



### EDUCATION UPDATES

by Sandra McCleaster RRT

Here are a few quick hits on the education front. The American Assoc. of Respiratory Care (AARC) is sponsoring a series of conferences to attempt to determine the future of respiratory care services as well as to identify the skills therapists will need in order to provide those services. The initiative is being referred to as RT 2015 and Beyond. The first of three planned conferences was held in March and was aptly titled Creating a Vision for Respiratory Care. This was no small endeavor. The AARC invited representatives from its entire community of interest. Employers, insurers, state and federal government agencies, The Joint Commission, and education groups among others, were all in attendance. Patient care was at the core of discussion. The outcomes of that conference will actually provide the foundation for two additional future conferences. Of particular interest to educators is that the next two conferences will address the skills,

attributes and credentials that respiratory therapists will need to possess for future practice. This will be a lengthy process, extending probably into the next few years, but in the end, all proceedings will be recorded and summarized for public consumption. Thankfully, our professional organization is

**Don't wait for the future to happen -  
Make sure to secure your place within it.**

not just sitting back, waiting for the future to happen. We've got to secure our place within it and the 2015 and Beyond initiative will hopefully provide us with a context in which to do that. Everybody who's anybody is looking forward to seeing how 2015 and Beyond will provide a glimpse into our future. And surely, this will be a topic for future Focus on Education articles.

#### **Basic Life Support**

It was in the *Mar/Apr 2007* issue of Focus that I wrote on the new guidelines for cardio-pulmonary resuscitation (CPR) which were issued in 2005. I concluded that article by predicting that those changes surely wouldn't be the last. But little did I expect that it would be only one short year later, that the media would be reporting new thinking on what is obviously a work still in progress.

Just last month the American Heart Association Emergency Cardiovascular Care Committee (AHA ECC) published an advisory to amend the guidelines for certain circumstances of sudden cardiac arrest. It's important to note that these latest recommendations are not for card-carrying health care providers, but rather, are directed to bystanders who witness an adult out-of-hospital sudden cardiac arrest.

Because the overwhelming majority of sudden death events occur outside of the hospital setting, the goal is to make CPR for laypersons easier to remember and perform. The 2005 guidelines had noted the need to increase the use and improve the quality of bystander CPR. To that end, I quote the latest AHA advisory. "Although the best method of CPR is compressions coordinated with ventilations, laypersons should be encouraged to do compression-only CPR if they are unable or unwilling to provide rescue breaths." The guidelines also recommend compression-only CPR for 911 phone assisted instructions to untrained bystanders.

This concept is evidence-based on research published subsequent to the 2005 guidelines being issued. In summary, according to the AHA advisory, three studies of bystander CPR were published in 2007 and none of these three studies demonstrated any negative impact on survival when ventilations were omitted from the sequence. The thinking also holds that compression-only bystander CPR will result in more and better compressions with fewer interruptions. More importantly, and probably most pertinent, is the assumption that being relieved of the responsibility of having to perform mouth-to-mouth breathing will result in many more bystanders stepping up to the plate and performing CPR when indicated.

The AHA acknowledges that the evidence to support its latest recommendations is far from complete and that there are legitimate concerns with the withholding of rescue breaths in certain victim populations (e.g. non-cardiac medical emergencies, such as drowning, airway obstruction, drug overdose, etc.) But the advisory stresses the concept of sudden cardiac arrest and the AHA feels the advantages far outweigh the disadvantages. And again, keep in mind that these changes are directed to the non-health care providers only - bystanders who are responding to victims of assumed cardiac arrest.

A post script: It's interesting to note that the European Resuscitation Council (ERC) has reviewed the available published scientific evidence and unlike the AHA, considers the evidence insufficient to alter its current ERC guidelines for basic life support.

#### **NBRC Credentials**

The National Board for Respiratory Care (NBRC) had previously established a deadline for pre-2005 graduates of advanced level programs to earn the RRT credential. If these "registry-eligible" folks didn't become RRTs by the end of 2007, they would be required to become "re-credentialled" by retaking and passing the CRT exam in order to regain eligibili-

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ty for the registry exam system. The 2007 deadline has come and gone. Now the NBRC has granted an amnesty period, extending that deadline until the end of February 2009. They offered little explanation for this magnanimous gesture, but do state that from this point on, there will be no further extension of the deadline.

On another note, educators have asked if questions on the NBRC entry level and registry exams will reflect the most current CPR guidelines for health care providers. The answer is "yes." The NBRC has stated that the 2005 CPR guidelines for health care providers will be incorporated into both the entry-level and advanced level exams effective June 2008.

**That All-Important Baccalaureate Degree**

Respiratory therapists have officially joined the rank of "professionals." Baccalaureate prepared RRTs can now qualify as commissioned officers, along with nurses, pharmacists, and other similarly educated health care providers within the Public Health Service. Make no mistake about it. This recognition didn't happen all by itself. It's the result of years of behind-the-scenes effort and advocacy on the part of the AARC.

There's also another movement afoot to allow services provided by registered respiratory therapists with bachelor's degrees to be compensated under Medicare Part B when these services are performed under the umbrella of a physician practice. Bills have been introduced in both the House and Senate. Educators should be actively supporting this legislation. No matter which way this goes, I think we can see the handwriting on the wall. The winds of change are pointing to that all important bachelor's degree as a critical key to our professional future.

*Sandra McCleaster, MA, RRT is a veteran therapist, author, lecturer and educator. She is an adjunct faculty member at Bergen Community College in Paramus, NJ.*

**Thoracentesis..** *Continued from page 22*

*Effusion secondary to pulmonary embolism* - Usually bloody and associated with pleurisy and dyspnea.

*Tuberculous Effusion* - These are predominantly lymphocytic exudate. Glucose may be low (<60 mg/dl) and adenosine deaminase usually elevated (>70 IU/l). Pleural fluid smears for acid fast organisms are rarely positive but cultures are positive approximately 25% of the time. However, thoracoscopic pleural biopsy is positive 80% of the time.

*Effusions secondary to Collagen Vascular Disease* - Effusions secondary to rheumatoid arthritis are predominantly mononuclear cell exudates, typically with low glucose levels (<10 mg/dl), high titers of rheumatoid factor (>640) and cloudy appearance (pseudochylous or cholesterol effusions).

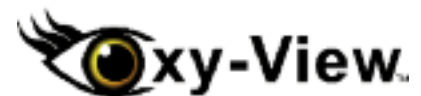
Atelectasis is a common cause of small to moderate effusions. Frequently they are seen postoperatively or with prolonged bed rest. There are no diagnostic criteria, they have normal glucose with WBC counts of 1000-2000 cells/mm<sup>3</sup> with mononuclear cell predominance.

As you can see, causes for pleural effusions are numerous and their identification not always clear, but a classification based on the type of effusion is useful, and in fact necessary for proper diagnosis of the patient's condition.

*Don Steinert is an Associate Professor in the Department of Nursing and a faculty member in the Respiratory Therapy Program at the University of the District of Columbia.*

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