Adult Acute Care Bulletin

March/April '99

Notes from the Editor

by Nicholas Widder, RRT

Respiratory therapists lost a friend in January. W. Joseph "Joe" Mesick, MD, was one of the six full time trauma surgeons on staff at my institution, Carolinas Medical Center in Charlotte, NC. But more than that, Joe was one of respiratory therapy's quiet supporters.

Joe was born on July 17, 1954, in Mocksville, NC. He graduated from the University of North Carolina at Chapel Hill and from the UNC Medical School. He completed his surgical residency at Strong Memorial Hospital in Rochester, NY, and went into private practice in Banner Elk, NC. Five years later, Joe completed a fellowship in trauma and critical care in Chapel Hill. He joined our staff nine years ago.

In addition to authoring numerous scientific papers and serving as the medical director of the trauma ICU, Joe was the medical director of the respiratory care program at Stanley County Community College, one of two respiratory programs in our community. Joe made arrangements to allow students to round with the trauma team, bringing them into the "fold" by including them in discussions of ventilator management with the rest of the team. He would often use the students to assist him in teaching his residents by having them answer questions that residents had answered incorrectly. Joe would engage the staff therapists in similar discussions with the residents, in his own quiet way validating us as an integral part of the team.

In my own career, Joe played a small, but significant role. He was there the first time I set up independent lung ventilation and the first time I set up an ultra high frequency jet ventilator. We had many discussions about high PEEP versus inverse ratio ventilation. Joe asked me to moderate a physician panel discussion at a multi-disciplinary critical care conference on mechanical ventilation of the ARDS patient. Joe was also the president of the Virginia-Carolina chapter of the Society of Critical Care Medicine and was partially responsible for my joining that organization. He personified the concept of a team approach to critical care.

Last year Joe developed a dilated cardiomyopathy after a viral infection. He ended up on the transplant list, had a short time on the ventilator after he developed congestive failure, and finally ended up being flown to New York, where he was entered in an experimental protocol. Joe's absence from the trauma service was noted by all. After many weeks, Joe returned to Charlotte but remained out of work on disability. Eventually, rumors of his return started to circulate through the hospital. He was spotted visiting on several occasions and finally returned part time, essentially as a visiting professor.

After his return, Joe decided to share his experiences with his colleagues. He presented grand rounds, where he discussed his illness, his medical care, and his convalescence. He went into great detail about his experiences, explaining that while the grand scheme of his care had been planned by his physicians, his actual care had been driven by his bedside care team, including nurses and respiratory therapists. It was eye-opening for most of the residents and yet another validation for those of us in the trenches. Joe, who had always made a point of humanizing all of his patients to the staff, became even more active in this regard. He added a kind, caring touch to the dehumanized world of high-tech medicine.

Joe finally got back to doing the things he loved. He went back to his gardening, back to coaching youth soccer, and eventually, he came back to the trauma service full time. Joe once again was able to add his calming voice and demeanor to the often-frenetic activity in both the trauma room and the ICU.

One day it ended. Joe came through the unit to round on a few of his sickest

"Notes" continued on page 2

American Association for Respiratory Care

"Notes" continued from page 1

patients. He was not feeling well and was going to go home. Instead, he ended up in the cath lab, then the OR, and finally in the cardiovascular recovery unit. I ended my professional relationship with Joe by helping to manage his ventilator. While it may somehow seem fitting, I do not recommend it as a way to say good-bye to a friend.

While Joe may not have been known nationwide by respiratory therapists, his absence will be felt by many. He allowed my chosen profession to be used to its fullest in his presence and brought forth our value as members of the health care team to another generation of physicians. He will be missed greatly. ■

Bylaws Changes Hold Implications for Sections

by Lynn Smyrk, RRT, La Crosse, WI

At the annual meeting in Atlanta, GA, the second reading of the proposed bylaws was approved by both the House of Delegates (HOD) and the Board of Directors (BOD). The new bylaws will go into effect on December 14, 1999. The following article discusses what these changes will mean to the Specialty Sections.

Adult Acute Care Bulletin

is published by the
American Association for Respiratory Car e
11030 Ables Lane
Dallas, TX 75229-4593
(972) 243-2272
FAX (972) 484-2720
e-mail: info@aarc.org

Kelli Hagen
AARC communications coordinator

Debbie Bunch
Bulletin managing editor

Edwards Printing
Bulletin typesetting

Section Chair
John M. Graybeal, CRTT
(717) 531-8568
FAX (717) 531-4110
e-mail: rabbitfarm@yahoo.com

Chair Elect
Dennis Hastings, RRT
(409) 772-8190

Medical Advisor
Frederick A. Oldenburg, MD (ACCP)
(207) 942-6096

Bulletin Editor
Nicholas Widder, RRT
Lead Therapist, Department of Respiratory Care
Carolinas Medical Center
PO Box 32861
Charlotte, NC 28232
Phone (704) 355-2389
Fax (704) 355-8185
e-mail: NAWidder@aol.com

Board of directors

The BOD will consist of at least 18 members (currently there are 15). In addition to six officers, there will be six "directors-at-large" who are nominated by the HOD and elected by the general membership, and six "specialty section directors." If the number of specialty sections increases to more than six, the number of directors-at-large will also increase and so will the size of the BOD. If the number of specialty sections decreases to less than six, the number of at-large directors will increase to maintain a minimum of 18 board members.

Specialty section directors

The active members of each specialty section will elect a chair-elect every third year. The chair-elect will serve a one year term and then succeed to the chair of the section for a term of three years. A seat on the BOD will be granted to those specialty sections consisting of at least 1,000 active members. Nominations for the section chair-elect will come only from members of that specialty section. Nominations for directors-at-large will come only from the HOD. All nominees will be screened by the Elections Committee.

The screening of candidates by the Elections Committee seemed to be a bone of contention at the section meeting in Atlanta. Apparently, some feel that the screening of candidates puts all the "power" into the hands of a few and perpetuates the "good old boys" network.

This is how the process works: The Elections Committee is composed of five members. Three are nominated and elected by the HOD and two are nominated and elected by the BOD. They do not have to be members of those bodies (although they often are); they are simply nominated and elected by the HOD and the BOD. The chair of the committee is chosen by the HOD.

Once a candidate is nominated for the position of director-at-large, he/she is "screened" by the Elections Committee for the following qualifications. (Qualifications of section directors *have not* been clearly defined at this point but will probably be *similar* to the current requirements for directors.) They are:

1. Must be an active member of the AARC.
2. Must have served at least three years in a leadership role in a chartered affiliate, or must have served at least two years as an Officer or Delegate or Alternate Delegate of a chartered affiliate, or must have served as a member of the Board of Directors or Officer of the AARC.
3. Must have an employer that is supportive of the obligations and time commitments inherent to the office:
   a.) a minimum of 14 calendar days absence for Association meetings.
   b.) frequent telephone and written communication with Association leadership.
   c.) other time away from work as necessitated by Association business, activities, or projects.

For this system to be effective there must be a basic foundation of trust in the idea that the individuals elected to office are representing the people who elected them. Affiliate members elect their own delegation and section members elect their own chairs. Some of these same people are then elected to serve on the Elections Committee.

Unanswered questions

There are still a lot of unanswered questions regarding the specialty section directors. Of particular concern is the requirement that sections must have 1,000 active members in order to hold a seat on the board. Currently only the Acute Care, Pediatrics, Management, Home Care, and Subacute Care Sections have enough active members to hold board seats. So, the following questions remain unanswered:

"Bylaws Changes" continued on page 3

"Bylaws Changes" continued from page 2

- Should sections be combined?
- When will the official 1,000 member tally take place?
- What if a section falls below the 1,000 member limit during the three year term of the elected director?
- How long does a section have to hold 1,000 members?
- How long will sections with fewer than 1,000 members continue to be sections?
- Who will decide to dissolve or create sections?

Transition Committee

To address these issues and to develop a plan that will put the new bylaws into effect, AARC President Dianne Kimball has appointed a Transition Committee. Members of this committee come from both the HOD and the BOD. The committee is chaired by Past President Cindy Molle. If you have any suggestions for this committee, please contact your delegate, Dianne Kimball, or Cindy Molle. ■

FYI . . .

Patients have key concerns about end-of-life care

University of Toronto in Ontario researchers who combined the results of interviews from three recent studies that examined the quality of end-of-life care from a patient's perspective found five main areas of concern:

- 61% of patients want to avoid a drawn-out death, and many are afraid of "lingering" and "being kept alive" after they can no longer enjoy their lives.
- 39% of patients would like to strengthen their relationships and communication with loved ones throughout the end-of-life experience.
- 38% of patients want to have a sense of control over the care they receive and the choices that are made about their care.
- 38% of patients are concerned about the burden that their illness will place on their loved ones; specifically, providing physical care, witnessing their death, and being asked to make life-sustaining treatment decisions for the patient.
- 22% of patients are concerned about getting proper pain relief and symptom management.

The authors suggest that these five areas of concern could provide a useful checklist that could be easily used at the bedside to review the dying patient's quality of care and clarify the goals of treatment.

Dutch population suffering from lung function decline

Dutch investigators who studied 1,155 people age 25 to 70 found that more than 52% (604 persons) showed symptoms of previously undiagnosed COPD or asthma during a health screening. Of those with symptoms, 384 agreed to participate in a two-year follow-up monitoring project. In this group, more than 20% showed either a persistently reduced or a rapid decline in lung function. More than 19% of the remaining participants showed objective, mild signs of COPD or asthma.

According to the investigators, the "two-stage detection program revealed that a large proportion of the general undiagnosed population showed symptoms and objective signs of COPD and asthma." To support their initial screening criteria, a random sample of 200 additional persons who tested negative was followed for 3.6 years. None of those individuals were diagnosed with either COPD or asthma during that time period. (American Journal of Respiratory and Critical Care Medicine, 12/98)

Experimental antibiotic kills drug-resistant bacteria

Brown University researchers have found that an experimental antibiotic called moxifloxacin can kill six strains of drug-resistant bacteria that cause respiratory tract infections in a single dose, with no regrowth of the bacteria. The strains include those resistant to penicillin and erythromycin.

"The findings suggest that moxifloxacin should be useful in treating infections caused by Streptococcus pneumoniae bacteria, which are susceptible to treatment with, yet resistant to, penicillin and erythromycin," says Stephen Zinner, MD, professor of medicine. Zinner presented the results of the study last October at the Interscience Conference on Antimicrobial Agents and Chemotherapy, and the model was described in two papers in the journal *Antimicrobial Agents and Chemotherapy* in November. (Brown University)

Respiratory nurses set research priorities

A Task Force of the Nursing Assembly of the American Thoracic Society (ATS) has prepared an official statement on Research Priorities in Respiratory Nursing that has been endorsed by the ATS board of directors. The statement highlights research needs in three areas: "Health Promotion and Disease Prevention," "Therapeutic Strategies: Acute Care," and "Therapeutic Strategies: Chronic Care."

In the "Health Promotion and Disease Prevention" section, the report stresses that tobacco use reduction is the single best way of lowering illness and death from emphysema, chronic bronchitis, and lung cancer. The report calls for research aimed at:

- Preventing tobacco use among children and adults.
- Designing and testing effective cessation programs.
- Developing cessation methods that adequately address the problems encountered by socioeconomically disadvantaged, under-served, and culturally diverse smokers.
- Determining the risk factors for pulmonary complications such as lung collapse, acute respiratory distress syndrome, and pneumonia.

In "Therapeutic Strategies: Acute Care," the Task Force focused on patients using ventilators for seven days or longer, saying that studies are needed to:

- Facilitate the weaning process for those on long-term ventilation, emphasizing high-risk patient needs, the appropriate ventilator mode, and clinical decision-making by the acute or subacute care team.
- Simplify end-of-life decision-making by identifying actions that will support families as they consider withdrawing or withholding treatment.
- Ensure that patients are comfortable and free from pain at the end of life through support efforts by special care

"FYI" continued on page 4

"FYI" continued from page 3

teams and the appropriate use of narcotics and sedatives.

In "Therapeutic Strategies: Chronic Care," studies of asthma, COPD, lung transplantation, sleep apnea, TB and HIV infections, bronchopulmonary dysplasia, and cystic fibrosis are discussed. The report calls for studies on:

- Interventions connected with exercise therapy and the coaching of patients to control COPD through effective pulmonary rehabilitation, as well as those aimed at increasing COPD patients' appetites and intake of nutrients.
- Effective strategies to educate both patients and providers about the signs and symptoms of sleep disorders in adults and children.
- The risk factors associated with drug resistance to TB, including HIV infection, socio-demographic factors, treatment history, and the quality of the TB control program.
- The physiologic, developmental, and psychological outcomes of infants with bronchopulmonary dysplasia (BPD).
- Effective disease management techniques for cystic fibrosis patients, along with coping strategies for these patients as they await further treatment breakthroughs.
- The efficacy of comprehensive pulmonary rehabilitation and specific interventions for children and adults with restrictive lung disease and alpha-1 antitrypsin deficiency.

(American Journal of Respiratory and Critical Care Medicine, 12/98) ■

AARC Provides Travel Resource for Oxygen Dependent Patients

The American Association for Respiratory Care (AARC) is proud to announce the Breathin' Easy Travel Guide. The Guide has been in publication for the past two years, and now, the updated 1999 edition is available. Breathin'Easy founder Jerry Gorby, oxygen dependent himself, developed the Guide to make traveling easier for oxygen dependent patients.

The Breathin' Easy Travel Guide has served as an excellent resource for traveling oxygen users and also for the home care providers and therapists who work with them. Updated annually, this Travel Guide is a "must have" reference book for every oxygen dependent patient. It lists information on oxygen refill sites throughout the United States and also provides helpful travel tips for oxygen patients.

One oxygen dependent patient, John S., recently told us about his 4,172 mile cross-country driving trip. "I had my liquid oxygen tank filled by five different providers, four of which came to my attention in the Guide. The Guide made planning the trip quite easy, and I'm grateful to you for producing it."

Also, be sure to visit the new Breathin' Easy website, http://www.breathineasy.com (or oxygen4travel.com). Already visitors like Cheryl V. are singing its praises. "Kudos to the AARC for developing the new website for traveling with oxygen . . . I will be passing it on to all O2 patients as a way of encouraging them to get moving," she says.

Be the first one in your area to take advantage of promotional opportunities available with the Breathin'Easy website and printed Travel Guide. For more information about getting listed in the Breathin' Easy Travel Guide, contact Jerry Gorby at 707/252-9333, or to purchase a printed guide ($19.95 + $4.65 s&h), call 972/406-4663. For more information about promotional opportunities on the Breathin' Easy website, http://www.breathineasy.com (or oxygen4travel.com), contact Tim Goldsbury by e-mail (goldsbury@aarc.org) or by telephone at 561/745-6793. ■

Patient Assessment Course:Back By Popular Demand

Earn 16 hours of CRCE credit and learn how to:

- Function as a member of an interdisciplinary care team.
- Determine the patient's physical condition, assess the patient's needs, monitor and evaluate services and outcomes, and document services and activities.
- Look at the whole person,including family life, living conditions, work situation, and leisure activities in relation to the disease state of the patient.

Philadelphia	**April 30-May 2**
Phoenix	**July 18-20**

For more information about this excellent continuing education opportunity, contact the AARC at 972/243-2272.

Review of CPGs

The AARC Clinical Practice Guidelines Steering Committee would like your help in revising the Clinical Practice Guidelines (CPGs).We need the respiratory community to identify specific areas of the CPGs for revision. Note that the CPGs are evidence based; therefore, please identify areas for revision, provide suggestions for revision, and cite peer reviewed literature to support those suggestions.

Please e-mail your specific comments to the chair of the Steering Committee, Dean Hess, PhD, RRT, FAARC, at dhess@partners.org or fax them to 617/724-4495.

You will find copies of all the CPGs published by the AARC at: http://www.rcjournal.com/online resources/cpgs/cpg index.html