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Minnesota Society for Respiratory Care

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The Bronchus

Official Newsletter of the Minnesota Society for Respiratory Care

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President's Message
Gary Johnson

As the year winds down, I would like to thank the MSRC leadership and its members for the wonderful opportunity to serve as President of the MSRC. Serving as President allows for another perspective of the MSRC and the concerns of its membership.

2005 offered many challenges and was a year of change:

- *To lower the cost of registration to educational offerings.*
- *To offer educational programs that hit the specialty interests of RTs.*
- *To improve communication to RCPs and increase participation in the society.*
- *The first joint Northern Regional Respiratory Care Conference.*
- *Teleconferencing capability for Board meetings and Committee meetings.*
- *The moving of Board meeting to various locations to support interest and participation.*
- *Letters to all of the RCPs in Minnesota to invite them into and make them aware of the society.*
- *To develop the MSRC website into a valuable communication tool for the society*

President's Message continued on page 6.

Avian Influenza: Panic or Pandemic?

Here are some Avian Flu FAQ from the World Health Organization (WHO)

WHAT IS AVIAN INFLUENZA?

Avian influenza, or "bird flu", is a contagious disease of animals caused by viruses that normally infect only birds and, less commonly, pigs. Avian influenza viruses are highly species-specific, but have, on rare occasions, crossed the species barrier to infect humans.

In domestic poultry, infection with avian influenza viruses causes two main forms of disease, distinguished by low and high extremes of virulence. The so-called "low pathogenic" form commonly causes only mild symptoms (ruffled feathers, a drop in egg production) and may easily go undetected. The highly pathogenic form is far more dramatic. It spreads very rapidly through poultry flocks, causes disease affecting multiple internal organs, and has a mortality that can approach 100%, often within 48 hours.

WHAT IS SPECIAL ABOUT THE CURRENT OUTBREAKS IN POULTRY?

The current outbreaks of highly pathogenic avian influenza, which began in South-east Asia in mid-2003, are the largest and most severe on record. Never before in the history of this disease have so many countries been simultaneously affected, resulting in the loss of so many birds.

Article continued on page 7.

A Man on Many Missions
by Stacey Miller

Minnesota RT Opens Respiratory School in Afghanistan, Treats Soldiers in Iraq among Other Things

Heeding advice from the pilot, Staff Sgt. Joseph Buhain, BS, RRT, EMT-B, braced himself as the plane swerved from left to right and back. He followed more of the pilot's orders, strapping on his helmet and loading his weapon. Looking out the window of the plane that departed earlier that evening from Kuwait, he saw occasional traces of light cut through the darkness—bullets being fired from the ground.

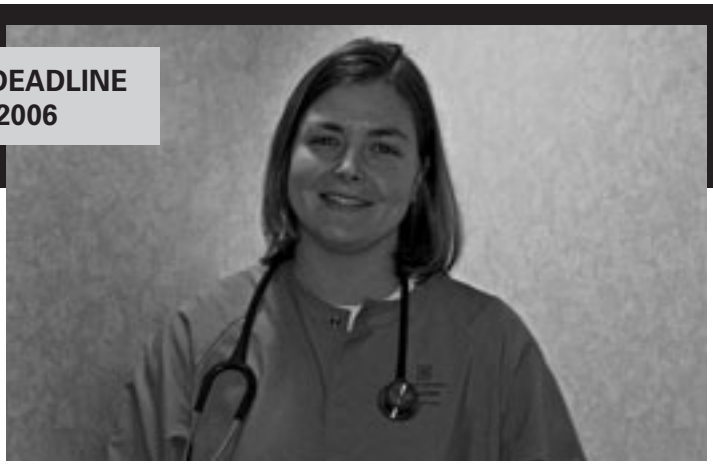
"I kept thinking what's going to happen—are we going to crash?" he recalled. But through the darkness, he heard and felt the thud of the plane as it roughly but safely landed. Yet, safety for the passengers on-board—all Army medics—was miles away. "The pilot said 'Welcome to Baghdad. You have officially been christened.'"

In the 14 months following that chaotic initiation of Iraq in late April 2004, Buhain, 34, an Army reservist for the past 12 years, experienced more than most people do in a lifetime.

Article continued on page 10.

Editor's Note

SPRING ISSUE DEADLINE
MARCH 6, 2006



I would like to send a big THANK YOU out to everyone who participates in the MSRC. We are all volunteers and being an active member can sometimes be a full-time job in itself. Every member is an important part of our network no matter how big or small your role is. For myself, being apart of the MSRC has brought a wealth of knowledge and experience that you just couldn't get anywhere else. I think it's great to be able to communicate and share with other Respiratory Therapists from around the state. These are the people who understand the trial and tribulations of our jobs- things my husband will never get and doesn't have the patience to listen too!

It has been a time of transition for those working on *The Bronchus*. With Kyle Oen's absence (it's ok Kyle; we are still keeping our heads above the water!), we've been contemplating how many cooks we really should have in our kitchen. We have had some great help lately from our Eagle Eye Proof-Reader, Deb Haider, and Carrie Bourassa has had some wonderful influence on this issue also. I don't think *The Bronchus* would survive without Naomi Teske of Amplio Marketing though! So I would like to extend an invitation to anyone who would like to get their feet wet and gain some networking experience with other RTs to join our committee. Send me a line or give me a call- or just contribute an article sometime even! Thank you to everyone and all that you do!

Megan Schultz
Editor

MSRC
Minnesota Society for Respiratory Care

The Bronchus is the official newsletter of the Minnesota Society for Respiratory Care, and an affiliate of the AARC. Published in Minneapolis, Minnesota. *The Bronchus* welcomes articles from respiratory therapists, physicians, nurses, and other health care personnel interested in pulmonary care.

Editorial Guidelines:
The Bronchus welcomes contributions from readers, whether in the form of editorials, counterpoints, or commentaries. The editors of *The Bronchus* make the final decision on what letters are published. All letters must include the writer's name, address, telephone number, and email address if available. This information will be included in the letter if it is published. Any reader responses to a submitted letter will be referred back to the author. Letters must also include the writer's signature. We reserve the right to edit all letters. Letters should be kept brief. By submitting a letter to the editor, a counterpoint letter or a commentary article to the MSRC you are agreeing to give the MSRC permission to publish the letter or article in any format and in any medium. All letters submitted become the property of the MSRC.

All materials for publication including advertisements should be in: MS-Word, Illustrator or QuarkXPress format sent via E-mail to:

The Bronchus:
Megan Schultz: meganterveen@hotmail.com

Change of Address?
If you change your address or are having problems receiving *The Bronchus*, please notify the MSRC c/o:

Jeff Anderson
8400 Coral Sea St. NE Suite #200 Blaine, MN 55449
(763) 780-0100 jander7337@aol.com

It will also be necessary to notify AARC Membership Services at:
11030 Ables Lane Dallas TX, 75229
so that you continue to receive AARC publications.

Would you like to advertise in *THE BRONCHUS?*

2006 RATES	3 Issue Rate	Single Rate	One Time Set-up Fee
Full Page	$425/issue	$450/issue	$100/issue
Half Page	$250/issue	$275/issue	$60/issue
Quarter Page	$150/issue	$175/issue	$40/issue

Building Ads — At present, those customers who do not have the means to construct ads may submit materials* to *The Bronchus* and we will have basic ads constructed for a fee of:

Full Page	$175
Half Page	$150
Quarter Page	$125

** Photos, logos, discs, and script — The builder does not accept camera ready art, please call Ad Manager for assistance.*

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One additional color beyond B&W add:	$80/issue, any size
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Inside Front Cover, full page ads add:	$50/issue
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The website is currently under construction and details regarding job placement and vendor ads are not finalized at this time.

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Fax: (763) 520-4755
nick.kuhnley@northmemorial.com

AARC Hosts Tobacco Cessation Summit

October 10, 2005

The AARC was awarded a grant from the Smoking Cessation Leadership Center located on the University of California at San Francisco campus for the purposes of convening a national summit on the important topic of tobacco cessation. Potential participants were invited to submit answers to a questionnaire demonstrating their expertise and commitment to making a difference in the area of tobacco cessation. The AARC selected 15 participants from an extensive list of potential candidates to participate in a tobacco cessation summit at the AARC Executive Office in Irving, Texas on October 8th and 9th.

Tobacco Cessation Summit Participants at the AARC Executive Office

The participants were:

Janette Salo Korby, (Minnesota) Cynthia Cary, (New York), Roland Romano (New Jersey), Alisa French, (Ohio), Sharon Grindal, (Louisiana), Laura Van Heest, (Michigan), Christine Rossi, (Maine), Lynda Erfurth, (Idaho), Susan Hinson, (North Carolina), Melynn Wakeman, (Arizona) Anne Stark, (Iowa), Kimberly Hunchuk, (Pennsylvania), Mikki Thompson, (Florida), John Wolfe, (Colorado), Karen Schell, (Kansas).

The summit was lead by a professional facilitator, Jolie Bain Pillsbury and was also attended by Connie Revell and Reason Reyes from the Smoking Cessation Leadership Center, AARC President John Hiser and key representatives from the AARC staff. The purpose of the summit was to convene respiratory therapists with expert skills and experience in tobacco cessation to develop an action plan for the profession that will place respiratory therapists in a primary position to impact identification of smokers and provide early intervention techniques.

The summit participants were provided with an overview of key statistics, important findings in the scientific literature and survey results that framed the question, "where are we now?"

Smoking Cessation Leadership Center Deputy Director, Connie Revell addresses the summit participants

A series of discussions combined with small break out sessions provided direction on the key questions of "where do we want to go?" and "how do we get there?"

The final result of the summit was the completion of an action plan that contains the following major premises:

Respiratory Therapists should be role models for a tobacco free lifestyle.

- Respiratory Therapists are uniquely positioned to identify smokers in hospitals and provide front line information/basic counseling on tobacco cessation.
- RT Department Directors should be an advocate for Respiratory Therapists providing tobacco cessation counseling in their institutions by providing proposals to their respective CEOs.
- Training programs are needed to educate RT Directors on key elements of tobacco cessation programs and to provide specific training for Respiratory Therapists.
- Educating consumers and having an impact on the number of people who use tobacco is one of the most profound areas of impact for Respiratory Therapists. The desired affect is to decrease the prevalence of lung disease and ease the financial burden of tobacco related health problems.

A series of techniques and strategies will be employed by "Tobacco Cessation Champions" throughout the United States. A key measure of accomplishment will be increasing the number of respiratory therapists who are involved in tobacco cessation in hospitals. A baseline survey of over 800 respiratory therapy managers and supervisors indicated that in 25% of the reported departments, none of the Respiratory Therapists were involved in tobacco cessation efforts. The goal of the Summit team is to decrease that number by 5% per year over the next 3 years utilizing the implementation plan just developed.

John Wolfe from Colorado makes a point during a break out session

One of the most immediately visible parts of the implementation plan involves asking Respiratory Therapists to indicate their level of interest in a Tobacco-Free Lifestyle Roundtable

Look for a visible presence at the AARC booth at the upcoming International Congress in San Antonio regarding the "Respiratory Therapist's role in Tobacco Cessation," and stay tuned for other updates and calls to action.

GET READY FOR THE

2006 MSRC

STUDENT CAREER FAIR!

SEE PAGE 11 FOR DETAILS...

CPAP Compliance—Everyone wants it, but how do you make it happen and measure it for success?

by Jessie Christopherson, RRT, RCP

Sleep Medicine has been around for over 30 years and much has changed to help patients accept, adhere and enjoy the benefits of positive pressure therapy.

First recognize that Obstructive Sleep Apnea (OSA) is a chronic disease. Symptoms are improved with therapy but the underlying cause does not go away- not even completely with weight loss. In fact most patients after weight loss will continue on a lower level of pressure. OSA is not just a weight issue but has several underlying causes, from airway issues, to complex cerebral issues.

Compliance in general is about as good as pharmaceutical interventions for diabetes and asthma at approximately 50%. However with all chronic disease there are ways to improve these odds.

There are a couple of investigational studies that are up for discussion. One study that has some merit involves "Motivational Enhancement" (ME). It is an intervention that directly targets the constructs of readiness, importance and confidence (Miller and Rollnick, 1991, 2002) ME involves five principles:

- Develop discrepancy
- Express empathy
- Avoid argumentation and accept ambivalence
- Roll with resistance
- Support self-efficacy

DEVELOP DISCREPANCY:

Have the patient distinguish the current risky behavior and the patient's self-identified goals and values. The patient's recognition that the behavior is hindering goal attainment or is not consistent with the values increases negative affect.

EXPRESS EMPATHY:

Change does not come from making a person feel bad about his or her behavior. It is important to create a supportive, patient centered atmosphere where the patient feels comfortable exploring conflicts about change.

AVOID ARGUMENTATION AND ACCEPT AMBIVALENCE:

The patient's argumentation for change will decrease the likelihood of change. The ambivalent patient will naturally want to assert his or her autonomy and argue the opposite side of ambivalence especially in the context of not feeling control for his or her health.

ROLL WITH RESISTANCE:

It is important to support the patient's autonomy by emphasizing that it is his or her choice whether he or she wants to change.

SUPPORT SELF-EFFICACY:

Self efficacy is the person's perceived ability for change in a particular area. Self-efficacy can be augmented through the clinician optimistic statements about the patients ability to change, setting small but achievable sub goals, and by reviewing other efficacy-building experiences and discussing how the achievement of those goals were to due to intrinsic factors within the patient.

To put this in a context that directly pertains to positive pressure adherence here are a few examples where ME can work positively for acceptance. This involves two separate sessions and follow up phone calls.

First session:

- Assess the patient's readiness and confidence to use CPAP as recommended
- Explore the patient's ambivalence about using CPAP
- Provide personalized feedback about the effects of Sleep Disordered Breathing (SDB) on health in a non-threatening, neutral, and non-judgmental manner.
- Provide personalized feedback on how the use of CPAP can improve the patient's own health.
- Build and strengthen the patient's motivation to use (or to continue using) CPAP as directed.

The clinician should review the pretreatment sleep study with him or her. This includes determining what the patient already knows about SDB and then offering to fill in the missing pieces. The clinician briefly reviews the pathophysiology of sleep apnea and, using an anatomical chart, discusses the cycle of falling asleep, upper airway restriction, increased effort to breathe, and forced awakenings to resume breathing. This informational exchange should also review the causes and symptoms of SDB and the medical consequences of SDB for the general population. Following the general discussion, the clinician reviews the patient's sleep study results, highlighting the patient's respiratory disturbance index (RDI) and O2 saturations results. The clinician informs the patient that people who score in the moderate to severe ranges on these measures are at increased risk of hypertension, stroke, and heart disease.

The clinician should empathize and use reflections, ask open-ended questions, adopt a curious and eliciting interview style, personalize results, and focus on the patient's concerns and reactions.

After reviewing the patient's sleep study, engage the patient in a discussion on the benefits of CPAP use, particularly those benefits that are relevant to the patient. During this information exchange, the clinician should review the results of the titration night sleep study. The clinician should emphasize how O2 desaturation and RDI were improved with CPAP use.

To wrap up session 1, the clinician assesses if the patient understands the importance of changing his or her behavior and how much confidence the patient has that he or she can change. Next, negotiate a plan. The clinician and patient identify steps that the patient can do, think about, or notice related to CPAP use. Some sample goals include (a) using CPAP for a portion of the recommended hours each night and having a plan to gradually build up to recommended amount; (b) trying two different strategies to enhance adherence with CPAP before the next meeting; (c) focusing on two benefits of CPAP use every day; and (d) recording improvements in mood and daytime sleepiness every day.

At the end of discussion, the clinician should provide a brief summary of what was discussed, review the patient's goals for the next week, and emphasize the importance of the patient returning for the second session.

Session 2 goals:

- Eliciting subjective appraisals of CPAP use
- Helping the patient to think about the impact of untreated OSA on his or her health and quality of life.
- Exploring ambivalence about routine use of CPAP
- Identifying discrepancies between current (or anticipated) use of CPAP and personal values and long-term goals.

(continued on page 8)

President's Message
(continued from cover)

Thank you to the members of the planning committees for the NRRCC and MN educational programs. Deb Skees and Denise Johnson are to be congratulated on making the joint educational meeting a success. Laurie Tomaszewski, Vicki Engmark and Peggy Lange coordinated our Winter and Fall educational programs and are busy planning educational offerings for 2006.

The MSRC website will have a new look by the New Year. 50 Below Zero, a website development company out of Duluth, MN, is now our website manager. They will aid in the revision and management of the MSRC website and facilitate training of website editors to allow for timely updates of the website. Derek Hustvet will chair our website committee and I, Nick Kuhnley, Megan Schultz, Naomi Teske, Carrie Bourassa and will also participate on the committee. The site will have a new look and will greatly improve our ability to communicate to the RCPs in Minnesota. Our website address has not changed. So feel free to visit it and comment on what you like and what you would like changed. The MSRC website address is www.msrcnet.com.

This past year has increased my appreciation for the AARC. The AARC is working hard to increase membership and currently national membership is approaching 39,000 members. They are being creative in the development of web chat for the specialty areas and have actively promoted RT reimbursement for Home Care. They have been a sounding board for MSRC issues through out the year and their support has been greatly appreciated.

January 1, 2006 will bring our newly elected leadership into office, new goals, and new initiatives will be started to increase communication and better serve Minnesota's RCP population. Carrie Bourassa will continue the commitment to improve communication and increase member opportunities to participate in the MSRC.

The MSRC's Winter Workshop will take place on Friday, January 20, 2006, at the St. Paul College, in St. Paul, MN. The workshop will be free to those who pre-register, or will be $20.00 for walk-ins. It will provide three CEU's, and be followed by the MSRC board meeting. Register on the web at www.msrcnet.com. Guests are encouraged to attend the MSRC board meetings.

The next educational offering will be the Northern Regional Respiratory Care Conference on May 3 – 5, 2006, in Duluth MN. at the DECC. 13 CEU's are planned for this meeting and will cover areas of interest for the various Respiratory Care specialties. This will be the second joint educational meeting between Minnesota and Wisconsin and we hope to see you there. You may find more information regarding the conference on the MSRC website at www.msrcnet.com. Hotel rooms can also be booked at this time in preparation for the meeting.

Communication by the use of e-mail contacts help the MSRC improve communication by submitting to the MSRC President or President Elect your e-mail address and your area of interest in the field of Respiratory Care. Once developed, it would allow for improved communication to our RCPs and aid in controlling the cost of newsletters. The e-mail list would only be used for official MSRC/AARC communications. Please participate in this effort and send your e-mail address to gjohnson@nchs.com or carrie.a.bourassa@healthpartners.com and we will begin to develop the e-mail list for future mailings.

MSRC committee support is needed. For 2006, the Asthma Committee chair position is open as of this time. If interested, please contact Gary Johnson at gjohnson@nchs.com or Carrie Bourassa at carrie.a.bourassa@healthpartners.com and express your interest.

If you would be interested in more information regarding the various committees and their role within the MSRC, feel free to contact one of us. The more participation on a committee the better and I think it will only increase your willingness to do more as a member of the MSRC.

In closing, there was a lot of change that took place this past year and I look forward to supporting the initiatives of our incoming Leadership during the next year. Thank you for the opportunity to have served as your President!

Respectfully submitted,
Gary A. Johnson, RRT - RCP

Avian Influenza...
(continued from cover)

The causative agent, the H5N1 virus, has proved to be especially tenacious. The H5N1 virus is also of particular concern for human health.

WHAT ARE THE IMPLICATIONS FOR HUMAN HEALTH?

The widespread persistence of H5N1 in poultry populations poses two main risks for human health.

The first is the risk of direct infection when the virus passes from poultry to humans, resulting in very severe disease. Unlike normal seasonal influenza, where infection causes only mild respiratory symptoms in most people, the disease caused by H5N1 follows an unusually aggressive clinical course, with rapid deterioration and high fatality. Primary viral pneumonia and multi-organ failure are common. In the present outbreak, more than half of those infected with the virus have died. Most cases have occurred in previously healthy children and young adults.

A second risk, of even greater concern, is that the virus – if given enough opportunities – will change into a form that is highly infectious for humans and spreads easily from person to person. Such a change could mark the start of a global outbreak (a pandemic).

WHERE HAVE HUMAN CASES OCCURRED?

In the current outbreak, laboratory-confirmed human cases have been reported in four countries: Cambodia, Indonesia, Thailand, and Vietnam.

HOW DO PEOPLE BECOME INFECTED?

Direct contact with infected poultry, or surfaces and objects contaminated by their feces, is presently considered the main route of human infection. Exposure is also considered most likely during slaughter, defeathering, butchering, and preparation of poultry for cooking.

DOES THE VIRUS SPREAD EASILY FROM BIRDS TO HUMANS?

No. Though more than 100 human cases have occurred in the current outbreak, this is a small number compared with the huge number of birds affected and the numerous associated opportunities for human exposure, especially in areas where backyard flocks are common. It is not presently understood why some people, and not others, become infected following similar exposures.

HOW SERIOUS IS THE CURRENT PANDEMIC RISK?

The risk of pandemic influenza is serious. With the H5N1 virus now firmly entrenched in large parts of Asia, the risk that more human cases will occur will persist. While neither the timing nor the severity of the next pandemic can be predicted, the probability that a pandemic will occur has increased.

WHAT IS THE STATUS OF VACCINE DEVELOPMENT AND PRODUCTION?

Although a vaccine against the H5N1 virus is under development in several countries, no vaccine is ready for commercial production and no vaccines are expected to be widely available until several months after the start of a pandemic.

Because the vaccine needs to closely match the pandemic virus, large-scale commercial production will not start until the new virus has emerged and a pandemic has been declared. Current global production capacity falls far short of the demand expected during a pandemic.

WHAT DRUGS ARE AVAILABLE FOR TREATMENT?

Two drugs (in the neuraminidase inhibitors class), oseltamivir (commercially known as Tamiflu) and zanamivir (commercially known as Relenza) can reduce the severity and duration of illness caused by seasonal influenza. The efficacy of the neuraminidase inhibitors depends on their administration within 48 hours after symptom onset. For cases of human infection with H5N1, the drugs may improve prospects of survival, if administered early, but clinical data are limited. The H5N1 virus is expected to be susceptible to the neuraminidase inhibitors.

CAN A PANDEMIC BE PREVENTED?

No one knows with certainty. The best way to prevent a pandemic would be to eliminate the virus from birds, but it has become increasingly doubtful if this can be achieved within the near future.

WHAT STRATEGIC ACTIONS ARE RECOMMENDED BY WHO?

In August 2005, WHO sent all countries a document outlining recommended strategic actions for responding to the avian influenza pandemic threat. Recommended actions aim to strengthen national preparedness, reduce opportunities for a pandemic virus to emerge, improve the early warning system, delay initial international spread, and accelerate vaccine development.

IS THE WORLD ADEQUATELY PREPARED?

No. Despite an advance warning that has lasted almost two years, the world is ill-prepared to defend itself during a pandemic. WHO has urged all countries to develop preparedness plans, but only around 40 have done so. WHO has further urged countries with adequate resources to stockpile antiviral drugs nationally for use at the start of a pandemic. Around 30 countries are purchasing large quantities of these drugs, but the manufacturer has no capacity to fill these orders immediately. On present trends, most developing countries will have no access to vaccines and antiviral drugs throughout the duration of a pandemic.

For more information please visit:

http://www.who.int/csr/disease/avian_influenza/

CPAP Compliance...
(continued from page 5)

- Building or strengthening motivation to use (or continue using) CPAP as directed.
- Having the patient identify rewards that will encourage ongoing use of CPAP
- Setting goals or small steps that will facilitate the use of CPAP.

After going in detail with above elicited steps finally, the clinician should provide a summary of this session and what the patient has agreed to do, which should include the following:

- Concerns the patient has over his or her health and continuing with untreated SDB.
- Symptoms related to untreated SDB and other medical conditions that the patient may be at risk for.
- Any benefits the patient may have experienced after trying CPAP
- The patient's motivation and confidence to use CPAP
- The ultimate goal the patient has for using CPAP.
- Barriers or difficulties related to recommended use.
- Specific goals the patient has set or changes that the patient would like to make.
- A reminder that ultimate success may take some experimenting with different strategies.
- Informing the patient that the clinician is confident that he or she can meet his or her goals.

The follow up phone call:

The follow-up phone call is designed as a booster session for patients. An assessment is conducted of the patient's CPAP use. The patient is reinforced for any attempts at using and a discussion is held regarding his or her intended or desired use. Motivation to use is assessed, as well as the implementation of any behavioral methods designed to improve CPAP use that were discussed in the face-to-face sessions. Additional strategies are discussed to address any additional barriers to treatment.

Once again, this is at a point of investigational design but something to seriously think about concerning CPAP compliance and effectiveness. We have to get away from thinking we are just an equipment focused community, and instead, address more of patient's fears, overall acceptance and motivation for using CPAP.

I have highlighted a few of the ideas of ME. If you wish to get additional information please see "Behavioral Sleep Medicine", 2 (4), 205-222. Clinical Management of Poor Adherence to CPAP: Motivational Enhancement.

We all need to step out of our box of comfort and make sure we are measuring our successes and areas of needed improvement when it comes to patient education. Effective change is not only difficult for patients but can be for clinicians as well. We tend to stay with what we know and not always what is best for the patient.

There is nothing more rewarding then being a part of positive outcomes, both for the patient and the clinician, due to hard work, increased knowledge and goal setting.

You can make a difference one person at a time!

November Declared COPD Awareness Month
by Carrie Bourassa, RRT

November Once Again Declared COPD Awareness Month in Minnesota


STATE OF MINNESOTA
Proclamation
CHRONIC OBSTRUCTIVE PULMONARY DISEASE AWARENESS MONTH

COPD affects at least 10 percent of adults over the age of 40 throughout the world and is the 4th leading cause of death. The World Health Organization estimates that 600 million people worldwide have COPD and many of them remain untreated. Respiratory therapists play a vital role in diagnosing, treating, controlling, and preventing COPD as well as educating their patients about this devastating disease.

The MSRC encourages you to check the AARC website at www.aarc.org for resources in the fight against COPD.

Where We Work

C.O.R.E. Respiratory Services

by Barb Sheerwood

When asked why I enjoy working for C.O.R.E. Respiratory Services, a company that provides staffing to hospitals and BLS education, the answer is easy. I love the versatility of my job. I get the opportunity to see all patient ages and types including premature babies, trauma/burn patients, chronically vent dependent patients. I also am happy that I get to teach CPR classes in addition to patient care.

Working for C.O.R.E. allows me the flexibility to do the things that I enjoy as well as the opportunity to learn new things. Working as a part of all these different teams allows me to participate in many aspects with the different departments and many procedures, as well as equipment used at various sites. With this exposure I can share experiences from one department that may be beneficial to another department.

All of these things help to make my job one that I love. However, what makes my job the most fun is the people. I get the chance to work with such great people in diverse departments in addition to all of my great C.O.R.E. coworkers.

The people are what make my job great!

GET READY FOR THE 2006

SPUTUM BOWL

SEE PAGE 11 FOR DETAILS...

A Man on Many Missions
(continued from cover)

His list of accomplishments during that time is lengthy. Following a six-month stint in Iraq, Buhain served eight months in Afghanistan. While there, he started a respiratory school for Afghan medical students and built from scratch, an ICU in a hospital in Kandahar. Recognizing his efforts in both countries, the Army awarded Buhain both a Bronze Star and the Army Commendation Medals. Other awards and medals include the Operation Iraqi Campaign Medal, Operation Enduring Freedom Medal, Overseas Service Ribbon, Good Conduct Medal, and Combat Medical Badge.

In his civilian life, Buhain's work is just as prolific. He's the director of the Respiratory Care program at St. Paul College in St. Paul, Minn., and a staff therapist at Mayo Clinic in Rochester, Minn. He will receive his master's degree in business administration in December. By that time, he also hopes to have logged the 20 hours he needs to earn his pilot's license.

THE UNITED STATES OF AMERICA

THE BRONZE STAR MEDAL

TO STAFF SERGEANT JOSEPH P. BUHAIN
TASK FORCE VICTORY

FOR EXCEPTIONALLY MERITORIOUS SERVICE WHILE SERVING AS A MEMBER OF THE COMBINED/JOINT TASK FORCE – 76, IN AFGHANISTAN. STAFF SERGEANT BUHAIN'S PERSONAL COURAGE AND COMMITMENT TO MISSION ACCOMPLISHMENT IN A COMBAT ZONE, UNDER THE MOST EXTREME OF CIRCUMSTANCES, GREATLY CONTRIBUTED TO THE SUCCESS OF OPERATION ENDURING FREEDOM. STAFF SERGEANT BUHAIN'S PERFORMANCE REFLECTS GREAT CREDIT UPON HIMSELF, THE COMBINED/JOINT TASK FORCE – 76, AND THE UNITED STATES CENTRAL COMMAND.

FROM 29 MAY 2004 TO 12 MAY 2005

GIVEN UNDER MY HAND IN THE CITY OF WASHINGTON

For now, his military career is on hold due to a knee injury he sustained when a grenade hit his unit's vehicle in a convoy medical mission in Afghanistan. He tore some ligaments in his leg and required a complete ACL reconstruction as a result of the blast. He was awarded the Combat Medical Badge for this incident as the direct medic in charge of the wounded. All troops made it home that day. Buhain was the only injured personnel. Since June 8, he has been home in Rochester healing and catching up on lost time with his wife, Dawn Marie, a nurse anesthetist, and daughters, Abigail and Emily. Their will soon be a third addition in the upcoming 9 months.

'Saddest Month of My Life'

Seeing two war zones in one deployment is rare for a reservist, someone whose commitment to the military is confined to a weekend per month. But Buhain's dual background as a medic and respiratory therapist made him indispensable. His original assignment was with a civil affairs unit to be based in Afghanistan, but when a medic of another unit that was deployed to Baghdad was injured, the Army rang.

"The officer-in-charge said 'We need you in Baghdad. There are men dying on ventilators over there. We are short RTs.'"

Four days later, he left for Ft. Hood, Texas then went on to Fort Bliss, Texas, and finally his group of 80 active army medical personnel landed in Kuwait where they prepared to head to Iraq. Anticipating the potential threats that awaited them in the bordering country, the troops got their NBC (nuclear, biological and chemical) masks ready for use, dressed in the full uniform, loaded their weapons and learned last-minute drills in case of a convoy attack or bombing.
"As a Respiratory Care Practitioner, you go to work and think 'OK, it's time to put on the stethoscope.' It's the same thing there, but you carry a gun instead of a stethoscope.'"

His first full month in Iraq—May 2004—was the "saddest month in my life," Buhain said. That month he tried to save many Americans, but many Americans including coalition personnel died. A day without a mass-casualty call was an unusual day at the 31st Combat Support Hospital. That month, 60 U.S. service men and women including national coalition members were killed in Iraq. Although it was heartbreaking, my job was to do the best I can do. All medical personnel including nurses, RT's and Docs worked long hours. Medical personnel worked to save the lives of hundreds of coalition uniformed members and prisoners of war. Trauma was great and it was each person's will, admiration and dedication that gave courage for all of us to work longer hours. When you see a comrade in uniform down, all you can think of is helping as much as you can. You where sometimes ordered to go to sleep but as medics, we learned to forget about the word sleep.

"There was neuro patient after neuro patient, intubation after intubation. EMTs were intubating out on the field but they didn't know how to manage ventilators so the RTs were called," he explained. RT's had to learn to manipulate ventilator settings. We used Eagle Ventilators and those where extreme. We learn to break it down and put it back together again quickly. H cylinders where used to maintain oxygenation and those ran quickly. Patients where sometimes in and out, but the real sick ones where being managed the best we could on a daily basis."

Two American deaths remain vivid in Buhain's mind. The first patient who died under his care was a young Asian man. Also Asian, Buhain felt a connection with the young man as he gave the soldier CPR, sadly to no avail. The other, a female soldier, was critically injured when a suicide bomber attacked a Memorial Day picnic in the mess hall.

"I don't know her name but I can picture her face every day in my mind," he said. "She just looked so innocent and her eyes looked right at me, and I said 'It's going to be OK. I'm an RT.'" But she didn't survive. This was hard for me to tell people but this was a few of many instances military personnel go through on a daily basis. Buhain stated: "I am not upset about going to this country; I am not even upset about doing my job under such circumstances. I only sometimes wish I could do more."

"After awhile you get upset," he told ADVANCE. "Ten Americans would come to the hospital, and the next patient would be the insurgent who attacked them. It made me angry because they were just kids—18 or 19 years old." As the soldiers would come in, we would treat them with utter respect and complete medical care. Nothing lacked behind. We would treat them as if they where in a regular hospitals except you would hear the booms and the gun fire on the background. Buhain still remains angry at times about some situations which he had to accept, however Buhain had learned that war is not to be glorified. This is not the movies and these are real bullets.

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Student's Corner

MSRC Student Career Fair and Sputum Bowl Competition!

STUDENT CAREER FAIR

Last year 125 Respiratory Care students had the opportunity to speak to 25 potential employers at the MSRC Student Career Fair . February is a great time for graduating students to begin making decisions about employment.

Attending this event will give them more information about what opportunities are available for them. Employers interested in attending will find registration information on the MSRC website in December.

A CALL FOR ALL TO JOIN THE SPUTUM BOWL

Just a friendly reminder to all RCP's and students of Respiratory Care in the great state of Minnesota. The state conference will be here before we know it along with the spring thaw. No more of winters glorious snowbanks to dig out of. What better way to welcome the greening of Spring than with a friendly competition. Yes, that's right! It's time to get that team together and join us in Duluth for the annual Sputum Bowl

Did you know that researching questions, quizzing each other about all kinds of respiratory information builds more character than just snow shoveling?

Yes, it's a fact! This winter why not put your knowledge and skills together and create the winning team? Applying is quick, easy and simple. And the team requirements are relatively painless: write a few questions (100), take some digital pictures of respiratory related stuff (15) and send them in. What could be easier?

If you would like to apply or just want more information, drop me an email at rwsherwood@healtheast.org for information, rules and forms or visit the MSRC website to download the rules and the MSRC forms.

Available by request are sample questions to help get you started with yours.

Tobacco Free in Minnesota

by Jan Salo Korby

Do health care costs concern you? Do you feel as though things are out of control, and you can do nothing to stop it? Did you know that in Minnesota alone, each year tobacco use costs our economy 2.64 billion dollars? That is $314 for every person in Minnesota, and about $7 taxpayer expense for every pack smoked.[1] The supposed high "fee" on cigarettes that you hear complained about in Minnesota is $1.43 per pack.[2] This means that for every pack purchased, taxpayers subsidize $5.57 of each pack. And, far worse than the economic burden to our state, are the 5,618 Minnesotans who die in our state every year due to their tobacco use.[3] In addition, Respiratory Care Practitioners know first hand that death can be a small part of the suffering that tobacco users experience.

What can you do? Respiratory Care Practitioners are in a unique position in that we see tobacco users every day. Every Therapist can easily do at least the minimal intervention – (Ask, Advise, Assess, Assist).[4] Surveys repeatedly show that as many as 70% of Minnesota smokers WANT to quit and less than 3% are successful.[5] They need and want our help.

In Minnesota, our residents have free counseling and nicotine replacement available to them through the Minnesota Partnership for Action Against Tobacco (MPAAT) sponsored QuitPlan. They can access this through the telephone, online, or in person throughout the state.[6] An easy way to refer your patients to cessation help would be the national hotline. It is so easy to remember, you can help patients right at the bedside, even in the emergency room **(1-800-QUIT NOW)**[7]

If you need more information, help is on the way.

The AARC has received a grant from the Robert Wood Johnson Foundation and others in order to help respiratory therapists as leaders in tobacco cessation. Fifteen members of the AARC from all over the nation participated in a Tobacco Summit in October.[8] A short list of some of the results of the summit includes:

- A webcast entitled, "RT's role in Smoking Cessation" is being developed,
- Small booklets are being printed that are entitled, "*Helping Smokers Quit – A guide for Respiratory Therapists*",
- The AARC has a roundtable discussion group via the internet that you can join to have your voice heard and to hear more about how RT's are involved in cessation across the country.

Please join the discussion group[9] to hear more of the resources available to you on this topic. Also watch your future *Bronchus* as tobacco free lifestyles are discussed further.

Closer to home, our own MSRC has a committee currently entitled Tobacco Cessation Task Group. Please consider adding your cessation expertise to this committee as we reconnect in this next year to develop our goals. For more information, contact Jan Salo Korby at jsalokorby@aol.com

[1] http://www.health.state.mn.us/divs/hpcd/tpc/tobtoll03.pdf
[2] http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf
[3] http://www.health.state.mn.us/divs/hpcd/tpc/tobcosts.pdf
[4] http//:www.surgeongeneral.gov/tobacco/clinpack.html
[5] http://www.health.state.mn.us/divs/hpcd/tpc/quittingsmoking.pdf
[6] http://www.mpaat.org
[7] http://www.smokefree.gov
[8] http://www.aarc.org/headlines/tobacco_free/
[9] http://www.aarc.org/community/tobacco_free_roundtable/

Respiratory Care Week 2005

by Sommer Jensen, RRT

Respiratory Care Week proved to be action-packed this year for the Respiratory Care Department at North Memorial.

Several events throughout the week were designated to show appreciation to our staff. Respiratory therapists at North Memorial are appreciated all year long, however, Respiratory Care Week is a reason to celebrate our profession with organized activities and events. These events do not have to drain your department's budget. We came up with several inexpensive ways to honor and thank our therapists for their hard work and dedication.

- We prepared "Survival Kits" for each of our therapists to personalize our appreciation towards each and every therapist. The kits included several small items with creative anecdotes to accompany them.
- Everyone loves door prizes. Donated items allowed us to draw names out of a hat every day of the week. The staff looked forward to these daily drawings and many people were able to take something home.
- Our staff quickly determined the need to loosen their belts due to several meals catered in and numerous treats being dropped off. Coordinators from the department put on their chef's hats and prepared breakfast one morning and provided an ice cream social one afternoon.
- Tuesday night was designated for a fun night outside of work at a local bowling alley, but due to everyone's busy schedules, this event did not take place.

This designated week should also be a time to educate the public and promote respiratory therapy to the community.

- A tabletop display was set up in the lobby of our hospital as a way to recognize our therapists and educate the public about various respiratory topics. The display consisted of photos of therapists on the job, a description of our job responsibilities, and several handouts about chronic obstructive pulmonary disease, asthma and tobacco dependence.
- A community event was scheduled for Thursday evening to target our local schools. The event was called Asthma Awareness Night and was a complimentary program open to students with asthma, and their family members. With approximately 120 participants and many positive compliments, we considered the night a success.

There are countless ways to celebrate our profession during Respiratory Care Week. Respiratory Therapists work hard in our profession and deserve to be recognized. Make it fun!

So how did other Respiratory Care Departments from around the state celebrate Respiratory Care Week?

Rice Memorial Hospital, Willmar, MN:

- Lots of free food for RT Staff from a variety of people including Department Director and Assistant Director.
- New insulated lunch bags with Respiratory Care logo were given to all Respiratory Therapists.
- In-services presented included one by Jessica Christopherson from Respironics on ALS and noninvasive ventilation.

St. Joseph's Area Health Services, Park Rapids, MN:

- The Respiratory Care Department served nachos at the hospital along with a Respiratory Care quiz for staff to take and prizes were awarded for the top three quiz scores.

Grand Itasca Hospital, Grand Rapids, MN:

- Unfortunately the department was in the process of moving to there new facility and Respiratory Care Week had to fall to the wayside.

A Man on Many Missions

(continued from page 10)

Buhain, his team of four RTs and the rest of the medical team channeled their anger elsewhere. "We'd do CPR for hours on a soldier because none of us could give up. Everyone worked that hard, and no one left a patient's side for one second. If they were going to breathe their last breath, I stood nearby because I couldn't them die alone." For a soldier to give his life to his country, Buhain felt it was his obligation to try and be a part of his family. Buhain made it his personal commitment to be a father, brother or family member to some of these soldiers.

For his work in Iraq, Buhain received the Commendation Medal for intubating 18 patients and treating 16,000 coalition soldiers—everything from breathing treatments to ICU care. Buhain volunteered for missions that took direct enemy fire and supported medical training for active duty for RT's. His duties included neonatal management in the ICU with burn children or children that needed respiratory care management.

First Respiratory School

Last October, Buhain left Baghdad, Iraq to meet up with the unit he was originally assigned to in Kandahar, Afghanistan (Task Force 168). Here, he saw some change in Baghdad. Instead of getting shot at, as was a daily event in Iraq, his unit was seeing a lot of roadside bombings. And instead of delivering trauma care in the combat support hospital, here Buhain supervised a four-man EMT team as members of a provincial reconstruction team (PRT). Along with rebuilding roads and wells, the PRT's mission was to travel from village to village trying to "win the hearts and minds of the people," Buhain said.

Along the way, he met Col. Richard Gonzales, MD, an orthopedic surgeon from Puerto Rico. Gonzales was committed to helping the medical students in Afghanistan gain a better understanding of orthopedic surgery and other medical fields. Given his experience running the respiratory program at St. Paul College, Buhain was asked to teach residents something respiratory-related. This was above the mission related medical assignment.

"The residents had no idea what respiratory care was," Buhain said. "They had no ventilators, nothing like that. They had no idea what CPR was. All they knew about death was that Allah has taken them. When I introduced them to the idea of breathing in the mouth (CPR), they were questioning it."

Sensitive to their culture's blending of religion and medicine, Buhain explained it's possible to revive people who can't breathe: that simple treatments like CPR can save lives. This was a sensitive issue but Buhain managed to train a majority of the students.

"The next day one of the residents wrote to me and said he had saved a girl's life applying CPR," Buhain said.

Embracing simple therapies was only the beginning for these students. They were introduced to a facet of respiratory issues five nights a week for six months. Seminars covered topics including: Introduction to Mechanical Ventilation, Understanding Hemodynamic Monitoring, EKG Analysis, IV Placement, Sterile Techniques, American Ethics, Evaluation of Mass Casualty, and IV Analysis.

Buhain, an Orlando native, notified his mentor and former educator, Jeffery Ludy, EdD, RRT, director of the Cardiopulmonary Program at the University of Central Florida, of his plans. Ludy sent books and spread word to other respiratory educators. They too sent Buhain textbooks. St. Paul College sent even more books. Buhain contacted the 452nd Combat Support Hospital and with their assistance, SPC Asher, CPT Weideman and Major Rahm sent even more used medical books for the students.

Buhain's class of 350 graduated May 8.

"It was above and beyond my job duty. I felt like I did a lot of work." Bottom line, it was a success. Buhain would like to give credit to visiting Unifomred American MD's from other CSH units in the southern Afhgnaistan region for volunteering their time. Buhain would also like to give credit to his 4 medics for a continued persistence in training and their overall workload.

Another Goal Realized

Work in Afghanistan never slowed or seemed to stop for Buhain. He joined his unit for convoys and missions during the day, sometimes eight hours, sometimes 12. When he returned at 6 p.m., he headed straight for class, which ran until midnight.

"This is what I was doing because I believed that I needed to do something more than my mission," he said. "There were a lot of times I wanted to quit because it was a lot (of work). But it was something I had to continue doing." As Buhain stated with the Afghan medical residents, War can be won by several ways but to win the hearts and minds of these people, we must give them the power to win by the use of their minds through medicine. Buhain wanted them to use their minds and teach others and treat others rather than to pick up a gun and use it. Buhain further surpassed his expectations after he visited Mirwais Hospital. He became committed to building an ICU there. Not only did residents of Kandahar come here for medical care, people used this hospital who lived in four surrounding provinces—an area that more than 4 million people call home.

"Imagine your garage with several beds in one room, but don't clean it up—that's what this hospital looked like," he said. "You have a patient in the bed and family members all around. The floor is just awful; it's gross and just dirty."

(continued on next page)

A Man on Many Missions
(continued from page 14)

Mirwais had no EKG machine, no sterile equipment, no ventilators and none of the FDA-approved medications that Buhain relies on at the Mayo Clinic. Like with his mission with the school, Americans stepped in to help with donations. Chicago donated a pressure-regulated ventilator, the kind preferred by the Army. Mayo Clinic donated two vents, worth a total of $100,000.

Inside the hospital, Buhain juggled his many tasks—building the ICU and educating the students, but a war zone still flared outside. "I did lose guys in my unit. One guy was shot in the head. Two lost an arm. It's a small group of people making it hard for us to win there." Buhain still maintained vigilance as he continued to work in conjunction with these assigned duties.

Living Life to the Fullest

Buhain's internal voice often would drown out the constant background noise of gun shots, mortars and rocket-propelled grenades, asking weighty, existential questions.

"When you're getting fired on, your mind just runs: 'What do you want to do with your life?' 'I want the opportunity to do a lot more.' You learn to live each day as if it were the last because there are people all around you who won't live through the day."

Another epiphany struck Buhain during his tour of duty. He realized the depth of his dedication to respiratory therapy. "I've never seen as much need for respiratory therapists as I did over there," he said. "If ever a CRNA was busy, you bet it was an RT at the doctor's side. I realized my career is always going to be practicing respiratory therapist." Buhain continues, "All I ask from everyone is that they remember that Respiratory Care Practitioners are over their right now fighting for our freedom. I have seen the war, been the war, lived the war and can never forget the war." All I ask is that others remember the commitment those of us has sacrificed. Remember the veterans who have come home and those who have given the ultimate sacrifice. All I ask is for others to believe in us rather than degrade us. All I ask is for Americans everywhere to take the time and 'NEVER FORGET'."

"There were times I would question myself, asking if everything I was doing really worth it. Well, for me, as a Respiratory Care Practitioner, I did everything I could possibly do to win their hearts and minds in Iraq and Afghanistan. If I die tomorrow, I wanted to know that what I did there made a difference."

You can reach Stacey Miller at smiller@merion.com

The MSRC would like to thank Pressworks, Inc. for their support and help in printing this issue of *The Bronchus!*

Pressworks

In The News

Emergency Preparedness Plans Really DO Work

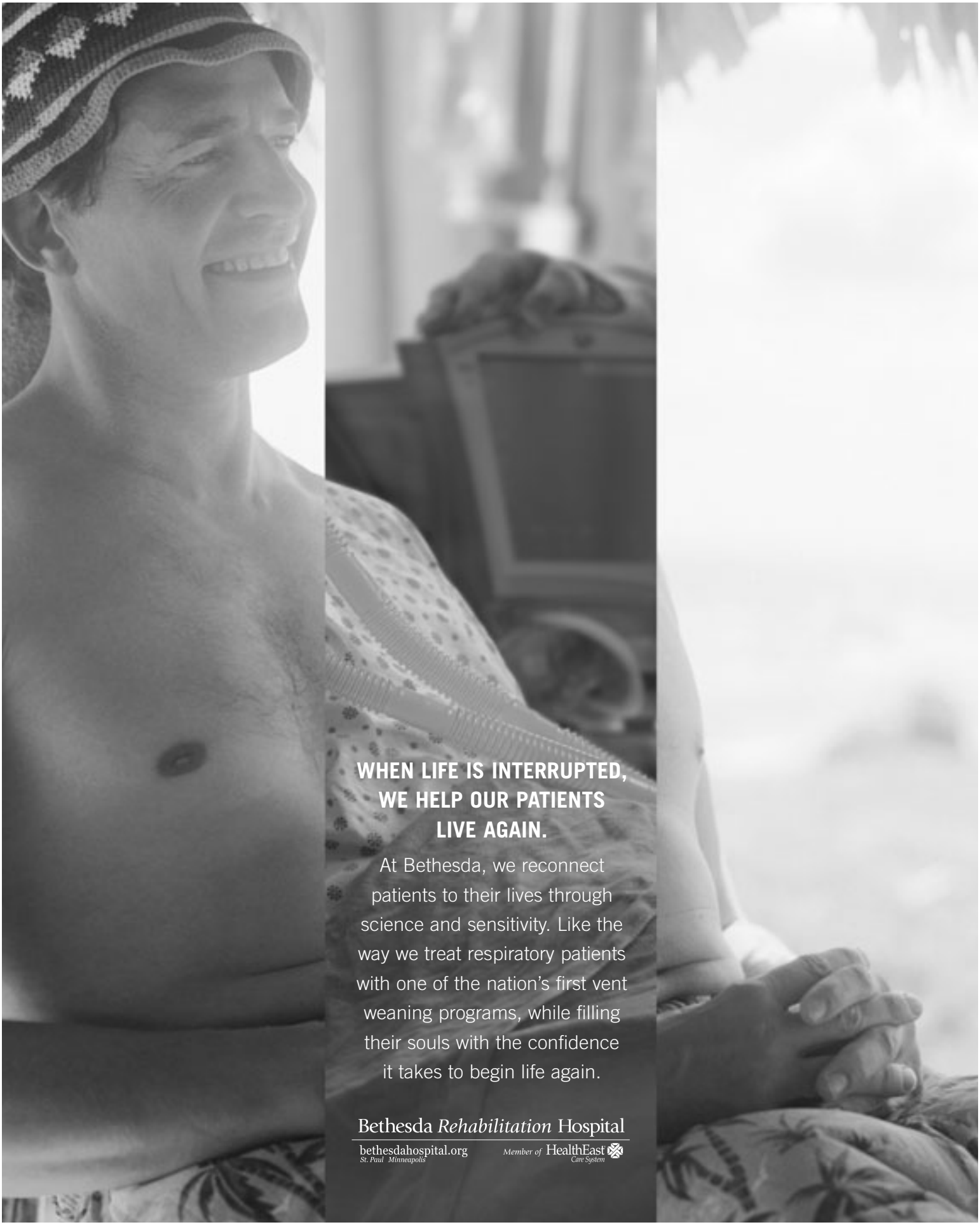
With all the concern over Emergency Preparedness across the country, the Twin Cities area recently experienced its OWN need for a plan due to the severe storm in the north and northwest metro on September 21st.

Liberty Oxygen and Home Care implemented an Emergency Plan in which all oxygen customers in the north and northwest metro were contacted to ensure they had electricity. If not, did they have enough portable oxygen tanks to last through the power outage due to the storm?

Using the "divide and conquer" strategy, half of the staff were calling oxygen customers in the storm ravaged areas to verify the status of their power and portable tank inventory. The other half of the staff (including owner Francis Sheehy), were out delivering additional oxygen tanks to customers in need.

The positive response and appreciation from customers, again helps Liberty Oxygen and Home Care to shape our mission of excellent service!

If you would like further info about how **Liberty Oxygen and Home Care** implemented their plan or have any other questions regarding our services, please call us at **952-920-0460**.


WHEN LIFE IS INTERRUPTED,
WE HELP OUR PATIENTS
LIVE AGAIN.
At Bethesda, we reconnect patients to their lives through science and sensitivity. Like the way we treat respiratory patients with one of the nation's first vent weaning programs, while filling their souls with the confidence it takes to begin life again.
Bethesda Rehabilitation Hospital
bethesdahospital.org
St. Paul Minneapolis
Member of HealthEast Care System

Save the Date

Important Dates for Upcoming Events.
MSRC 2005

January 20, 2006:	Winter Workshop: (Time TBA); St. Paul College – St. Paul, MN
February 17, 2006:	MSRC Student Career Fair and Sputum Bowl Competition; College of St. Catherine – St. Paul, MN
February 17, 2006:	BOD Meeting; College of St. Catherine – St. Paul, MN
March, 2006:	ALAMN Asthma Educator Certificate Course; Contact Glory Dennison, 651-268-7581 or glory@alamn.org
March, 2006:	ALAMN COPD Educator Course; Contact Glory Dennison, 651-268-7581 or glory@alamn.org
April 1, 2006:	3rd Annual Northern Plains Sleep Society Meeting; Park Nicollet Clinic Auditorium – St. Louis Park, MN *(Note: 7 CEU's through the AARC and APT applied for.)*
April 7, 2006:	Electronic BOD Meeting: 3:00pm; MSRC Website
May 3–5, 2006:	Annual NRRCC; Duluth, MN
May 18, 2006:	3rd Annual Asthma Sharing Conference; St. Cloud, MN Contact Glory Dennison, 651-268-7581 or glory@alamn.org