Notes from the Editor
by Fred Hill, MA, RRT

You get what you settle for.
— from the movie, Thelma & Louise

A discussion arose recently on the Education Section listserve regarding the recent trend among our graduates to delay the taking of the NBRC exams, especially the exams leading to registry. Many educators seemed to agree this is a widespread problem. But there is a disturbing difference of opinion on how to deal with it.

One educator, for example, cited a lack of incentive for taking the advanced exams due to a perceived low value for the registry credential vs. the certification credential. She noted that at a particular hospital, the pay for registered therapists is only $0.50 per hour more than that for certified therapists. The implication was that this is a trivial sum and hardly justifies bothering to take the advanced exams.

Another educator, however, quickly pointed out that the difference actually amounts to $1,040 per year or $5,200 over a five-year period. Hardly “chump change,” he says. But then yet another educator, agreeing with the first that it really isn’t worth it to seek the RRT credential, noted, “You have to consider that your raise will be whittled down by a third in income and payroll taxes. Now the year end savings for passing the exam is only $700. Many grads will pay over $300 to take a review exam that whittles the cost benefit down to less than $400. If you factor in the average 40 hour study and compute it to, say, $15/hour, a reasonable person would have to conclude that it doesn’t make economic sense to take the RRT exams. And this doesn’t include the fact that nearly half the students will fail the exam nationwide.”

I don’t think educators should be designing excuses for graduates to settle for mediocrity. If anyone is going to provide motivation for our students and graduates to reach their highest potential, it has to be us, the educators.

If graduates begin their careers with ready excuses for not achieving the original goal they settled on at the time of enrollment into a respiratory program, then something is very wrong. They have already invested many hours of study, classroom time, and clinical studies to get to the point of graduation. Should they have computed all of that time at $15.00/hour, or should it be less because they were still students?

I’m sorry, but hard work and study are part of the formula that leads to success. We should not pamper our students and graduates by inventing excuses for them. We should encourage our students to set high professional goals for themselves. Getting the credentials, regardless of beginning pay, is an early and necessary step toward building a career in respiratory care that moves beyond the entry level.

On another note, I am taking a break from my series on academic dishonesty this issue due to overwhelming end-of-semester activities. I do hope to resume next issue. In the meantime, Jeff Welch, director of education and director of respiratory therapy programs at the California College for Health Sciences, has responded to my first article in the series by sending three web site addresses that deal with plagiarism. With the wealth of materials available on the Internet, students can easily copy materials, put them into a word processing program, and pass them off as original papers. These web sites offer services that have been developed to try to detect this type of academic fraud. The addresses are as follows, should you wish to check them out: http://www.turnitin.com/, http://www.integriguard.com/, and http://www.plagiarism.com/. Thank you, Jeff, for sharing.
Notes from the Chair
by Susan P. Pilbeam, MS, RRT

You have undoubtedly noticed by now a number of communications from the NBRC addressing the issue of recredentialing (NBRC Horizons, Nov/Dec, 2000; NBRC Horizons Jan/Feb, 2001; AARC Times Feb, 2001 “NBRC Insight”). Basically, recredentialing will require credentialed practitioners to take part in continuing educational activities to improve or maintain their professional proficiency. For a majority of you, this is something you are already doing. Your attendance at local, state, national, and international meetings is one example of your efforts to keep abreast of new therapies and changes in the profession. Most, if not all, state licensing laws have mandatory requirements for continuing education as well.

So there is not much reason for us get stirred up, as it were, over the NBRC’s efforts to be in compliance with its accrediting agency, the National Commission for Certifying Agencies (previously, the National Commission for Health Certifying Agencies). Please be aware that the continued competency program was not created in isolation. The AARC and CoARC, as well as the public, were also involved. If you had an opportunity to review the proposed policies (NBRC Horizons, Jan/Feb, 2001), you saw that every attempt was made to cover all possible issues that might arise.

Basically, the proposal suggests a minimum of six hours per year of continuing education, with a five-year window for completion (i.e., 30 hours in five years), which is the minimum amount that any state law currently requires. As of this writing in early spring, the Board was scheduled to formally consider the draft of the policies at its April meeting, and by the time this Bulletin reaches you, we will have undoubtedly had the opportunity to hear the outcome. I’d like to thank the Board members and the commission they appointed for their diligent work on this effort.

Much of the publicity on the recredentialing program has centered around the continuing education requirement. But the program also includes a provision that would allow educators and practitioners alike to retake an NBRC credentialing examination in lieu of earning the continuing education hours. The current proposal allows you to retake the examination for the credential you hold through the NBRC. For example, if you are currently holding the RRT credential, you would take the RRT examination. A passing score would serve as renewal for your credential.

Personally, I like this re-examination option, but it may strike terror in the hearts of some of you. When was the last time you took the exam? Was it the time you had to take it in order to get credentialed? If you were as nervous as I was the first time you experienced the test, then no one would be surprised that you do not want to go there again. But for educators, I think this is our best option. If you are actively involved in a respiratory care program, don’t you think your students would like to know that you understand what the most recent version of “the test” looks like? Frankly, if you are teaching in an accredited program, I think you should be required to take one of the NBRC exams at least every three years. And don’t tell me you have the matrix, so you don’t need to take the test!

Not too long ago I told the clinical coordinator for our program that we were going to take the entry-level exam, particularly since the matrix had been revised. The anxiety on her face was clearly visible. The excuse of money was quickly dismissed, since the college would cover the cost. Concern that our recent graduates would be at the same examination site was legitimate, but then they would never know our “scores.” However, even this excuse has been done away with now that the test is computerized and administered at any time at a variety of test sites. After considerable reassurance and calming of nerves, she reluctantly saw my point. I even reassured her that no one would ever know her score. After the test, she was delighted to reveal that she had passed with fabulous scores, which didn’t surprise me in the least.

As a site-visitor for CoARC, I often ask program faculty when they last took the NBRC examination for which they are teaching. Let me assure you this is not a CoARC standard, so there is no reason for concern. And it’s probably none of my business. But if it will do the students and the program some good and you no harm, I cannot resist the temptation to ask anyway. I hope if you have not taken the opportunity availed to us through the NBRC, you soon will. You can take it at your leisure through computerized testing and no one will be the wiser. There is no risk to your pride and everything to gain for your students and yourself.

So “hats off” to the NBRC and the supporting organizations and individuals. We look forward to the results of the April Board meeting.

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http://aarc.org/sections/section_index.html
Profile of an Educator
by Susan P. Pilbeam, MS, RRT

Editor’s Note: Oftentimes, individuals who work hard as professionals and educators are not well known — not because they are underachievers, but because they are the kind of individuals who maintain a low profile. Beginning with the following article, we are starting a new feature in the Bulletin to highlight such individuals. If you know someone who fits this profile, please contact either myself or Sue Pilbeam at the addresses/numbers listed on page 2.

If you read Kevin Lord’s curriculum vitae, you would notice that it is short. This is not because there is little to say, but because Kevin is one of those reticent individuals who does not like to say much about himself. Kevin is a full-time faculty member of the department of cardiopulmonary science in the School of Allied Health at the Louisiana State University Medical Center in New Orleans. He started working full-time in the position last year.

After graduating from the LSU program in 1995, Kevin went to work as a staff therapist for the Medical Center of Louisiana in New Orleans. Just a year later he was promoted to education coordinator, initially working for the cardiopulmonary division and then taking on an expanded role that included the cardiac catheterization lab as well. He provided education programs for the divisions of cardiopulmonary, nursing, radiological technology, and cardiovascular technology. In addition to these full time duties, he taught clinically for the LSU respiratory therapy students and worked on his master’s degree in health sciences, which he completed last year.

During this same time frame, Kevin also completed a chapter on home care and transport ventilators for the Cairo textbook on Respiratory Care Equipment from Mosby Publishers. And, his wife, Stephanie, gave birth to their first child, a son, Reece, born on November 7, 1999. Clearly, Kevin is a busy guy. But there’s something a little extra about Kevin that he is less likely to talk about.

First of all, between 1995 and 1998, Kevin restored a historic, 85-year-old New Orleans home. For those of you unfamiliar with this kind of activity, it included all parts of reconstruction, including moving walls, tiling, stripping old wood finishes, plumbing (including a new wet bar), wiring, and the usual finishing work. When the faculty had an opportunity to see Kevin’s handiwork, it wasn’t long before he was helping those folks out as well. After the dog ate Dr. J. Cairo’s air conditioning unit, Kevin helped him install a new one and protect it from further teething efforts by the kindly K-9, Copper. He then helped Dr. Andy Pellett redo his deck and even helped Dr. John Zamjhan redo his master bath. (We all know what Kevin can do for a living if he ever gives up respiratory care.)

In addition to his professional and home repair activities, Kevin also coaches little league baseball at one of the local playgrounds in his parish, and until recently, he was an important mentor for two young men in his neighborhood who are mentally challenged. The boys, it seems, were having difficulty obtaining full-time employment, even though they really did want to do something constructive. Kevin helped them go to work mowing neighborhood lawns. One or two days a week he would gas up his lawnmower, gather up the boys, and tackle the landscape. After they were finished with their work, the neighbors would pay the boys (Kevin never took any of the money), then he would take them out for a “snow ball” and some candy. Word of the service spread, and before long more neighbors, anxious to help out, signed up to have the boys cut their lawns as well. Pretty soon the number of lawns on the schedule far exceeded the number of days in the week. Two broken lawn mowers and a broken window later, Kevin finally retired and passed the lawn service along to another volunteer. (Stephanie, Kevin’s wife, recently put in a request that he take a one year sabbatical from his volunteer activities, and now we know why!)

Currently, Kevin is pursuing a PhD in pharmacology at LSU. He feels there are some great opportunities in this field and that this specialty will help round out the department where he works. At the present time, he is also involved in a research study that is looking at the cardiovascular effects of the recreational drug, “Ecstasy” (MDMA), in a rat model. Previously, he was involved in designing techniques for measuring capillary pressures and looking for changes in pulmonary capillary pressures associated with the use of vascular volumes, histamine, and dopamine in oleic acid-treated animal models. He has also been collecting data in a clinical study to evaluate useful parameters for determining weaning success.

We would like to wish Kevin Lord the best in his pursuits.

Remembering a Friend
by Susan P. Pilbeam, MS, RRT

Many of you know the name, Ken Scheiderman. I am sorry to report that Ken died April 17 after being hospitalized with a serious illness. Ken was my friend for more than 20 years. Most of you will remember him for the leadership he provided to the California College. I will always think of him as a very close and giving friend who loved and enjoyed life and who remained a gentleman and a class act to the end. So, have a glass of good wine and think of Ken. He’d like that.

New Classroom Videos Available

Pediatric Ventilation: Kids are Different — The significant differences in the anatomy and physiology of the respiratory systems of adults and children may pose problems for practitioners. This video has been edited for classroom use to better explain why actions that are normally taken with adult patients must be reassessed when dealing with pediatric patients. Featuring Mark Heulitt, MS, FAAP, FCCP, and Richard D. Branson, BA, RRT. 46-min. videotape. Item ED05. Member price: $49.95 plus $7.25 shipping and handling ($99.00 for nonmembers plus $9.25 shipping and handling). Online link —http://store.yahoo.com/aarc/pedvenkidare.html.

“Classroom Videos” continued on page 4
Respiratory distress syndrome (RDS), also termed hyaline membrane disease (HMD), is the leading cause of death among premature infants. In the United States about 250,000 infants are born prematurely each year. Approximately 50,000 of these infants develop RDS; and of those who develop the disease, 5,000 to 8,000 die. Historically, RDS has been the condition most associated with the specialty of neonatology. Although advances in the prevention of premature births and treatments of RDS have reduced the number of deaths, the condition continues to be a significant cause of morbidity and mortality. It has been over 30 years since the death of John Fitzgerald Kennedy. He was 50 years old and died of a brain hemorrhage.

During the past three decades, dramatic improvements have surfaced in the treatment of RDS, including synthetic surfactant treatment.

Clinical manifestations

The typical onset of RDS occurs in a premature infant immediately at birth or a few hours after birth. The infant with RDS (usually 28 to 32 weeks gestation) breathes initially, but quickly develops respiratory distress. Normally, a neonate’s respiratory rate is between 40 and 60 breaths per minute. However, when RDS is present this rate will elevate to well above 60 breaths per minute. In addition to the increased rate, nasal flaring is frequently observed in infants with RDS. Nasal flaring is facial reflex to facilitate the movement of gas into the tracheobronchial tree, which provides a larger orifice for gas to enter during inspiration. Other common symptoms associated with RDS include poor chest excursion, inspiratory retractions, expiratory grunting, rales, frothing at lips, cyanosis, edema, and a weak cry.

Diagnosis

Diagnostic procedures of RDS include inspection, x-ray, and arterial blood gases (ABGs). All three of these procedures can be used to determine RDS, however, the definitive measure is usually assessed by x-ray. Inspection is often done at birth and includes the Apgar and Silverman tests. The Apgar score is a scoring system used to rapidly evaluate the neonate by measuring the heart rate, respiratory effort, muscle tone, reflex irritability, and skin color. The score ranges from 0 to 10, with 7 or more at 1 minute indicating a normal response. Infants with an Apgar score of 6 or less at 1 minute may need aggressive care. The Silverman score is a grading system of the lung’s compliance changes while compressing and decompressing a film of lung extract. He compared the lung extract contained to a detergent-like structure that accounted for the hysteresis of the lung’s pressure. This detergent-like structure is pulmonary surfactant. Surfactant is a surface-active agent that reduces the surface tension of pulmonary fluids and contributes to the elastic properties of pulmonary tissues. Pulmonary surfactant is composed of lipids and proteins. Ninety percent of surfactant is composed of the phospholipid, dipalmitoylphosphatidylcholine (DPPC), while the other 10% is composed of proteins. Most biological surfactants will have a polar (electrically charged) and non-polar group. The polar end resembles those compounds that are freely soluble in water, hydrophilic, and the non-polar group resembles the compounds that are soluble in oils, hydrophobic. DPPC has a hydrophobic end and a hydrophilic end. The hydrophobic end is repelled upward towards the air-liquid interface and the hydrophilic end is attracted into the liquid.

The physiological function of surfactant includes the ability to rapidly absorb, spread, and reform a monolayer in the dynamic conditions associated with the respiratory cycle. Surfactant lines the alveolar surface and prevents atelectasis at end expiration. Pulmonary surfactant also plays an important role in keeping the alveoli dry. By keeping the alveoli dry, pulmonary
“Synthetic Surfactant” continued from page 4

surfactant helps to prevent the formation of
the characteristic hyaline membranes. When placed in a liquid bulk phase, pulmo-

nary surfactant is quickly absorbed onto the
air-liquid interface.

Figure 1-A illustrates bubbles that are
rising to the surface of the liquid. Surfactant
reduces the surface forces and permits these
bubbles to form a monolayer with the
hydrophobic end in the gaseous phase and the
hydrophilic end in the liquid phase. This soap-like film decreases surface tension and
prevents alveolar collapse as these bubbles
to continue to rise, while increasing the
surface area of the original air-liquid
interface.

Another example of how surfactant
plays a role in reducing surface tension is
by eliminating the fluid formation of a bead
on a smooth surface. In the absence of sur-
factant, internal forces will constrain a fluid
to form a bead on the smooth surface. This
is due to the unopposed attractive forces of
the surface tension, which will require extra
work to reduce the attractive forces as the
surface area increases. The substance
capable of reducing these forces and sup-
plying the extra work that is needed to
bring further molecules to the surface is
surfactant.

Figure 1-B illustrates a bead being
formed on the left, but the fluid is spread
thinly over the surface on the right. This is
exactly what happens to the alveoli in the
presence or absence of pulmonary surfac-
tant. In the absence of pulmonary surfac-
tant, there will be nothing to reduce the sur-
face tension of the alveoli. This increased
surface tension will cause the alveoli to col-
lapse at end expiration. In this case, a bead
will form because there is no substance to
reduce the surface tension at the air-liquid
interface. On the other hand, in the pres-
ence of pulmonary surfactant, a thin film
will be placed into air-liquid interface,
which reduces surface tension and prevents
alveolar collapse at end expiration. In rela-
tion to the illustration, instead of a bead
being formed, pulmonary surfactant
reduces the attractive forces of the fluid,
reduces the surface tension, and allows the
fluid to wet the smooth surfaces. In fact,
surface tension can actually enable the
surface of water to support needles and razor
blades if they are placed carefully. Moreover, surface tension also has capillar-

y action when it forces a liquid to rise in
a thin tube when the tube is dipped in the
liquid.

Etiology

RDS is caused by the absence, deficien-
cy, or alteration of pulmonary surfactant.
The absence of pulmonary surfactant
results in decreased compliance, reduced
alveolar ventilation, and an increased work
of breathing. In addition, the neonate will
have a weak and unstable chest wall, thus
limiting the infant’s ability to maintain
the negative intrapleural pressure required to
keep the lung open at end expiration, result-
ing in atelectasis. Pulmonary surfactant
plays a tremendous role in the regulation of
ventilation in the newborn. The primary
cause of RDS in the neonate is a deficiency
or dysfunction of pulmonary surfactant. This
disease is common in the neonate
because pulmonary surfactant production is
not stable enough to support extraterine
life until 35 weeks gestation. Unfortunately, pre-term infants are at high
risk of lacking adequate production of pulmo-
nary surfactant, thus leading to RDS.

Synthetic surfactant treatment for RDS

The traditional methods of treating RDS
include continuous positive airway pres-
sure (CPAP) and positive end expiratory
pressure (PEEP) as support modes of venti-
latory support. There is evidence that early
use of CPAP can slow the progression of
RDS and enhance surfactant production.
However, there have been new methods of
therapy gaining widespread acceptance.
Since the altering of surfactant is the pri-
mary factor associated with RDS, it makes
common sense that it should be replaced so
the lungs of the neonate can function prop-

erly in their natural state. Researchers have
discovered a way to replace this surfactant
in the form of a treatment called surfactant
replacement therapy. The first attempts of
synthetic surfactant replacement therapy
occurred in the 1960s. Their attempt was
to aerosolize DPPC to infants with RDS
(Robillard 1964, Chu 1967). Unfortunately, this method was unsuccess-

ful because of improper routines of adminis-

tration and uncertainty in actual dosage.

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bring further molecules to the surface is
surfactant.
“Synthetic Surfactant” continued from page 5

Another concern in synthetic surfactant treatment is early versus delayed treatment. One of the most difficult controversies to solve at this time is whether surfactant should be administered immediately after birth to a population at risk because of gestational age or after the appearance of clinical manifestations. According to the Oxford Database of Perinatal Trials, four randomized controlled trials were done on this particular issue.19 Expectedly, early administration led to a decreased risk of acute pulmonary injury and a decreased risk of neonatal mortality and chronic disease compared to delaying treatment of such infants until they develop established RDS.20 However, there is no controversy at all concerning the effectiveness of synthetic surfactant treatment. Whether it is given as prophylaxis (early) or rescue (after manifestations), improvement in oxygenation and a decreased need for ventilatory support over the first few days of life is remarkable.1

Surfactant replacement therapy is now recognized as a life-saving and safe intervention in small premature infants, but there is little evidence concerning its risks and benefits in larger premature infants.21 According to the Clinical Research Division, Wellcome Research Laboratories, Research, a placebo-controlled, blind trial of 1237 infants were studied.21 All of these infants weighed at least 1250g. A total of 614 received surfactant, while the remaining (placebo) group received air. The results indicated that fewer infants in the surfactant group than the placebo group died within a month.21 The study therefore concluded that for infants weighing at least 1250g at birth who have RDS, two doses of synthetic surfactant will improve survival rates and reduce perinatal morbidity.21

Conclusion

Regardless of the severity of RDS, synthetic surfactant treatment has been demonstrated to improve clinical outcome.13 Throughout the many studies and clinical trials, surfactant replacement therapy remains the number one therapeutic measure for the pre-term infant with RDS. There are many complications that can arise from a lack or dysfunction of pulmonary surfactant. However, once surfactant is properly replaced, immediate improvements begin to surface. A premature infant with RDS can greatly reduce the risk of respiratory disorders by synthetic surfactant replacement therapy. It is reported that infants who received synthetic surfactant treatment have a decreased risk of pneumothorax, a decreased risk of pulmonary interstitial emphysema, a decreased risk of intraventricular hemorrhage, a decreased risk of bronchopulmonary dysplasia, and decreased risk of neonatal mortality prior to hospital discharge at 1 year of age.13 The following illustration gives a comparison or outcome of synthetic surfactant treatment of RDS. In conclusion, synthetic surfactant treatment is very important in saving the lives of the premature infants with RDS.

References

“Synthetic Surfactant” continued from page 6
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Submission Guidelines for Bulletin Articles

All section members are encouraged to share information about their programs through articles in the Bulletin. Here are our guidelines for submission:

**Article length:** Bulletin articles may be between 500 and 1,000 words.

**Format:** In addition to a paper copy, all articles must be submitted on a 3½ inch floppy disk saved in Microsoft Word or TEXT ONLY (ASCII) formats, or e-mailed to the editor in one of those formats.

**Article Review:** All authors may review a copy of their article before it goes to press. If you would like to review a copy of your article, please include a FAX number when you submit it to the editor. It is the responsibility of the author to: 1) request the opportunity to review the article before it goes to press, and 2) contact the editor by the stated deadline if any changes need to be made before the article goes to press.

**Send Submissions To:** Fred Hill, MA, RRT, Department of Cardiorespiratory Care, College of Allied Health Professions, University of South Alabama, 1504 Springhill Avenue, Room 2545, Mobile, AL 36604, (334) 434-3405, email: fhill@jaguar1.usouthal.edu.

**Deadlines:** All articles must be submitted to the editor according to the following schedule of deadlines.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date editor must have copy</th>
</tr>
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<tr>
<td>January/February</td>
<td>December 1</td>
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<td>March/April</td>
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<td>May/June</td>
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<td>November/December</td>
<td>October 1</td>
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Don’t forget to make your nominations for the 2001 Education 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.

Mail or FAX a short description of your nominee and why he or she is deserving of this award, along with his/her name and address and your name and address to the section chair at the address/number listed on page two. You may also submit your nomination online at http://www.aarc.org/sections/education_section/education.html.

Specialty Practitioner of the Year

The American Respiratory Care Foundation (ARCF) and VIASYS Healthcare* are pleased to announce the ARCF Healthcare Fellowship for Neonatal & Pediatric Therapists.

This fellowship is designed to recognize outstanding original research in the field of neonatal and pediatric intensive care. Special focus will be on bench studies, clinical research studies, and other qualified studies that involve mechanical ventilation. Recipient will be selected by the ARCF Board of Trustees based on abstract submission (final deadline July 17, 2001).

The recipient of the VIASYS Healthcare Fellowship for Neonatal & Pediatric Therapists will be presented a $1,000 cash award, a plaque, registration and airfare to the American Association for Respiratory Care’s (AARC) International Respiratory Congress and one night’s lodging in the convention city. They will receive their cash prize and plaque at the 2001 AARC Congress Awards Ceremony, which will be held December 1-4 in San Antonio, Texas.

ARCF Chairman Mike Amato is very pleased with the new addition to the Foundation’s line-up of respiratory therapy research awards. “As the respiratory therapy profession continues to grow, many therapists have devoted their careers to working with neonates and pediatric patients,” he said. “It’s time these therapists were encouraged to further advance their specialty field—this fellowship does exactly that.”

Amato said donors establish endowments with the ARCF to recognize achievements made by individuals working in specific areas of research. He said endowments not only encourage furthering education and research in the field of respiratory care but also bring recognition to the named donor supporting the respiratory profession.

“The Foundation, and most importantly the profession, is grateful to VIASYS Healthcare for its continued support of respiratory therapy,” Amato continued. “We look forward to a long and mutually beneficial relationship with VIASYS. This corporate group and the Foundation’s other industry partners make everything we do possible.” he said.

If you would like more information on the ARCF awards program, visit our website at www.aarc.org/arcf/awards.html or call Diane Shearer at 972/243-2272.

The American Respiratory Care Foundation is dedicated to furthering the art, science, quality, and technology of respiratory care. It is a not-for-profit organization involved in supporting research, educational, and charitable purposes. The Foundation seeks to ensure a better, healthier future for all by promoting quality treatment and prevention of a variety of respiratory and related diseases.

* Bear Medical Systems, Bird Products Corporation and SensorMedics Critical Care are subsidiaries of VIASYS Healthcare.
Specialty Practitioner of the Year

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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 Education Specialty Practitioner of the Year because _______

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Nominee
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Mail or FAX your nomination to the section chair at the address/number listed on page 2 of this issue, or submit your nomination online at http://www.aarc.org/sections/education_section/education.html.