and they push the patient towards extubation. While it is absolutely true that you cannot cookbook weaning, you can have an algorithm set up to allow flexibility. Ours is definitely a group effort between respiratory therapist, nurse (a key element, as to assure proper sedation and pain management), and residents/attendings. The residents cannot abandon the weaning process to the respiratory therapist or they get a good butt whipping. The protocols simply emphasize the importance of ventilator management and assure that everyone is on the same page — that page is to move the patient towards extubation."

I agree with the above approach completely. Broad-based protocols implemented by doctors, respiratory techs, and nurses ensure that decisions are not unnecessarily delayed.

(Quoting from previous USA MD posting), "The concept that 5 p.m. is too late in the day to make vent changes has disappeared." Agreed. However, I am still reluctant to extubate a short-term patient after 2200-2300 and a long-term patient after 1700. The decision to extubate beyond this time will depend on how badly the patient is tolerating the ETT and on the experience of the on-call resident of that shift.

USA MD #1: (Quoting a previous MD post), "We have started using a true weaning protocol in one ICU, and it is being expanded gradually to include up to eight hospitals." Would you be willing to share your protocols with the list, if not proprietary, or other issues with those responsible for development?

USA RT #1: We have done something similar. I have written two protocols, one for short-term patients (<72 hrs) and one for long-term, (>72 hrs). The short-term protocol contains two phases: a management only area and a weaning area. Physician approval is needed to move into the weaning phase. Without that approval, the respiratory therapists manage the patient's ventilation until such approval is forthcoming.

This has worked well here, and both our short-term and long-term ventilator length of stay numbers are down.

The real reason is consistency. I have slightly less than 100 therapists here who all do hands-on patient care. I also have seven adult ICUs complete with their own specific patient populations. Add to the mix 300+ physicians with ventilator management privileges (and no intensivists) and you get a glimmer of the picture.

Our respiratory protocols contain criteria that cover only those alterations in care that local physicians have agreed should always occur when protocol criteria are met. The care is altered based upon objective findings specified in the protocols, not based upon individual judgment or therapeutic preference.

USA RN #2: (Quoting previous post by South African MD #1), "Why do you need an order to wean the patient? Surely the object of any teamwork is to try and pull together in order to do the best for the patient. It can serve nothing to stand on your dignity and say, 'I didn't wean the patient because the order was not written.' You, yourself, have said that this failure to wean leads to pneumonia, etc., so in essence you are allowing a situation to develop because you are more worried about 'turf' than the patient."

If this be directed to nursing, I can address it from that standpoint. We need orders because we have been taken to task many times for doing what is needed and not what is written, because we are not covered for liability when we deviate from this legal standard, and because we do not get credit when we do take these things on. When we assume responsibility (consciously or otherwise) for these decisions, we are not being compensated either in additional staffing to meet added demands or monetary compensation for added risk. We are at great risk at this time in our profession and cannot afford to take anything for granted. I don't agree with "protocoling" things to death, but unfortunately, nurses can no longer afford to do things silently to ensure quality outcomes. We've no room to breathe ourselves.

USA MD #3: Wow, you all have certainly stirred up a hornet's nest on the subject of protocols. After reading a couple of days worth of assertion and unsubstantiated hype, let me suggest that one of the educational things that can be culled from CCM-L is to start with what we know and what is at play here. (USA Surgeon #2) is from the old school and (USA Surgeon #1) is singing enterprise efficiency. Both ends of the spectrum require 1) outcomes, 2) inputs, 3) costs or cost/benefit ratio, and 4) an understanding that operative surgery is a form of socialized sterile trauma by appointment upon several sets and subsets of patients. Apply simple algorithms of anesthesia wake up to young road warrior trauma victims without the DTs to those with the DTs or drug withdrawal problems and you will look stupid in (USA Surgeon #2)'s vision. It is easy to devise protocols for the fast throughput patients, and protocols can shave cost without hurting outcomes.

No one is citing the classic papers in respiratory care, and some were published before 1967. So only old cowboys like me can remember. The classic book by Pontoppidan, et al., called Respiratory Care covers a healthy portion of the early work. The surgeon Bartlett developed incentive

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spirometry and laid down some good evidence of the effects on FRC.

Others did the same for IPPB, and Grenvik and others in CHEST made the case for mask CPAP and now BiPAP. All of these are labor intensive, as is proning, the latest addition backed up by CT scanning methods perfected by Gattinoni and applied with zeal and demonstrated outcome improvements by Albert, et al. As in all critical care modalities of treatment, the patients are different and the underlying disease processes exert effect beyond what one studies with the tunnel vision of a single outcome. This does not diminish the value of the protocol for the easy inliers. I work in a very protocolized trauma ICU with busy surgeons, thin house staff, respiratory therapy spread thin, etc. My approach is a blend between (USA Surgeon #1) and (USA Surgeon #2). If you start with Shoemaker's famous quote, "protocols do not promote excellence but may prevent disaster," you will see that (USA Surgeon #2) and most American trauma surgeons follow very strict trauma resuscitation and management protocols in the emergency room. Even there the astute judgment of the experienced attending is mandatory.

In post operative respiratory care I begin with the simple maxim that, "patients have no obligation or duty to adhere to a protocol." But with time, we learn how to continuously improve the protocol. Most of these protocols require an appreciation of what kind of patients we treat. CV surgery basic trauma are basically homogenous, as is basic standard COPD care after abdominal surgery, as was shown in the '70s by the Beth Israel group in Boston (see Applied Physiology in Respiratory Care, Hedley-Whyte, et al.). Progress, pace of change, and weaning schedules require judgment at a higher level. And APACHE III does not capture hypermetabolism in trauma patients, as we found when we studied the ventilator outliers. It took six trauma centers in the APACHE III UHC benchmark study to raise this question, and we at least came up with some answer as to why the regular protocols we have don't apply. This requires a lot of data, and that carries a price — which brings us to the winter of (USA Surgeon #2)'s discontent.

Protocols need continuous physician and other caregiver inputs. I suggest everybody read the Troyan Brennan and Don Berwick book, New Rules, by Jossy Bass Publishers, 1996. They creep up on the point that economic stress may produce declining quality outcomes. This, I submit, can be studied by protocol-driven analysis with full spectrum outcome assessment (negative outcomes, body bags, whatever you want to label the concern).

There are too many troubles these days, but hopefully the thought of these two keen and capable minds can resonate together for the common interest.

USA MD #3: I agree that you cannot be transfixed by the protocol. Ours is joint between medicine, surgery, and the respiratory therapists (how about that: getting medicine and surgery to agree on something!), and there have been changes made based upon data compiled over time. I think the key is establishing the guideline, collecting the data, and then being willing to change it based upon the data.

USA Surgeon #3: Actually, I think that M. Kollef published something on this subject — Crit Care Med (1997 Apr) 25(4):567-74. He randomized patients to protocol vs. physician-directed weaning from the vent. There was a significant decrease in time off the vent in patients who were on protocol-directed weaning. Reintubation rates were the same. The study included medical and surgical ICU patients.

South African MD #1: (Quoting USA RT #1), "The real reason is consistency. I have slightly less than 100 therapists here who all do hands-on patient care. I also have seven adult ICUs complete with their own specific patient populations. Add to the mix 300+ physicians with ventilator management privileges (and no intensivists) and you get a glimmer of the picture."

Sorry, but this is a little too much. You might just as well say that you are in charge of the whole of the United States.

It is a little sad to think that all those seven ICUs are so dependant on the instructions of a nebulous chief. Because there is no way that any individual doctor can give individual attention to patients in each of those units in the sense that a good doctor can give attention. In other words, you have become an administrator with the same problems as an administrator — problems of cost effectiveness, utilization of resources, client satisfaction, and so on.

Precisely the sort of person who relies upon a protocol!

USA MD #4: There was an editorial in Anesthesia & Analgesia — must be all of 15/16 years ago now — wherein the thrust was that incentive spirometry and all other modalities of respiratory therapy in the post-operative period were only of benefit for the moments they were in place. As soon as the physiotherapist/respiratory therapist left the room, the patient's respiration returned to the same pattern it was in prior to the therapy.

I haven't seen much in the intervening years to improve the situation. No doubt I will be shown the error of my ways.

Watch for the next edition of the CCM-L Discussion in your May-June Bulletin. ■

Early Bird Savings for the 47th International Respiratory Congress

How can you get up to 25 hours of continuing education credit (CRCE) for the lowest possible price? Take advantage of the opportunity for early bird savings by registering now for the AARC's 2001 International Respiratory Congress, to be held this December 1-4 in San Antonio, TX. As the longest running respiratory therapy convention in the world, the AARC's annual show boasts:

- The lowest cost of continuing education per credit of any show, anywhere. And the early bird savings make your costs are even lower.
- The largest and most impressive exhibit hall with the most vendors.
- The largest gathering of respiratory care experts in the world.
- The most diverse and most dynamic series of lectures.
- The largest presentation of original research in the profession by RCPs.
- The most opportunities for YOU to participate in your profession through research and networking.

	By April 15	By Oct 15	After Oct 15
Active Member	$290	$300	$330
Associate Member	$290	$300	$330
Student Member	$135	$140	$145
Non-Member	$430	$440	$465

The following chart provides the registration deadlines and costs for each phase of registration. So secure your low-cost registration fee by signing up to attend today. Registration forms are available in AARC Times magazine, online at www.aarc.org, or by calling the AARC office, (972) 243-2272. Hotel reservation materials will be available soon, and you can learn more about San Antonio, a great holiday destination, at www.sanantoniocvb.com. ■

The AARC Online Buyer's Guide: Your Ultimate Resource for Respiratory Product Information

The AARC Online Buyer's Guide is your ultimate resource for locating product information, company profiles and contacts, and trademarks and brand names.

Since it is updated continually throughout the year, the Buyer's Guide contains the latest information on companies and products. What's more, the Buyer's Guide is your source for information about new product releases. Three main information resources provide you with everything you need to find the products you're looking for: the Company Directory, the Equipment and Supplies Directory, and the Trademarks/Brand Names Directory. Product information is only a click away with our email and URL links, and you can also access unbiased information to assist you in selecting products, such as "Clinical Perspec-tives" articles from AARC Times and peer reviewed articles from the science journal Respiratory Care. The Buyer's Guide is also just one click away from the National Library of Medicine and free access to Medline. Visit the Online Buyer's Guide today at http://buyersguide.aarc.org. ■

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:
May-June Issue: April 1
July-August Issue: June 1
September-October Issue: August 1
November-December Issue: October 1 ■

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 Site Visit Reports

As of the end of February, the section had received the following responses to its request for information about JCAHO site visits:

Hospital
Facility: St. Mark's Hospital, Salt Lake City, UT
Contact: Jack Fried, MA, RRT
Inspection Date: November 10-12, 2000
1. What was the surveyors' focus during your last site visit?
Orientation check lists, annual age specific competencies, annual performance appraisals. There was an emphasis on pain management. Also emphasis on performance improvement.
2. What areas were cited as being exemplary?
Interdisciplinary cooperation and involvement on ICU rounds.
3. What suggestions were made by the surveyors?
Be sure to comply with internal policies. For example, if v/o cannot be consistently signed within time stated in policy, re-evaluate policy.
4. What changes have you made to improve compliance with the guidelines?
No answer.
Additional comments: On every unit the surveyor asked about the role of the RT in the hospital. They wanted to know if responsibilities were shared (i.e., do other disciplines draw blood gases? Under what circumstances do RTs intubate?).

Facility: Carondelet Holy Cross Hospital
Contact: Traci L. Burqkwist
Inspection Date: October 30-November 1, 2000
1. What was the surveyors' focus during your last site visit?
Assessment of pain, patient/family education, multidisciplinary care approach to all aspects of care
2. What areas were cited as being exemplary?
Interdisciplinary care plans, teaching tool, focused charting process
3. What suggestions were made by the surveyors?
That we work on multidisciplinary assessments and continue to develop pain assessment, since the new standards went into effect in 2001.

Specialty Practitioner of the Year

Don't forget to make your nominations for the 2000 Perinatal-Pediatrics *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 Perinatal-Pediatrics *Specialty Practitioner of the Year* because

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Nominee	***Your Name***
______________________	______________________
Hospital	Hospital
______________________	______________________
Address	Address
______________________	______________________
City State,Zip	Your Name
______________________	______________________
Phone	Phone

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

call for abstracts

RESPIRATORY CARE • OPEN FORUM 2001

The American Association for Respiratory Care and its science journal, RESPIRATORY CARE, invite submission of brief abstracts related to any aspect of cardiorespiratory care. The abstracts will be reviewed, and selected authors will be invited to present posters at the OPEN FORUM during the AARC International Respiratory Congress in San Antonio, Texas, December 1-4, 2001. Accepted abstracts will be published in the October 2001 issue of RESPIRATORY CARE. Membership in the AARC is not required for participation. All accepted abstracts are automatically considered for ARCF research grants.

SPECIFICATIONS—READ CAREFULLY!

An abstract may report **(1) an original study, (2) the evaluation of a method, device or protocol, or (3) a case or case series.** Topics may be aspects of adult acute care, continuing care/rehabilitation, perinatology/pediatrics, cardiopulmonary technology, or health care delivery. The abstract may have been presented previously at a local or regional—but not national—meeting and should not have been published previously in a national journal. The abstract will be the only evidence by which the reviewers can decide whether the author should be invited to present a poster at the OPEN FORUM. Therefore, *the abstract must provide all important data, findings, and conclusions*. Give specific information. Do not write such general statements as "Results will be presented" or "Significance will be discussed."

ESSENTIAL CONTENT ELEMENTS

Original study. Abstract *must* include (1) Background: statement of research problem, question, or hypothesis; (2) Method: description of research design and conduct in sufficient detail to permit judgment of validity; (3) Results: statement of research findings with quantitative data and statistical analysis; (4) Conclusions: interpretation of the meaning of the results.

Method, device, or protocal valuation. Abstract *must* include (1) Background: identification of the method, device, or protocol and its intended function; (2) Method: description of the evaluation in sufficient detail to permit judgment of its objectivity and validity; (3) Results: findings of the evaluation; (4) Experience: summary of the author's practical experience or a lack of experience; (5) Conclusions: interpretation of the evaluation and experience. Cost comparisons should be included where possible and appropriate.

Case report. Abstract *must* report a case that is uncommon or of exceptional educational value and must include (1) Introduction: relevant basic information important to understanding the case. (2) Case Summary: patient data and response, details of interventions. (3) Discussion: content should reflect results of literature review. The author(s) should have been actively involved in the case and a case-managing physician must be a co-author or must approve the report.

FORMAT AND TYPING INSTRUCTIONS

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