



Neonatal Pediatrics

May / June 2002

Bulletin

Notes from the Chair

by Timothy R. Myers BS, RRT

As you can see from the front page of this Bulletin, your section has a new name. At their March meeting in Dallas, the AARC Board of Directors (BOD) approved a motion by the section to change our name from Perinatal-Pediatric to Neonatal-Pediatric.

The name change came about after a section member at the Annual Business Meeting at the International Congress in San Antonio last December pointed out that the term "neonatal" was more reflective of our daily practice in neonatal respiratory care than the term "perinatal," which refers more to perinatal medicine. Section members also felt that the name change would fit better with an acronym being considered by the National Board for Respiratory Care for a proposed credential for those who pass the Neonatal-Pediatric Specialty Exam. We are pleased that the BOD listened to our concerns and affected the name change.

By the time this edition of our newly-named Bulletin comes to many of you, we will be well into the summer months. Unfortunately, this season is frequently referred to as "trauma season" at many children's hospitals across the country. The mix of sunny days and warm weather coincides with an increase in motor vehicle accidents and near drownings. This is also the time of year when most children's hospitals have an increase in surgical activity. In tune with that theme, this edition of the Bulletin contains an exciting article by Alan Roth regarding medical/surgical missions for pediatric heart patients overseas.

As many of you are aware, every year each of the AARC Specialty Sections sponsors a Specialty Practitioner of the

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Notes from the Co-Editor

by Melissa K. Brown, RCP, RRT

In this issue of the Bulletin we have an excellent article by Alan Roth, of Mount Sinai Medical Center in New York. In "Respiratory Care Goes Global: Medical Missions Overseas," Alan describes his experiences coordinating and recruiting respiratory therapists to serve as anesthesiologist assistants for medical missions to Guatemala, China, Russia and the Dominican Republic. I found this article particularly interesting because not only is Alan providing essential care to children who need it, through these efforts he is also promoting our profession.

I have often wondered as I read or watched news stories about medical teams dispatched from the U.S. why RTs were generally not included. Alan took this question one step further and actively pursued a place for therapists on overseas medical missions. As he illustrates, we RTs often have to prove we have something to offer.

Our problem seems to lie with the fact that we have no clear identity. How many times have we all heard the question: What is a respiratory therapist? And this problem is not restricted to the general public. Often other medical disciplines - including nursing and physicians - have little knowledge about our education, training and background. I, personally, have had conversation with RNs who were shocked to find out that RTs take courses in anatomy and physiology, microbiology, pharmacology, physics, etc. And that we also have detailed course work in hemodynamic monitoring, chest tube management and chest x-ray interpretation, and practiced skills such as intubation and line placement. It is no wonder that Alan and his team had to prove they could be valuable members of the OR team.

Those of you who work in a teaching facility with residents and fellows have a great opportunity to make a lasting impression and shape how new physicians view RTs. Often they come to the NICU or PICU with little or no knowledge of ventilator or airway management and are promptly left alone all night with a unit full of ventilated children. Many are relieved to find a skilled RT at the bedside who can show them the ropes. Of course, others are more resistant to our advice, either because they are not aware of our skills or because they believe that, as the physician, they should have all the answers.

I remember one fellow I worked with, who had no previous ICU experience but would bark out orders at night for all sorts of wild things, such as "give Albuterol for 'wheezing'" (when the problem was a large leak around the ETT). He was overly confident, and often the RTs would have to go toe-to-toe with him. We constantly asked him what the indication was for the therapy he had just ordered. As a last resort we would downright refuse to give a therapy and sometimes threaten to call the attending physician at home. But throughout his fellowship we made an active effort to teach him all we knew about respiratory care and to demonstrate how we could help provide the best care for his patients.

In the third year of his fellowship he was orienting a new first year fellow who was taking on-call alone that night for the first time. I just happened to be standing behind them in the nurses' station. When the new fellow expressed concern about the 16 ventilated patients in the unit and his lack of knowledge in this area, this gentleman, who had given us so many problems when he was new, told him, "Don't worry - just call the respiratory therapists and they'll tell you what to do."

I couldn't help but feel proud of the positive impression we had made, which directly resulted in his dramatic change in attitude towards RTs. The next year he moved on to an attending job in another unit. I'm confident he looks to the RTs in his new facility to be an integral part of his team.

My point is that every contact we make, whether it be with an RN, MD, or member of

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Section Connection

GET IT ON THE WEB:

Help the AARC increase its efficiency by signing up to receive the Bulletin via the section homepage on the AARC web site (www.aarc.org). To change your option to the electronic Bulletin, send an email to: mendoza@aacrc.org.

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Please consider sharing information about your most recent site visit by filling out the form on the AARC web site found at the following link: www.aarc.org/members_area/resources/jcaho.asp.

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American Association for Respiratory Care

11030 Ables Lane

Dallas, Texas 75229-4593

(972) 243-2272

FAX (972) 484-2720

e-mail: info@aarc.org

Chair & Editor

Timothy R. Myers, BS, RRT

Pediatric Administrative Manager,

Dept. of Respiratory Care

Rainbow Babies & Children's Hospital

Asthma Clinical Studies Coordinator,

Dept. of Pediatrics

Case Western Reserve University

11100 Euclid Avenue #6020

Cleveland, OH 44106

(216) 844-1954 • FAX (216) 844-5246

timothy.myers@uhhs.com

Co-Editors

Melissa K. Brown, RCP, RRT

NICU Clinical Specialist

Pulmonary Services

Sharp Mary Birch Hospital for Women

3003 Health Center Drive

San Diego, CA 92123

(p/vm) 858-493-1636 • (fax) 858-541-3343

melissa.brown@Sharp.com

Kathleen Deakins

Rainbow Babies & Children's Hospital

11661 Mayfield Rd

Chardon, OH 44024

(440) 285-5022

kathleen.deakins@uhhs.com

Resource Panel

Mike Czervinske, RRT

University of Kansas Medical Center

Department of Respiratory Care Education

3901 Rainbow Blvd.

Kansas City, KS 66106-7606

(913) 588-4631 • FAX (913) 588-4631

mczervin@kumc.edu

Respiratory Care Goes Global: Medical Missions Overseas

by Alan Roth, MS, MBA, RRT, FAARC, director of clinical operations; clinical instructor, school of medicine, department of anesthesiology, Mount Sinai Medical Center, New York, NY

When I started going on medical missions for Heart Care International almost ten years ago, my involvement with the organization, team members and country representatives was really an afterthought. Often during the planning phase I was told that the organization, which sends medical professionals to countries in the developing world to perform pediatric open heart surgeries, would rather have another ICU or OR nurse as part of the skill set instead of an RT. Their rationale was that respiratory care at their institutions (pediatric cardiac ICU, PICU, NICU) did not manage the ventilators. The nurses did that, and they could "flip dials." After all, what else does a "tech" do? Many had not had a single positive experience with a respiratory therapist or any idea of what we do or how positive we could be on a mission.

By 1994, however, I had convinced the group to allow me to participate on a new pediatric cardiac team being formed to go to Guatemala. It was to be a special team, as the organization had committed to a five-year plan for training/educating staff and helping with the creation of a heart program in that country. The mission was to be documented by a group of photographers and U.S. television crews.

On the first operating day, we had major complications with equipment and patients. And on that day, respiratory care became forever linked with these missions, and never again did anyone question our necessary place alongside the rest of the team. Since then, we have gone to China, Russia and the Dominican Republic, as well as back to Guatemala.

RTs are used on these missions as anesthesiologist assistants to assist the anesthesiologist in starting the preanesthesia/postanesthesia portions of the case. This includes several broad categories:

- See the patient, elicit significant history for anesthesiologist.
- Establish arterial lines.
- Transport the patient from the holding area to the operating room.
- Set up the monitors; establish baseline values on monitors.
- Establish the record for the vital signs.
- Laboratory blood sampling and analysis in room as necessary.
- Access the airway.
- Assist in placement of central lines.
- Establish and maintain an artificial airway.
- Postoperatively wean from mechanical ventilation.
- Extubation criteria.
- Transport to PACU with appropriate monitors and oxygen.
- Verbal report to caregivers.

This year we took eight RTs with us to the Dominican Republic to work in critical care/OR. We set up four operating rooms, three ICUs and a step down unit. We rounded with the staff on morning and evening rounds, and the team actively sought out our concerns and plans. We extubated 70% of the pediatric hearts in the OR without a single need to reintubate. This exemplifies the confidence the team now has in our ability to manage from a respiratory/critical care prospective.

I have a dedicated staff of therapists who join me on these trips, and each year I try to recruit one additional person. In addition, Guatemala now has a respiratory care school to train therapists for that nation. The school is using the U.S. model, and students will take the NBRC exam upon graduation. The Heart Institute is up and running under the direction of cardiac surgeon Aldo Castaneda.

Our ability to solve respiratory related problems continues to pay off for the team. Last year in the Dominican Republic, for example, we had a "small" problem that needed to be addressed at the hospital. We were running out of oxygen! Remember those formulas concerning liters in different size cylinders and liquid systems conversions we all learned in school? After much nervous calculation, we realized that we would run the hospital dry in approximately eight hours. We stopped surgery and tried extubating all children possible, using low flow nasal CPAP, and reducing oxygen usage to a minimum.

I was then "chosen" as the person to go to government officials and explain how this problem was endangering the children and the mission. Little did I know that the government official I



During one of their medical missions overseas, Alan Roth and his colleagues used an inflatable oxygen bag, placed behind a patient's head, to deliver oxygen via a tube on the side of the bag. The bag was attached to a manual resuscitator and used for transport from the operating room.

therapists as assistants in the OR and is currently pursuing formal training methodology with New York State authorities.

Much has been made in the field these last years concerning our identity and worth and the need to reach out to others to help them understand our role. This is not an easy task, but it is one that we need to work on. Our skills-set for assessment, innovation, patient advocacy and technical expertise needs to be explained to anyone who will listen.

I have written a paper concerning my logistics and administrative role on these medical missions and would be happy to share it with anyone interested. A version of this paper has also been accepted for publication in *Anesthesia and Analgesia*. If you are interested in joining medical missions overseas, the American Academy of Pediatrics (AAP-ChildDisaster Network), Society of Pediatric Anesthesia (SPA/VMSA -Volunteer Medical Services Abroad) and International Medical Volunteers Association (IMVA) have web sites (see below) that list organizations and their needs. Respiratory therapists are listed as a category of practitioners in need of volunteers.

If you would like more information about medical missions and/or the expanded role of the respiratory therapist in the OR, email me at: alan.roth@mountsinai.org.

Medical mission resources

1. http://www.pedsanesthesia.org/vmsa_search.iphtml
2. <http://www.aap.org/disaster/index.htm>
3. <http://www.imva.org> ♦

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was being sent to meet was in fact the president of the country! I knew I would be on difficult ground when, on live TV, the president asked in his only English without the translator, "What's a respiratory therapist?" After much technical talk on oxygen gas requirements, we were able to resolve the issue, and by the morning we had an adequate supply, with more to come later in the day.

Over the years many solutions to problems we faced during the missions have come down to critical thinking and the ability to adapt and improvise without experimenting. In China, for example, we used an oxygen pillow for transport, as we did not have oxygen cylinders. We have also used pulse oximetry on the tongue. These are just a couple of examples of our ability to make a difference in a difficult situation.

My current position with the Mount Sinai department of anesthesiology is a direct result of my work on these missions. The chairman of anesthesiology, Dr. Paul Goldiner, is an advocate for respiratory care and a trustee of the NBRC. He firmly believes in using respiratory

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NOTES FROM THE CHAIR

Year (SPOY) award, which is presented to the recipient at the Awards Ceremony during the International Congress (this year, in Tampa, FL, in October). As the nomination deadline for the Neonatal/Pediatric SPOY approaches, I encourage all members to start brainstorming names of worthy candidates and preparing nominations for submission. (See article in this issue on how to submit a nomination.) A committee of volunteers will be assembled to assist with the selection of our SPOY. If you are interested in participating on the SPOY Committee, please send me an email at the address listed on page 2. SPOY Committee members will be identified in an upcoming edition of the Bulletin.

As always, I want to encourage any section members who would like to contribute to the section newsletter to contact one of our Bulletin co-editors, Melissa Brown or Kathy Deakins, at the addresses or numbers listed on page 2. They work hard to bring you six Bulletins a year and could use your help and input.

I would also like to encourage everyone who hasn't already joined us on the neonatal-pediatric email listserve to do so soon.

Now, without further adieu, let's get on with the exciting articles in this edition of the Neonatal-Pediatric Section Bulletin. ♦

The AARC needs you!

Did you know it takes more than 500 active volunteers to successfully run the vast and varied programs and services offered by the AARC every year? Who should take on these responsibilities? How about you?

President-elect David Shelledy, PhD, RRT, is currently seeking volunteers to serve on various AARC committees and in numerous other capacities during his presidency in 2003. If you'd like to sign up - or just find out more about how you can become more involved in your professional association - check out the following link on AARC Online: www.aarc.org/headlines/volunteer. ♦

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NOTES FROM THE CO-EDITOR

another discipline, leaves a lasting impression about respiratory therapists. It is up to us to show them what we are capable of. It is up to us to educate ourselves, keep abreast of the current literature and demonstrate that we are professionals.

Unfortunately, I am probably singing to the choir. Those of you who are an active member of your professional association and also reading this publication are already doing all of these things. But as you are all aware, sadly we are often judged as a group by our lowest common denominator. Our challenge is to figure out how to bring the rest of our peers along with us. One thing we can all do is to ask our co-workers if they belong to the AARC and encourage them to join. Post your copy of the Neonatal-Pediatric Bulletin for everyone in your department to read. Bring someone to the International Respiratory Congress who has never attended before. Suggest they submit an abstract to the Open Forum. Or do what Alan has done: be a leader in our profession. Actively pursue new roles for RTs, especially those that involve decision-making skills, such as ventilator management and patient driven protocols. Every one of us has the power to make a difference! After all, if not us, then who? ♦

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