



# Transport

January / February 2003

Bulletin

## Notes from the Chair

by Steven E. Sittig, RRT

Greetings to all section members! As I sit down to write my first "notes from the Chair" column for 2003, the holidays are a mere two weeks away. It has been two months since the AARC International Respiratory Congress in Tampa, FL and my assumption of the chair position of the Transport Specialty Section. Since then, I have had the distinct pleasure of conversing with a growing number of section members across the U.S. I am hoping to contact as many programs as I can to ask for input on how to best serve your needs. If I have not called your program, rest assured I will be doing so soon. But if you would like to talk with me in the meantime, my contact information is listed on page 2. Send me an e-mail or leave me a voice mail and, I'll be glad to set up a time to speak with you personally.

Because there is currently no national listing of all programs that utilize RTs in transport, one of our goals for 2003 is to create such a database by year's end. To that end, I would appreciate it if every program out there would send me basic contact information for their program and the name of a contact person. Because not all programs have a section member, it would also be helpful if you would include a list of other programs in your area that use RTs (Please include basic contact information for them).

As most of you know, our top goal this year is to increase membership in the section and the AARC. Your membership in the section, and especially in the AARC, shows your dedication to the profession. By belonging to your professional association and promoting the concept of RTs in the field of transport, each of you is helping ensure our role in this important area of care.

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## Is Your Program's Name Really Yours?

by Wes Ware, RRT, Arkansas Children's Hospital

It is safe to say that all of our programs have spent a lot of money, fuel, time, and effort to establish a name in the areas we serve. Our efforts are rewarded when a physician or EMS service asks for us by name when it is time to transport a patient.

But what if you were forced to change your name? Or worse, pay damages to another program and still change your name?

The United States Patent and Trademark Office defines a trademark as: "A word, phrase, symbol or design, or a combination of words, phrases, symbols, or designs, that identifies and distinguishes the source of the goods of one party from those of others." A "service mark" is the same as a trademark except that it identifies and distinguishes the source of a service rather than a product.

Is your program named Careflight, Trauma One, Flight for Life, Critical Care Medflight, Miracle Flights, or Angel Flight? Those names are either servicemarked or trademarked. Do you own the trademark? If you don't, the entity that does can force you to stop using it and possibly hold you responsible for damages.

For information on trademarks, servicemarks, copyrights, and patents visit the United States Patent and Trademark Office web site at [www.uspto.gov](http://www.uspto.gov). There you can search the trademark database and see if your program's name is trademarked.

I am a respiratory therapist, not a lawyer; however I can tell you that it will cost your program a lot of time and money if you are told to stop using your current name. Uniforms, signs on ambulances and/or aircraft, publications, charts, and how you answer the phone would all have to change. It may be worth looking into. ♦

## AARCTimes and the AARC Web Site Focus on Transport

Here is an excerpt from the Focus on Transport article on the AARC web site:

You scan the skies for signs of bad weather every time you leave for work, wondering what risks the day will bring. You pride yourself on being able to respond within a moment's notice when the call comes in. You do your job crouched in the back of a helicopter or ambulance, working shoulder-to-shoulder with nurses and EMTs to provide a lifeline for the critically ill. As a transport therapist, you live in a different world from most RTs. But that doesn't mean you have to operate in a vacuum. The AARC's Transport Section can hook you up with the news, the information, and most importantly, the people you need to thrive in this exciting but stressful environment.

"Transport therapists face very different challenges from other respiratory therapists," says section member Wes Ware, BS, RRT, NREMT, flight therapist at Arkansas Children's Hospital in Little Rock.

"We work as minorities in an environment where paramedics and RNs are the majority." Transport RTs need a way to network with each other, and he believes "the Transport Section is the only way to do that." Fellow member Thomas Cahill, RCP, RRT, EMT-P, echoes those sentiments. As a flight therapist and RT manager at Shriners Hospital for Children in Cincinnati, OH, he's yet to find a better forum for transport RTs

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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](http://www.aarc.org)). To change your option to the electronic Bulletin, send an e-mail to: [mendoza@aarc.org](mailto:mendoza@aarc.org).

### SECTION LISTSERVE:

Start networking with your colleagues via the section listserv. Go to the section home page on [www.aarc.org](http://www.aarc.org) and follow the directions to sign up.

# Transport Lapel Pin Nears Completion

by Steven E. Sittig, RRT

For those of you who have not heard, shortly after the AARC International Respiratory Congress in Tampa, the AARC approved the issuance of a transport RT lapel pin to section members. The pin prototype is currently being designed by the AARC's artist and will most likely be available early this year. The pin is being designed to represent all medical transport provided by RTs, whether by ground or air.

As your new section chair I am very enthused about the pin and feel it will be a great promotional tool for our specialty and the AARC. ♦

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### **AARCTIMES AND THE AARC WEB SITE FOCUS ON TRANSPORT**

to interact with their peers. "It is a great network of RTs who have the same interests... I find the newsletter enlightening and utilize the listserv almost weekly to get current, up-to-date news and information on the latest and greatest equipment for transport."

Diane Randall, RRT, a pediatric transport RT at Alfred I. DuPont Hospital for Children in Wilmington, DE, has been a section member for about four years now and agrees with her colleagues that it's the best thing out there for RTs working in this unique specialty area. "Transport can be very exciting, but very challenging... you have to trust your own experience and knowledge, as well as that of your team members." Belonging to the section gives her the support and resources she needs to do the job. "One of the biggest benefits for me is realizing I'm not alone...we all have a lot of the same concerns, which can lead to discussions of howto problem-solve and handle different situations."

Read the rest at [www.aarc.org](http://www.aarc.org)!

**Want to receive this newsletter electronically?**

**E-mail: [mendoza@aarc.org](mailto:mendoza@aarc.org) for more information.**

## CAMTS Update

by Thomas J. Cahill, RCP, RRT, EMT-P, AARC Special Representative to CAMTS

There have been some exciting developments at CAMTS since my last report in the Bulletin. The new standards are now in effect, and we are currently in the process of assessing changes for the next edition. We're presently seeking input from programs, so if you have any suggestions or areas you believe we need to address, contact me. My contact information appears in the box on this page.

If your team is looking at accreditation, I suggest purchasing a copy of the CAMTS Best Practice book for review. The book provides examples of some creative ways accredited programs are meeting or exceeding the standards. It is a great resource for preparing for the CAMTS process.

As of this writing in mid-December, 94 programs have been accredited through CAMTS. To see the complete list, visit the CAMTS web site at [www.camts.com](http://www.camts.com). While you're there, you can also order a copy of the new standards and the Best Practice book for your program.

Our summer meeting took place in New York City. Our guest speaker was Nadine Levick, MD. Dr. Levick is an ER physician who is leading the way in ambulance safety regulations. She is a proponent of tiered dispatch, ALS first responders, and better safety standards for ambulance manufacturers. It is interesting to note that ambulance crashes are not reported or investigated by the National Highway Safety and Traffic Administration (NHSTA). Ambulances are exempt from these regulations and the safety standards that all passenger vehicles must meet. Dr. Levick calls ambulances the deadliest vehicles on the road. Her goal is to stop the needless deaths of patients and attendants (RNs, RRTs, EMT-Ps, EMTs). She also discussed other safety issues involving patients and securing them to our stretchers for ground transport. The issues raised by Dr. Levick are some of the same issues which have been incorporated in standards required by CAMTS since its inception. The thought of the day is SECURE, SECURE, SECURE - the patient, the equipment, and yourself.

Our fall/winter board meeting coincided with the Air Medical Transport Conference in Kansas City. This meeting included a CAMTS workshop for programs seeking accreditation or updates on the process. An update on the dreaded HIPPA standards and how they will affect the survey process was also presented to the CAMTS board.

That's it for now. I look forward to seeing everyone in Louisville, KY, for the Critical Care Transport Medicine Conference. ♦

# A Brief History of Intravenous Therapy

by Steven E. Sittig, RRT

Critical care transport incorporates many different skills and pieces of equipment. Respiratory therapists involved in transport are often cross-trained to do multiple tasks aimed at making the team more efficient. For many the concept of I.V. placement is a practice for only nursing or medics. The growing number of RTs in transport indicates RTs should be skilled and comfortable in placing and maintaining peripheral I.V. catheters. The history of I.V. therapy is an interesting one. Indeed, the science of I.V. therapy has evolved over a long period of time.

Modern IV therapy is less than a century old, but the first recorded attempt at I.V. infusion occurred in 1492, when physicians caring for the ailing Pope infused blood from three healthy youths into the pontiff. After a vein-to-vein anastomosis, the Pope and donors died. By the 1600s, doctors knew that medications could be injected into a vein, although little success had been achieved with early attempts because of insufficient scientific knowledge. In the 1600s scientists came to understand how blood vessels and body fluids work.

In 1638 a British physician, William Harvey, described the circulatory system after experiments with deer carcasses. He discovered that the heart circulates blood throughout the body, acting as both a muscle and a pump and producing a continuous blood circulation. Up to that time, it was believed that although arteries and veins contained blood, blood flowed like "human breath." Until Harvey identified the capillary network, the liver was regarded as the center of the circulatory system.

In 1658, the architect of St. Paul's Cathedral in London, Sir Christopher Wren, fashioned a quill and a pig's bladder to instill wine, ale, opium, and liver of antimony, a substance of a liver-brown color obtained by fusing together antimony sulfide with alkaline sulfides, into a dog's veins. Six years later, J.D. Major made the first injection of unpurified compounds into humans. Disastrous results of early experimental efforts often ended in death from complications.

From 1835 to 1890, there were no further developments in I.V. techniques, although there were some experiments using injections of sugar, honey, milk, egg yolk, and cod liver oil that met with little success. The first plastic IV device, invented in 1945, was a polyethylene catheter, inserted either as a cutdown or through needle percutaneously.

However, in 1950, a remarkable event occurred with the invention of the Rochester plastic needle. This over-the-needle device was developed by David Massa, a resident in anesthesiology at the Mayo Clinic, and the Rochester Plastics Company (Rochester, MN). It was fashioned from a shortened 16-gauge Becton Dickinson (Franklin Lakes, NJ) needle that was notched in several places to provide a firm junction, with polyethylene plastic tapered at the end. A steel needle was inserted as an inner stylet. The entire unit, approximately two inches in length, was attached to a syringe during insertion and was available only in the 16-gauge size. An inner plastic stylet with a metal hub was developed eight years later, allowing for intermittent use. Before heparin was used to flush the catheter, this was the only intermittent device available and was used only occasionally.

Until the invention of the over-the-needle cannula, the use of armboards was common. Even so, infiltration was a regular occurrence. The Rochester plastic needle provided a major breakthrough in cannulization techniques because it prevented easy infiltration, allowed patient mobility, and produced less leaking at the IV site than did the intracatheters. A major drawback was that the plastic sometimes separated from the shoulder of the steel hub, so that there were random reports of catheters embolizing into patients' hearts. Nurses were prepared to tourniquet the arm if they found a hub when discontinuing the IV. Because few irritating IV drugs were given in the 1950s, phlebitis was uncommon and IV-related sepsis was rare. This over-the-needle cannula was the forerunner of the Jelco (Critikon, Tampa, FL) needle and other similar designs that were produced in the early 1960s. Butterfly needles remained the easiest to insert and were widely used until the 1970s - and still remain useful for many purposes today. They also led to the development of an over-the-needle plastic winged catheter in 1963.

In the next Bulletin we will look at specific issues related to the insertion and maintenance of IV sites and complications that may occur during IV therapy. While some may feel that IVs are not in our scope of practice, personnel involved in transport need to be multiskilled and adaptable. Placement of an IV is a skill similar to intubation, a task in which many transport RTs are well recognized as experts. ♦

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## NOTES FROM THE CHAIR

However, as I talk with my fellow department members about AARC membership, and about the section to those in transport, I most often hear, "What do I get for my membership fee?" and "Where does the money go?"

What you get for your membership fee is an extensive list of benefits and services ranging from top-notch monthly publications, to an award-winning web site, to first-rate representation in Washington, DC. (For a complete rundown of benefits, check out [http://www.aarc.org/member\\_services/benefits\\_services.asp](http://www.aarc.org/member_services/benefits_services.asp).) Section membership affords you the opportunity to network with your fellow transport RTs from around the country, through this bulletin, through the section e-mail list, and through meetings and other special events.

As for where the money goes, AARC President David Shelledy, PhD, RRT, FAARC, covered a lot of important information about how these funds are allocated during his speech in Tampa. Did you know that, of the \$90 membership fee, \$12 goes to the state societies in the form of revenue sharing, to help accomplish local promotion of RTs.? That leaves only \$78 per member for the AARC to continue our work on a national level. These remaining membership dues provide you with two monthly publications (AARC Times and Respiratory Care journal) and help the AARC represent, promote, and advance the profession of respiratory therapy. The Transport Section is no different in that the \$15 you pay to belong to the section goes to printing the newsletter and promotion of RTs on transport.

Why this new emphasis on increasing membership? The short answer is: we're falling behind our colleagues in other disciplines. There are at least 110,000 RTs in the U.S., but we only have 31,000 members (28%). By comparison, over 90,000 of the 167,000 radiology techs in the U.S. are members of their professional association (54%). Of the 132,000 physical therapists (PTs) nationwide, 66,000 (50%) are members of their organization. Fifty thousand of the 78,000 occupational therapists (OTs) (64%) are members of their group. And 36% of the 58,000 physician assistants (PAs) belong to their professional society.

Perhaps their dues are lower, you say. Not so. Indeed, many of them pay more to belong to their professional organization than we do: PT-\$245; PA-\$215; OT-\$187. Our dues are the lowest among this group, yet we have the fewest members. This is unacceptable. We need to get the message out to potential-member therapists that we can't succeed without them. We need their numbers to enhance our ability to achieve effective representation on the national level that promotes the great work we do everyday.

As your new chair I am doing all I can to promote and grow the section, but I need all of you on the local level to talk with your colleagues about joining the AARC - and the Transport Section, if that is within their job responsibilities or their professional interest. We need to pull together to improve public awareness of our profession and advancement of respiratory therapy into ever-increasing areas of practice. ♦

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**We need 150 more members in Transport by  
Dec. 31, 2003 if we are to stay an AARC  
Specialty Section. Do your part, recruit a  
new member into the AARC and the  
Transport Speciality Section today!**

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## **AARC Membership: Join as a Group and Save!**

So you know some coworkers who are considering joining the AARC - and hopefully, this section - but the membership fee seems to be an issue for them. What can you do? Suggest the AARC's group membership plan. You can get a discount on your AARC membership if you join or renew as a group. "This program is great for hospital staffs or local RTs who want to pull together and purchase at least ten memberships in the AARC," says Sherry Milligan, AARC associate executive director for membership. New members get an especially good deal - they save the \$12.50 new member processing fee in addition to the discount on their membership fee.

Single membership in the AARC is \$90 per year. Through the discounted group program, you can save on bulk membership purchases:

- 10-19 memberships: \$85 per membership
- 20-39 memberships: \$80 per membership
- 40-99 memberships: \$75 per membership
- 100 or more memberships: Call the AARC for an even bigger savings

Every member can benefit from this group rate. As your renewal time approaches, get a group together and join at the same time and save money. For instance, by joining as a group of 12, and maintaining section membership, your total per member cost is only about \$1.92 a week. Cut out a couple of break-time snacks, and you're there!

By recruiting new members and retaining current members, the AARC and this section can grow. With numbers comes strength; we need practicing respiratory therapists to be active members in their professional organization. For more information about the group plans, contact Pat Lee at the AARC office, (972) 243-2272. ♦