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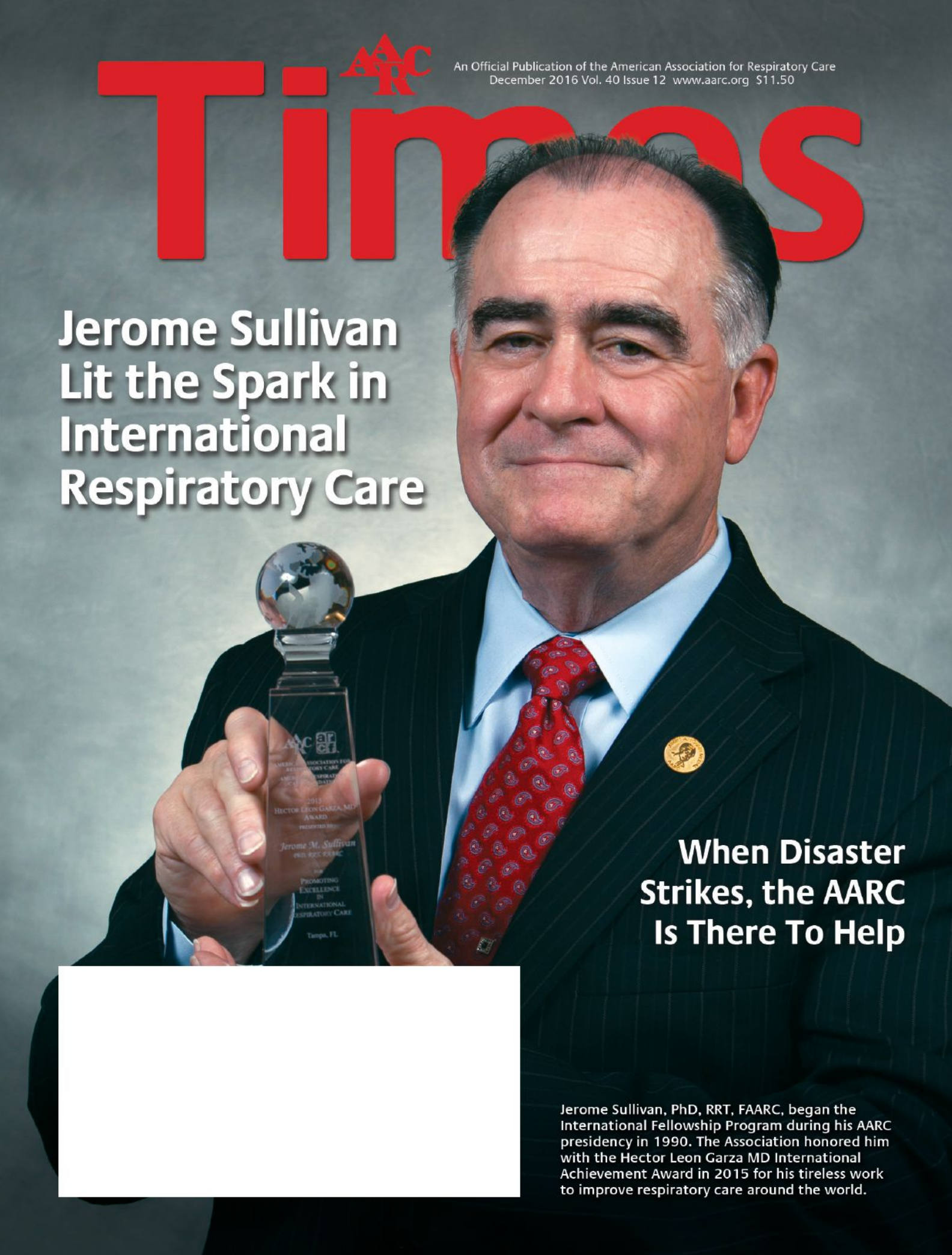
AARC Times

Jerome Sullivan Lit the Spark in International Respiratory Care

When Disaster Strikes, the AARC Is There To Help



Jerome Sullivan, PhD, RRT, FAARC, began the International Fellowship Program during his AARC presidency in 1990. The Association honored him with the Hector Leon Garza MD International Achievement Award in 2015 for his tireless work to improve respiratory care around the world.

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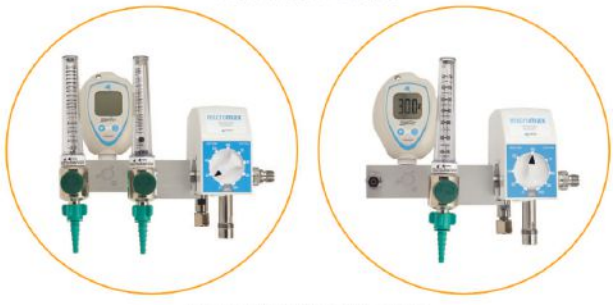

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1. Frat JP, Thille AW, Mercat A, et al. High-Flow Oxygen through nasal cannula in Acute Hypoxemic Respiratory Failure. *N Engl J Med* 2015; 372:2185-2196. doi: 10.1056/NEJMoa1503326
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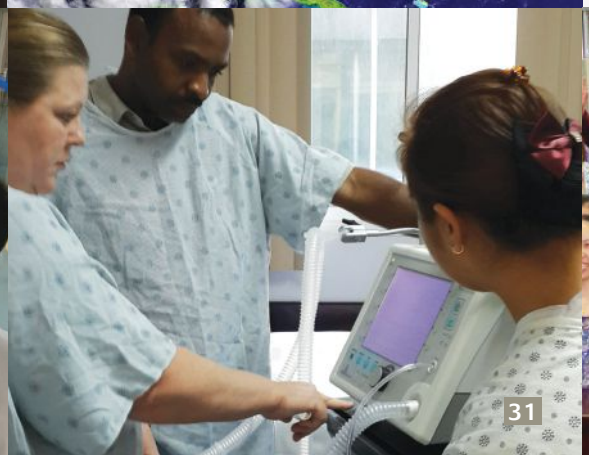

AARC Strategic Plan

The American Association for Respiratory Care has a Strategic Plan that includes its Mission and Vision Statements for 2015–2020.

Bookmark this page: http://www.aarc.org/member_services/mission/.

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Incident Reporting — It Can Be a Good Thing

by Anthony L. DeWitt, JD, RRT, FAARC

D.J. was two years old. She had a smile that could light up a room and was the center of her parents' world. She was a delight, but she had a problem: tonsillitis. It kept recurring. So the family practice doctor that mom worked for decided it was time for those pesky tonsils to come out.

Up to this point, the story could go one of two ways: a happy ending with abated symptoms, or a tragic ending with devastating consequences. In this case, it was the latter, and while medical and nursing negligence played a role in the outcome, it was the culture of the organization that ultimately cost this precious little child her life.

An organization's culture is a function of several things. It starts at the top with the way the organization's administration is perceived by employees, and it feeds all the way down to the bottom where employees make day-to-day decisions. One of the quickest ways to determine whether the organization has an operationally effective culture is to look at how staff perceives incident reports.

Every hospital risk manager will tell you that incident reports are never meant to be tools for discipline. She will tell you that in most cases incident reports help risk managers spot trends and identify risks. She will tell you that, while incidents are a bad thing, incident reports are a good thing. And in 90% of the hospitals where I have worked, and 100% of the hospitals that I have sued, no one believes a word of it. This is because everyone knows of at least one person who was fired because he or she wrote an incident report, or a physician wrote one on that person. In these organizations, incident reports become a way to "get someone."

It is widely accepted that "nobody's perfect." Everyone makes mistakes. In fact, the proof of that is that erasers are put on pencils. Show me a pencil with an untouched eraser, and I'll show you a pencil that has never been used. It's the same way with mistakes — they happen. Sometimes they are caught and fixed, and no one is hurt. Sometimes they don't get caught. Sometimes people die. But everyone recognizes that mistakes happen because people are human.

If you measure a hospital's quality by the number of incident reports, and assume that fewer incident reports mean higher quality, you're deluding yourself. In fact, it means exactly the opposite and is what killed that two-year-old child. A culture that encourages employees to hide errors to avoid consequences is an organization that is turning a blind eye toward the exact behavior that gets hospitals sued.

The LPN who cared for D.J. after surgery did not use a volume-limiting device on the IV line, and similarly, did not use a pump. Inside 20 minutes, a full liter of salt-poor solution infused into this 25-pound child due to the LPN's error. Instead of notifying her charge nurse, writing out the incident report, and notifying the physician, she instead opted for camouflage. She wrote "new bag hung" in the record and told no one, because everyone knew what happened to people who wrote incident reports. The incentive, if you wanted to keep your job, was to hide your errors. In this case, she buried hers. The child's brainstem herniated from hyponatremia.

Hiding mistakes is like playing Russian roulette. Your mistake may stay hidden the first or even the second time you make it, but eventually one will come back to haunt you. Even if you do not get fired, do you really want to live with the guilt of having caused the death of another person?

about the author...

Anthony L. DeWitt, JD, RRT, FAARC, is an attorney and a partner in the firm Bartimus, Frickleton, and Robertson, PC, and resides in Opelika, AL. He has also published two books and numerous legal journal articles. This article is not a substitute for legal advice.

It's also worth noting that other than intentionally dangerous conduct (e.g., pranks), most mistakes are fixable, and that's particularly true in respiratory care. If you neglect to set alarms properly, and it's discovered by you or someone else, you should write an incident report not because you need to learn from your mistake (you already have). You write it so others may learn from your mistake. Give the wrong medication? Even allergies quickly identified can be treated. Mistakes (like esophageal intubation), if caught quickly, can usually be fixed. Walking away and hoping for a good outcome is whistling past the graveyard. A good organizational culture will recognize that it takes courage to write an incident report, and moral clarity to admit to peers that you are less than perfect.

Incident reports should be championed. Errors happen because people are out there giving care: they're doing exactly what they should be doing. Incident reports should be discussed at department meetings and used to teach lessons and give reminders about patient care. They should not be used primarily to discipline staff.

Note the use of the word "primarily." Incident reports are not and should not be exempt from those painful discussions that occur because someone either cannot or will not conform their behavior to institutional norms. Someone who makes 30 errors a month is someone you probably don't want to keep on staff. Incident reporting analysis can help managers spot weak clinical areas and provide training. But they can also spotlight behavior that is dangerous and risky. One way of looking at incident reporting is to suggest that if, on any day, any other therapist might make the same error, then the incident report exposes a systems problem that requires a systems approach to fix. If, on the other hand, the incident report shows that ignorance or—heaven forbid—hubris is at the core of the incident, then a conversation with the errant therapist about attitude, training, and behavior may be important. At the end of the day, a manager has to eliminate known risks, and allowing unsafe therapists to continue to work in the name of promoting honesty in incident reporting would be, in a word, stupid.

Good managers balance risks and benefits. Therapists should be encouraged to practice with great skill, attention to detail, and in the safest manner possible. They should also be encouraged to admit mistakes so that they and others can learn from them. Striking the balance between an open and honest reporting system and eliminating risks requires managerial skill. It's what makes management a tough job, but also a rewarding one. ■

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— 2016 —

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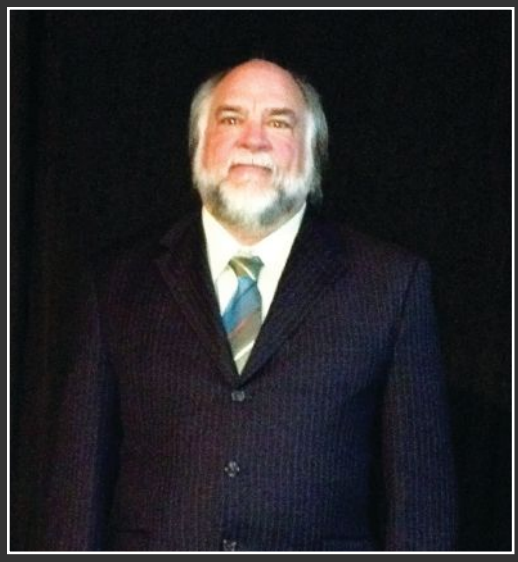
When Disaster Strikes, the AARC Is There

Disaster Relief Fund helps members in their time of need

by Debbie Bunch

An active member of the Louisiana Society, Shelia Guidry is proud of her Association for helping members in their time of need.



Jim Lanoha and his colleagues in Louisiana appreciate the help RTs in his state have received from the Disaster Relief Fund.

When Hurricane Andrew barreled on shore near Miami, FL, in August of 1992, it was the worst hurricane to ever hit the United States. With wind speeds up to 165 miles per hour, the category five storm devastated the suburb of Homestead, wiping out entire blocks of homes and killing 65 people before continuing on its way to wreak more havoc as a category three hurricane in parts of Louisiana. Other states bore the brunt, too, as tornadoes spurred by Andrew zeroed in on communities in Alabama, Georgia, and Mississippi.

Like the rest of the country, AARC leaders were glued to their television sets, watching as disastrous scene after disastrous scene unfolded before them. But when they learned some of their own members were caught in the crosshairs, they did more than just watch and sympathize. They came together in a meeting of the minds to decide what they could do to help, and the AARC Disaster Relief Fund was born.

Seeded with an initial $10,000 grant from the Association itself, the fund has gone on to assist more than 250 members across the country who have lost personal property as a result of a federally declared natural disaster. From hurricanes to tornadoes to floods to wildfires, the fund has been there when members found themselves reeling from devastating losses caused by Mother Nature. The grants they've received from their professional organization have not only helped them recover financially, but perhaps even more importantly, they have given them a much needed boost at a time in their lives when it seemed as if everything was going against them.

Hard hit state

Nowhere has that been truer than in Louisiana, where the fund has benefited some 100 members over the years. "Since the fund's inception in 1992 there have been 12 named hurricanes in Louisiana, with flooding and tornadoes on top of that," says Jim Lanoha, RRT, FAARC, a longtime member from Ventress, LA. They've all left a path of destruction, and the support the AARC has shown for members there has been much appreciated. Lanoha has had two such experiences himself.

All associations will tell you they are there for their members. The AARC walks the walk with its Disaster Relief Fund.

This is the view outside of one of Lanoha's rental properties during last summer's flood.

This used to be the kitchen of a nice waterfront home owned by Lanoha.

"When Katrina hit, I was in Gulf Shores, LA, for Labor Day weekend," recalls the Louisiana Society for Respiratory Care (LSRC) delegate to the AARC House of Delegates (HOD). "They evacuated us and I ended up in Atlanta, GA." When the storm subsided to the point where he could head home, it took a full four days to make what should have been an eight-hour trip, and the things he saw as he got closer and closer to Ventress were horrifying.

"On the way home it was like being in Vietnam — people fighting over five gallons of gas," Lanoha says. When he arrived at his house there was no power, and when power finally did return five days later and his phone rang for the first time, he was sure it was his mother finally getting through to check on him. It wasn't.

"First phone call I got when the phone came back on… was from AARC Director of Government Affairs Cheryl West. The AARC was calling to check up on people. Her first words were, 'What can the AARC do to help?' They were there like family," says Lanoha.

When Hurricane Gustav was on its way a few years later, Lanoha and his family evacuated to their home in Hot Springs, AR, where they remained for three weeks. His home back in Louisiana was extensively damaged and he decided to apply for a grant from the Disaster Relief Fund. When he got back in town, the power was still off. "Came home, no electricity, no Internet . . . but still bills for those services in the mailbox," he says. "The only good thing in there was the AARC check."

Getting that check at a time like that, he continues, did wonders for his outlook on life. "When you're in a situation where you're still getting bills for services you didn't get, to get a check in that same batch of bills when I got home, it did touch me."

Shelia Guidry, CRT, says she felt the same way after she received a Disaster Relief Fund grant to help pay for some of the damage she incurred during Hurricane Gustav. "This was a hurricane with peak winds of 90 miles per hour when it impacted my town, so it was more of a wind damage event rather than a flood event," explains the RT from Houma who also serves as an LSRC delegate in the HOD. "We suffered extensive roof damage, which led to water damage inside of our home, and we were also without electrical power for five days."

She and her family did have insurance, but with a hurricane deductible of $4,000 and additional damage to pay for at her husband's business office and warehouse, the check she got from the AARC was certainly welcomed. "I have been an AARC member since 1983 and felt honored that my professional association had a fund to help its members in times of need," she says. "Our LSRC board of directors donates to this fund every year so it can continue to grow and be there for many years to come for therapists in need."

Paying it forward

Debbie Linhart, BS, RRT, is one member who has given to the fund on an individual basis and believes it is something all members can and should do as well. The $1,000 check she wrote to the fund back in 2012 was inspired by a $500 check she had received from her fellow members of the AARC HOD a few years earlier when several adverse

events combined to put a financial strain on her family. The money could not be repaid to the individuals who had contributed it because their names and the amounts they had given were not known, so she donated it to the Disaster Relief Fund, matching it with $500 of her own.

"In July 2007 at the House of Delegates meeting in Reno, I developed a medical problem," explains the recently retired therapist from Winfield, IL. Linhart was unable to work for two and a half months, and during that time a small tornado or microburst hit her neighborhood. Power was out for four days during the heat of August and her basement was flooded, destroying most of her father-in-law's extensive collection of World War II memorabilia.

Linhart went back to work on October 1. Ten days later she went to visit a favorite aunt in the hospital. "At about 9 p.m., while I was holding her hand, she died unexpectedly," she says. Much of the night was spent grieving. The next morning Linhart awoke and went downstairs to find her husband lying dead on the kitchen floor.

"My husband, not yet 60, had no will, so some of our funds were hard to access and I had immediate expenses preparing for his funeral," she says. "Imagine my surprise and relief when I received a check for over $500 from my fellow members of the HOD. After feeling like life had been smacking me upside the head with a 2-by-4 for the last three months, it truly touched my heart that the AARC HOD cared and were trying to help take some weight off my shoulders."

Paying the money back and paying the generosity forward some five years later when she was named Outstanding Affiliate Contributor of the Year just seemed like the right thing to do. "I knew that the Disaster Relief Fund comes from donations, and my hope was to inspire others, so when they receive awards or recognition, or have a special event in their lives, they would celebrate their good times by making a contribution to help ease someone else's bad times."

More than a member number

According to the AARC accounting department, the Association disbursed $232,315 in disaster relief benefits to AARC members between 2000 and 2015, and, as of this writing in early fall, added another $9,400 to that total in 2016, with 17 grants alone going to members in Louisiana who suffered devastating losses as a result of the massive flooding that impacted the state in August. Jim Lanoha says the feedback from members in his state has been nothing but positive, and even more so in recent years since the AARC began giving grantees a one-year free membership upon renewal as part of the package. "That's a piece that's not expected when they get their check, and there's been a lot of appreciation for that."

Debbie Linhart believes the fund exemplifies the kind of organization the AARC is to its members. "The AARC, and our state affiliates that comprise it, are not only our public face, national voice, educator, and defender, but truly care about the wellbeing of our members as individuals," she says. "The AARC wants us to thrive, not just survive, as we help our patients do the same."

Having a fund that's there when members need help the most is the Association's way of walking the walk. "I know for a fact that I am not just seen as a member number, but as a person," Linhart says. "I never felt that more than when the AARC HOD came alongside me and lifted me out of a horrible situation by sending the check, and I am grateful I was able to help someone else, too." ■

Members Helping Members

The AARC Disaster Relief Fund would not be possible without generous donations from members like you. To donate to the fund, make a check payable to the AARC, with "Disaster Fund" in the memo section, and mail it to 9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063; call the AARC Customer Service Department at (972) 243-3372 and request to make a donation with a credit card; or go to http://appserver.aarc.org/WEB/Online/Donate/Online/Donate/DonateHome.aspx and donate online.

Your donation today will help make a big difference in a colleague's life tomorrow. ■

Boots on the Ground

AARC member joins Red Cross team to help Louisiana flood victims

Mark Gaines, RRT, RN, has seen more than his fair share of natural disasters. As a member of Disaster Medical Assistance Teams (DMATs) in Connecticut and North Carolina he was deployed during Hurricanes Katrina, Gustav, and Ike, and he was on the ground in New York City after the 9/11 attacks as well.

Now retired from respiratory care, the AARC member is still going strong in the disaster relief arena. Most recently he headed to Louisiana to help the Red Cross after floods ravaged the state last summer.

Worse than Katrina

"Our team was stationed out of Lafayette," says Gaines. "The United Way loaned Red Cross a huge amount of space for administrative work areas, and we also worked closely with Habitat for Humanity and Americorps, who were great partners." In some respects, he says the situation was worse than the one he encountered when he worked in the state after Katrina in 2005. "Driving down IH-10, I saw flooding in areas that were not flooded during Katrina. At least 40,000 homes were under water."

As a respiratory therapist, Gaines spent much of his two weeks in Louisiana assisting flood victims with their health care needs. "We arranged for people to be provided medications, walkers, glasses, and other special needs," he says, noting that when disaster strikes, these items are often left behind as people flee their homes. His first case involved an MDI refill and he saw a lot of problems related to mold and asthma. "We were busy for a few days, my being on a first-name basis with the pharmacy staff at Walgreens in Lafayette." The shelter they were working in actually opened onto the parking lot of the hospital ER, and he wheeled several patients over there during his stay — one of whom ended up in the ICU.

At one point, he was sent out to a rural area outside of Lafayette to address the medical needs residents there were having and was impressed by the ability they'd already shown to pull together and make sure their neighbors were okay. "Even all of the prescriptions and doctors' visits were taken care of," says Gaines. "These are folks in mobile homes and living in poverty. Their spirit left a profound impression on me."

We got the job done

Gaines and the other medical professionals on his team helped out by supplying shelter, food, and comfort to those affected by the flooding as well, with everyone pitching in wherever and whenever they were needed. "It was among the very best teams it has been my privilege to serve with in my entire career," he says. "We all switched roles and jobs constantly. We got the job done."

After two weeks in the state, Gaines headed home to North Carolina feeling good about the role he played in helping people in Louisiana deal with the devastating blow dealt to them by Mother Nature. "It was a very positive experience and I plan on doing it again," says the therapist. "I always remember that we could be calling in help to North Carolina after a hurricane. It could be us needing help next." ■

Cars were under water throughout the Lafayette area.

Mark Gaines has a long history of working in disaster relief efforts.

2016 TAX-SAVING IDEAS FOR THE RT

by Tony Lovio, CPA

I have traditionally written this article after year's end, when you're doing your income taxes for the prior year. That's fine, but it struck me that maybe it would be good to talk taxes ***BEFORE*** the year end so you might take some actions now that could lower the taxes you'll pay for 2016. So this article is appearing in 2016 instead of 2017 and we'll briefly discuss several strategies.

Remember also that the tips and information in this article are for general information purposes only. Your factual circumstances are unique to you; if you think these points can possibly help, you should consult with a local tax professional. All publications referred to herein are available on the IRS web site at www.irs.gov or by calling (800) TAX-FORM.

Postponing income and accelerating deductions

If you expect to be in a lower tax bracket in the future due to such events as retirement or job/life changes, it usually makes sense to delay income or accelerate deductions into the current year. Examples include:

- Delaying some bonus payment or other income you have control of, or paying property or income taxes early
- Making charitable contributions early (see more below)
- Selling loss-generating investments
- This can be as easy as making a January mortgage payment in December because it's paying December interest. (Once you start this, though, you need to do so at the end of each year.)

Postponing deductions and accelerating income

The opposite of the above is true if you expect your tax bracket to be higher in the future because of significantly increasing income or loss of certain deductions (like a house being paid off, children going out on their own or downsizing to a house with lower property taxes and interest). Here you can:

- Delay deductible expenses in the next year or
- Sell gain-generating investments

Other strategies discussed below can also help, depending on which side of this fence you may be on.

Payroll withholding taxes

Did your income from all sources (wages, investment, rental, etc.) significantly change during the year that might impact your taxes? While it's close to year-end, you still may be able to change your withholding status and change your taxes withheld so you will not have to pay too much or too little. Talk to your payroll department about signing a new W-4.

Contribute to your retirement plan

If you have access to a retirement plan through your employer, consider increasing the amount withheld from each paycheck. Retirement can sneak up on you — you wake up one day thinking "Wow! I need to do something!" Do it now and save the taxes.

Even with a modest increase in contributions, you still have time to make a significant difference before December 31 and in the long run. If you use a traditional 401(k), 403(b), or similar plan, your contributions reduce your taxable income for this year.

If you have an individual retirement account or another retirement plan that allows you to add money after the end of the year but before you file your return, it can be easy to put off making contributions.

That strategy may not be the best choice.

For one thing, it's easier to put the money aside little by little instead of trying to come up with the entire amount at tax time. By waiting, you risk not being able to contribute as much as you would have liked. Plus, the sooner you contribute to your retirement plan, the sooner your money starts working for you.

Health savings accounts

Similar to the retirement accounts, if you have a health savings account with your medical plan, you can check to see how much you and your company have contributed to it in 2016. You might be able to increase your contribution up to certain maximums and save on taxes.

Make cash and non-cash donations

Instead of waiting until December 31 to donate to your favorite charity, why not do it now?

This is the perfect time of the year before the holidays to sort through old clothes, kid's toys, and any outdoor equipment you no longer need and may never use again. I recently donated several old suits and clothes to a charity because, for some unknown reason, they had "shrunk." I don't understand it.

Donating larger items like an old car or truck are also possible, but your deduction is generally limited to what the charity later sells it for. Make sure you get a receipt (with a description of what was given) to document what was donated. You, however, are still responsible for assigning value.

If you donate an item worth more than $250, get an additional statement from the charitable organization that describes the item ***and whether you received anything of value in return.*** This is important because the IRS has denied deductions without such a statement even if you can prove your donation was given. Like I mentioned above, you will have to supply the value of the donated item yourself.

It's also a good idea to make charitable cash contributions now. If you wait until after the holiday season, you may be more pressed for money. You may find it advantageous to set up a regular charitable contribution plan. In some cases, you can select a set amount to be deducted from your paycheck and directly deposited to a charity. Or you can set up a recurring charitable gift online.

Last, make sure your charity qualifies as one that donations to are tax deductible. Not all non-profit organizations qualify.

Thinking of buying a new car?

If you itemize deductions, the IRS allows you to take a state income tax *or* state sales tax deduction, whichever

is greater. If your state income taxes are small or if you are in a handful of states that don't have an income tax, taking the state sales tax deduction is best for you. And if you take the sales tax deduction, you can add the sales tax for a new car purchase (or certain other large items) to the deduction you get from using the sales tax tables. This, again, gives you a further deduction in 2016 that might be your advantage instead of being in 2017.

Save taxes and energy at the same time

With winter approaching, it's smart to think about the energy-saving measures you can take now to avoid large utility bills when cold weather comes. And you can even lower your tax bill in the process.

When you buy insulation, windows, doors, or a roof, look for products that come with a manufacturer's credit certification. It could mean you qualify for a 10 percent credit on your cost, courtesy of the non-business energy property credit. Just keep in mind this credit is limited to $200 for windows, $50 for a furnace-circulating fan, $150 for a furnace or boiler, and $300 for any other single residential energy property cost. The total lifetime limit is $500. Not huge — but certainly a nice extra.

The residential energy efficient property credit gives you 30% back as a credit on your tax return when you buy alternative energy equipment. This includes items such as solar energy systems, fuel cells, small wind energy systems, or geothermal heat pumps. Fortunately, this credit has no limit (except on fuel cells). Also, if you can't use the entire credit this year because your income taxes are lower than your credit, you can carry the unused portion forward to next year. There are restrictions regarding when some types of property must be put in service to qualify, so check with your tax advisor to see if there's a potential benefit to you here.

Are you close to Social Security or Medicare age?

Endless reams of books and articles have been written on this, and I only bring it up to say if you are close to age 62 or 65 you should:

- Visit the Social Security website to validate your earnings and see your approximate future benefits (www.ssa.gov). You really should do the validation every year — starting now.
- Contact the Social Security Administration or your investment advisor if you are close to retirement and need to understand the options and impact on such things as your:
  - Continuing to work just before and after full retirement age
  - Social Security payment options
  - Health savings account
  - Medicare plans

It's complicated, with many potential pitfalls and penalties involved if not done right.

Fantasy football

It's football season. Are you a fantasy football player? If so, and you win money, the IRS says it's taxable hobby income. If you win big (>$600), you should even get a form 1099 MISC, which reports your earnings. Beyond winning, the only other good news is you deduct some hobby expenses (e.g. fantasy league entrance fee) but you must itemize to do so and include it under "miscellaneous deductions," which have a two percent of adjusted gross income level that must be exceeded.

Education credits

This tax article in past years (last one was in February 2016 *AARC Times*) has stressed the education credits and deductions available. These include:

- American opportunity tax credit
- Lifetime learning credit
- Tuition and fees deduction

The only new wrinkle in 2016 is that to claim any of these, you ***must*** have received a form 1098T from the educational institution you attended. There may be confusion as to why the amounts reported on 1098T don't agree with your payments made. This is often true because payments made include insurance, room and board, books, and health fees, which are generally not considered qualified tuition and related expenses.

Organization is the secret to good planning

This time of year is also a good checkpoint to assess your finances. It's hard to plan for your taxes if you don't know where you stand. Take the time to review your income and any tax-related expenses you've accumulated so far this year.

Sort through receipts, organize important documents, and tuck them away in a safe spot so you won't miss an important deduction when you file your return.

I have a top drawer in a dining room buffet that I put all my tax-related paperwork in from November until the day I start my return. In the course of doing my return, I create a binder (3-ring notebook type file) that I put all my tax documents in that I can easily refer to later or in future years as I need it.

Once your information is organized, set aside a few minutes to estimate your 2016 taxes. Doing so will help you determine if the right amount of tax is being withheld from your paycheck. If you're having too much or not enough withheld, use Form W-4 (mentioned above) to adjust your withholdings.

If you're self-employed, estimating your taxes is the best way to know if you're paying enough in quarterly estimated taxes. It goes without saying, if you are self-employed, make sure your estimates are made timely and as accurate as possible as there can be penalties for significant underpayments.

Staying organized will help you make smart decisions for the rest of the year and beyond.

Three tips to get your refund faster

1. *File early.* It's a good idea to file your return as early as you can. Fighting the urge to procrastinate will land you closer to the front of the line when the IRS starts processing returns. And that means you'll get your refund faster if you're due to receive one. Plus, filing early reduces the chances that a criminal will use your personal information to file a phony return. Remember, if someone gets access to your Social Security number (SSN), they can file a return in your name! Safeguard your SSN and file your taxes early.
2. *E-file your return.* Mailing a paper return can take several weeks longer to process than filing electronically. Filing your taxes online is faster than penciling numbers onto paper forms, and the IRS will process your return — and refund — more quickly. There are several good programs to do this and the cost is minimal. The program I use costs $10 for the federal return and provides information from the prior year to make the current filing that much easier.
3. *Choose direct deposit.* If you're due a refund, you'll get it sooner if you choose the direct deposit option rather than waiting for a check. In addition, the process is super easy — you just wait for your refund to show up in your bank account!

Another note about filing early

If you are claiming ***the earned income or child care credit*** for 2016, you won't see your refund until after Feb. 15, 2017, as the IRS is taking extra time to ensure such filings are accurate.

Publication 17: This IRS publication is far from a riveting novel but does provide a wealth of information relating to all types of income and deductions. It's worth scanning to see if something might apply to you that could be explored further.

Hopefully I have given you something to think about before your back is against the wall filing on April 14. I'm no expert on all aspects of tax law by any means, but if you do have a question, feel free to contact me at: lovio@aarc.org.

Advance planning beats a panic mode that usually costs more time and money. There are no easy answers here, but with a little effort you can make a difference in your financial life. I have this sign on my office wall which says it all… PLAN AHEAD. ■

About the Author

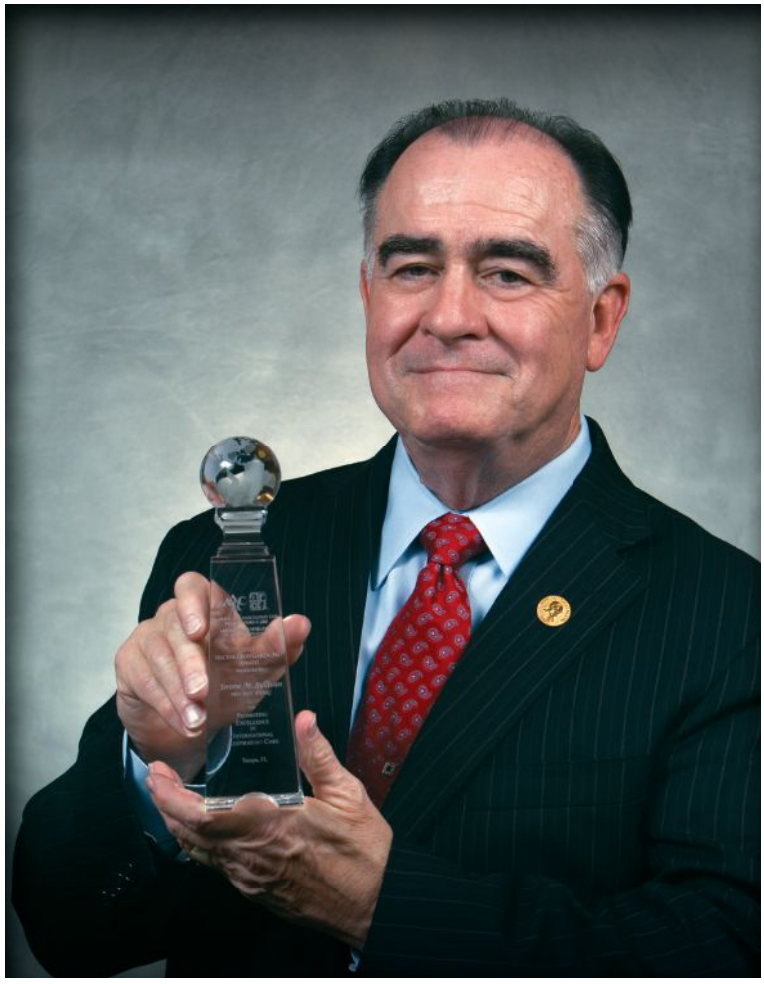
AARC Controller Tony Lovio is a CPA certified in Michigan and Oklahoma. He has more than 40 years of experience in public, private, and non-profit accounting as a chief financial officer, controller, or finance director and has written tax-tip articles for *AARC Times* for several years.

If you are in a 401K or 403B plan, it can get confusing about what funds to invest in, so if that's you, ask your plan administrator if your plan offers any sort of education or investment advice, internally or externally. At AARC, we have educational meetings and an investment advisor provided via our plan trustee, both of which help our employees with such decisions. ■

2015 Hector Leon Garza MD International Achievement Award Winner

Jerome Sullivan

Lit the Spark in International Respiratory Care



The globalization of our profession began with Dr. Sullivan and his mission to open up the lines of communication between U.S. RTs and their colleagues abroad.

Three decades ago, the concept of a separate profession for respiratory care was mainly limited to the United States and Canada. Hardly any emphasis was placed on the need to open up a dialogue with colleagues in other nations, and the idea that we could improve patient care through such an exchange of knowledge wasn't on the radar.

Enter Jerome Sullivan, PhD, RRT, FAARC. With a vision that looked past our borders to the infinite possibilities that existed for respiratory care through the process of globalization, he worked closely with other Association leaders to reach out to colleagues from abroad, a process that culminated with the creation of the AARC International Fellowship Program during his presidential year in 1990. Every international activity undertaken by the AARC since then can trace its roots back to that program, and Dr. Sullivan has spearheaded all of them. In the following interview, our 2015 Hector Leon Garza MD International Achievement Award winner explains why he believes these activities are essential to the success of us all.

How do you believe the fostering a greater sharing of research and information across borders enhances direct patient care for people with pulmonary disorders, both in the United States and abroad?

We often report on our outreach efforts to practitioners of respiratory therapy outside of the United States and the benefits they derive from our systems, support, and direct involvement in their respiratory-related seminars and programs. Less apparent, but just as important, is the tremendous benefit *we* gain through the exchange of knowledge with our counterparts in other countries.

It is this global exchange and interaction that can result in the establishment and application of evidence-based best practices for the treatment of respiratory disease and injury. The learning goes both ways, and sometimes we learn more from our international colleagues than they do from us. Since our international work began in the early 1980s, forward to the present day, I have been amazed by the dedication, professionalism, and high level of interest our respiratory colleagues in other countries bring to their practice. Early in this development, we recognized that the important central feature in our relationships outside the United States was a matter of common interests, not common credentials. Each country evolves its own brand of practitioner to meet the needs of their patients. At the same time, our international counterparts largely support our models of education, credentialing, and clinical practice as the benchmarks for respiratory therapy.

It was during your year as AARC president in 1990 that the whole idea of an international fellowship program was born. What spurred that idea?

In the mid to late 1980s, we had many questions from health care practitioners outside the United States attending the annual AARC Congress meetings regarding our scope of practice and how we were able to develop our profession as a distinct discipline. An even larger issue for them was how we had gained the support and trust of our physician colleagues. Often these questions were addressed at the AARC International Committee meetings. I recall my discus-

Jerome Sullivan began the International Fellowship Program during his year as president of the AARC.

Dr. Sullivan has nourished great relationships with international RTs like Chia-Chen Chu and his students in Taiwan, as well as fostered great exchange programs with RC professionals in various countries around the world.

sions with Jeri Eiserman, 1986 AARC president, on how we could respond to the interests and questions from the international community. Out of these discussions, the concept of the International Fellow became a reality in 1990.

We were particularly interested in responding to requests and invitations from practitioners outside of North America to help them develop respiratory therapy in their home countries. We took a page from our own development as a profession, noting we were only able to succeed with the support and advocacy of our physician partners. As a general criterion we wanted to pick Fellows who would be taken seriously back in their home countries. That is, we wanted people with influence who would have an effect on their health care systems and their governments. We looked for those committed to developing expert respiratory care knowledge in their homelands.

What did it take to convince AARC leaders at the time that it was worth pursuing?

Believe me, this was not a hard sell to the AARC leadership. They were committed from the start and we worked in concert to set criteria and raise funds for Fellow expenses. Since its outset, individual therapists, health care manufacturers and suppliers, colleges and universities, city hosts, the AARC and the NBRC, and the House of Delegates have financially supported the program. I was very fortunate in my year as AARC president to not only be involved in the establishment of the Fellowship Program but to actually serve as a city host for the first class of Fellows. What an honor, and we certainly learned a lot in the process.

Now, some 26 years later, the program continues to thrive, with 163 Fellows from more than 60 nations. The Fellowship program is like the "Energizer Bunny" — it is still extremely popular and just keeps on going.

How have the Fellows who have taken part in the program influenced the practice of respiratory care in their countries, and why is this important to U.S. RTs?

International Fellows have been responsible for developing numerous programs designed to improve education, training, and, ultimately, patient care in their countries. These programs range from two-day seminars, to six-month programs, to RT bachelor and graduate degrees. Additionally, Fellows have returned home to help establish RT credentialing examinations and national regulatory boards.

It is not possible to list all of the extraordinary accomplishments of the Fellows upon their return to their home countries, but I would like to mention a few. After her Fellowship, Dr. Kieko Hasegawa returned to

The ICRC Marks 25 Years of Global Cooperation

by Jerome Sullivan, PhD, RRT, FAARC

The organization we all know as the International Council for Respiratory Care (ICRC) operated informally as an interest group among international attendees at the AARC Congress for a number of years in the late 1980s. We would actually hold our meetings in my hotel room until the group became too large and we had to move into meeting facilities in the convention center. What started as a collection of 10 people had grown to almost 40 individuals from 11 countries. Finally, on December 9, 1991, 11 countries formally established the ICRC in conjunction with the AARC Congress in Atlanta, GA. The group has met each year since that time in its annual business meeting, and we celebrated our 25th anniversary in October of this year at the AARC International Respiratory Convention & Exhibition in San Antonio, TX.

The ICRC is composed of member countries and has its own mission statement, bylaws, operational rules, and strategic plan. The ICRC is not simply an extension of the North American RT model, and the independent nature of the organization is one of the most highly valued features for its members. Having pointed this out, it is important to add that the ICRC has a special, 25-year relationship with the AARC, and this true partnership is also highly valued by its member countries.

The council's membership has now grown to include 29 countries, with 27 countries holding full member status and two additional countries holding candidate status. The ICRC's main function is to provide a forum in which member countries can take formal actions and positions from a global perspective consistent with its mission to enhance the care of respiratory patients around the world. ■

Japan and worked with Dr. Kazunao Watanabe and the Japanese Association for Respiratory Care to develop the highly successful seminar, "The Physician's Mechanical Ventilation Workshop." This popular program has been offered more than two dozen times and is always fully subscribed, with a waiting list.

Further evidence of the Fellows' success is the work done by Chia-Chen Chu, MS, SRRT, and Chin Jung Liu, MS, RRT, to establish a respiratory therapy bachelor degree program at China Medical University in Taiwan. Our colleagues in Italy have developed a well-established master degree program at the University of Milan to produce respiratory physiotherapist graduates. Fellows assisted in the establishment of the Latin American Board for Professional Respiratory Therapy Certification, as well. The same is true in the Philippines and in Saudi Arabia, where Fellows were instrumental in establishing RT national credentialing examinations and national boards to issue their own credentials.

From Taiwan to Turkey, the Philippines to Mexico, Saudi Arabia to Panama, and many other countries, the International Fellows continue to exhibit leadership qualities and globalize respiratory care.

The International Fellowship Program spurred other international activities in the AARC, and you've been involved in all of them. Let's talk a little about the International Council for Respiratory Care (ICRC), where you have served as president since it was formed. Why did you believe this council was needed to promote respiratory care worldwide?

We all learn from our experiences and interactions in our careers, and I have never had more sincere and positive relationships than those I have been fortunate enough to form through the building of the ICRC. Over 30 years ago, individuals from outside the U.S. were coming to us with questions and suggestions and expert knowledge about the support and treatment of patients with respiratory disease in their countries.

The roots of the ICRC are firmly planted in this external force, with a central interest in globally enhancing respiratory care. While wanting to share in the acceptance and respect that respiratory care had earned in the United States, our international colleagues strongly desired to maintain their independence as practitioners. This is how the idea of a true partnership came to form the organizational basis of the ICRC. While strong partners with the AARC, each council member country has its own governor, each with individual votes that represent the position of their community of interest on critical education and clinical care issues. We needed an environment that would encourage the exchange of

RTs in Taiwan have raised the bar on respiratory care education.

quality clinical expert knowledge, educational strategies, research protocols, and international standards that would improve the care of respiratory care on a global level. Now in its 25th year, the ICRC continues to serve as a unifying force for respiratory care practitioners.

What do you think the ICRC has added to the international understanding of respiratory care, particularly as it relates to how respiratory care is delivered in countries outside of North America?

The ICRC has contributed to the understanding that delivering high-quality respiratory care at the bedside is a function of safe, effective competency stemming from education and training and not from what your title may be. This is probably the single most important contribution the ICRC has made to the practice of respiratory outside the United States worldwide; respiratory patients need service providers with specific contemporary skills, not specific credentials.

The ICRC's goal in working with other member countries is to respect their culture and their system of delivering health care, but at the same time, we insist on proper care that meets international standards. Because respiratory care as provided by RRTs in the United States is recognized as the gold standard, we may be asked to help them develop a system to produce practitioners who are called "respiratory therapists." This has been the case in several countries. Whatever the situation, the one thing we do require is that whoever provides the bedside care must be qualified by education and training that meets international respiratory care standards.

The last piece of the puzzle was the development of the International Education Recognition System (IERS). Tell us how you were involved in that effort and why the profession needed to establish this system to recognize educational courses offered outside the United States

The establishment of the IERS was ultimately motivated by a recommendation from the ICRC governors, who first documented the need for international standards by which respiratory care educational offerings could be measured for quality and consistency. Almost 10 years ago, the governors, representing 26 countries on the ICRC working in partnership with the AARC, began to lay the groundwork that resulted in the development of the voluntary system that today we know as the IERS. Our international colleagues want to attain and be recognized for a level of quality in their RT education

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Expansion of Respiratory Care in China: Our Three Weeks of Education and Sustained Collaboration

by Daniel D. Rowley, MSc, RRT-ACCS, NPS, FAARC, and Ryan Sharkey, MSc, RRT-NPS

Respiratory therapy (RT) in China is expanding, and this is attributed largely to the efforts of past AARC International Fellows networking and establishing a presence at respiratory care symposia, workshops, academic programs, and hospital-based training centers. The respiratory therapy department at Sir Run Run Shaw Hospital (SRRSH) in Hangzhou, China, has led this expansion. SRRSH is a 1,200-bed Joint Commission International-accredited hospital located approximately 100 miles southwest of Shanghai.

We traveled to Hangzhou to provide respiratory care lectures, workshops, and simulations as a sustained collaboration with the respiratory therapy department at SRRSH. The director of respiratory therapy, Yuan Yue-hua, RN, RT, is a past AARC International Fellow who has helped build a premier respiratory therapy department where respiratory therapy students, nurses, and physicians from many provinces in China learn to apply the art and science of respiratory care. Her department leadership team consists of two additional AARC

International Fellows: Vice-Chair Huiqing Ge, MSc, RT, and Educator/Researcher Peifeng Xu, RT, in addition to an expanding clinical management and bedside RT staff.

SRRSH's respiratory therapy department has created a reputable respiratory care internship program for nurses and physicians who have committed to learning the art and science of respiratory care from some of the best RTs China has to offer. Seeing the department firsthand, there is something special about the respiratory therapists who work there. The hospital uses multiple brands of ventilators to help the interns learn on different platforms. These nurses and physicians then go back to their home institutions with this knowledge to expand respiratory care. The reach that SRRSH respiratory therapists has is growing with every clinician who goes through the program, which includes RT students from other provinces who complete patient care clinical rotations as part of their formal respiratory care training. Many of these graduate respiratory therapists are now working at SRRSH within the RT department.

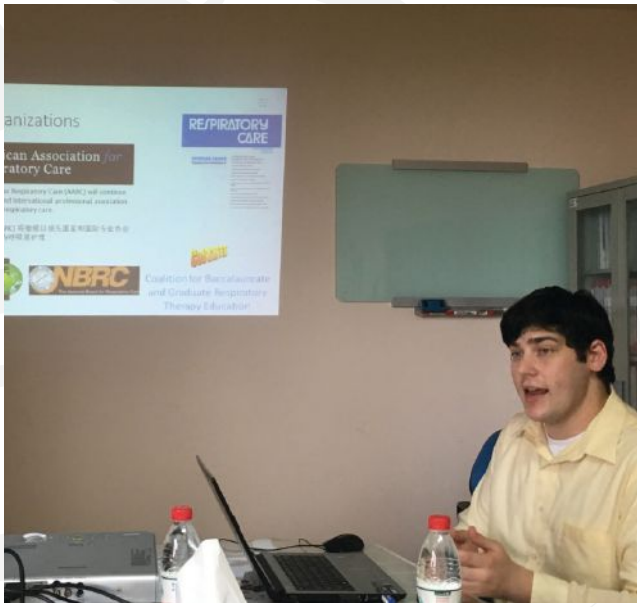
The growth of medicine in China has allowed two new hospitals to open in Hangzhou. As a highly regarded respiratory department, SRRSH's RT department had two of their respiratory therapists recruited to be the RT department directors at these new hospitals. One of those hospitals, Xiasha, is a sister campus to SRRHS. It was built to accommodate the needs of the G20 summit held in September 2016. The other hospital, which is not affiliated with SRRSH, is Zhejiang University International Hospital. These hospitals are creating new job opportunities for respiratory therapists in areas of RT department management and clinical practice.

As a respected department, SRRSH respiratory therapists consult on difficult cases and ventilator management. They often go to hospitals throughout Hangzhou and as far north as Beijing to provide expert respiratory care consultation on mechanically ventilated patients. Four respiratory therapists from SRRSH were selected to be on the G20 emergency team. Their role for the G20 meeting was to provide care to any attendee who required hospitalization requiring respiratory care interventions.

Several respiratory therapy students and interns were having their didactic and clinical rotations within one week after our arrival in Hangzhou. The RT department's leadership asked us to design ventilator workshops to help learners apply didactic content and clinical simulation skills rapidly in their clinical practice. These interactive sessions allowed the learners to get hands-on training with specialty modes of ventilation used less frequently in their practice, such as airway

Dan Rowley and Ryan Sharkey joined the RT staff at Sir Run Run Shaw Hospital for this photo during their visit.

Making the rounds with RT staff in the ICUs.



A thoracic meeting featured educational sessions led by pulmonary critical care leaders.

pressure release ventilation and neurally adjusted ventilation assist modes. We were able to provide test cases with computer simulation cables to help the learners visualize patient–ventilator interaction with normal, restrictive, and obstructive lung models. The small group workshops fostered discussion and critical thinking. Between workshops and lectures, we were invited to join rounds in the intensive care units (ICUs), where we observed the clinical practice of RTs and participated in patient care rounds.

Aside from Hangzhou, we presented at the First Sino-U.S. Clinical Application of Mechanical Ventilation Conference, along with Huiqing Ge, in Dongguan, China.

The regional director of The Chinese Thoracic Society planned an excellent program consisting of leaders in pulmonary critical care medicine from across China. Thanks to a smartphone translator app (Microsoft Translator), we were able to keep up with presentations and understand the hot topics presented on mechanical ventilation. We were invited to the First People's Hospital in Dongguan for a question-and-answer session with hospital administrators and attending physicians from neonatal, pediatric, and adult critical care units. There was lively discussion on mechanical ventilation best practices and how development of protocols has been used to effectively guide patient care with associated improved clinical outcomes. Specific prone-position therapy and lung-protective ventilation strategy protocols were offered to the chief of critical care as she and her team identified opportunities to improve acute respiratory distress syndrome management strategies following the mechanical ventilation conference and our group discussion.

Our last four days in China were spent in Shanghai, where we met with Dr. Yang Liu, who is also a past AARC International Fellow. Here we visited The Tenth People's Hospital of Tongji University, where Dr. Liu is an intensivist in the medical ICU. The director of the ICU, Dr. Shaolin Ma, invited us to deliver mechanical ventilation lectures and a

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About the Authors

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Seattle Children's Hospital and Children's HeartLink Work to Improve Cardiac Care in Fortaleza, Brazil

by Dave Crotwell, RRT-NPS, FAARC

My respiratory therapy career has given me the opportunity to make a difference in people's lives, and volunteering to help resource-limited countries has been one of my most rewarding career accomplishments. During my 21 years as a respiratory therapist, I have travelled to Latvia, Romania, and Brazil on medical missions. These experiences have given me valuable life perspective and have made me a better respiratory therapist and person. For those of you considering getting involved in medical mission work, I strongly recommend it; the experience will change your life forever.

Several years ago, Seattle Children's Hospital (SCH) developed a relationship with Children's HeartLink to help reduce the mortality rate of children with congenital heart disease. Founded in 1969, Children's HeartLink (Minneapolis, MN) trains doctors and nurses in underserved parts of the world using medical volunteer teams. Currently supporting partner hospitals in Brazil, Ukraine, China, India, Malaysia, and Vietnam, the teams work closely with partner hospitals to provide education, training, and mentorship programs to help diagnose and treat children with heart disease. Shortly

after the program began, I was asked by Susanne Matthews, a Seattle Children's cardiac intensive care unit (CICU) charge nurse, to accompany her and Titus Chan, a SCH CICU attending doctor, to take part in a medical volunteer trip through Children's HeartLink to Fortaleza, Brazil, in April 2016. Susanne had been to Fortaleza three times prior and felt having a respiratory therapist on this trip would be beneficial to the respiratory physiotherapists at the partner hospital.

We arrived in Fortaleza, Brazil, on April 13. After a brief rest we met with the Children's HeartLink staff and then traveled to meet the partner hospital's pediatric cardiac team. The partner hospital in Fortaleza is Hospital de Messejana (Hospital Dr. Carlos Alberto Studart Gomes), a tertiary hospital specializing in the diagnosis and treatment of heart and lung disease. Messejana's team was composed of pediatric cardiac intensivists, cardiologists, nurses, and respiratory physiotherapists. My job while in Brazil was to speak at the Brazilian Society of Cardiac Surgery Congress on the role of the respiratory therapist in the cardiac intensive care unit and provide teaching related to respiratory therapy practice at Hospital de Messejana.

In addition to speaking at the congress, Susanne, Titus, and I spent the next five days rounding with the team to learn their work flow and consult on patients with complex needs. Each day I gave several classroom lectures on nursing and respiratory-related topics such as ventilator-associated pneumonia prevention, capnography during mechanical ventilation, noninvasive ventilation (NIV), airway clearance therapy (ACT) techniques, extubation readiness testing (ERT), and ventilator graphics interpretation. I helped the respiratory physiotherapists at the bedside place a capnography device on a patient for the first time, and together we performed an ERT on a patient who had been difficult to wean from mechanical ventilation. I was amazed at the level of engagement the respiratory physiotherapists had in learning how we practice, and their ability to quickly put changes into clinical practice despite some resource limitations. This level of engagement became even more apparent when I walked into the CICU on the second day and witnessed a respiratory physiotherapist applying an ACT technique I spoke about the day before. They had another patient who had been ventilated in the ICU for many days on

Bedside teaching with respiratory physiotherapy staff at Hospital de Messejana.

Crotwell with some of the respiratory physiotherapy staff at Hospital de Messejana.

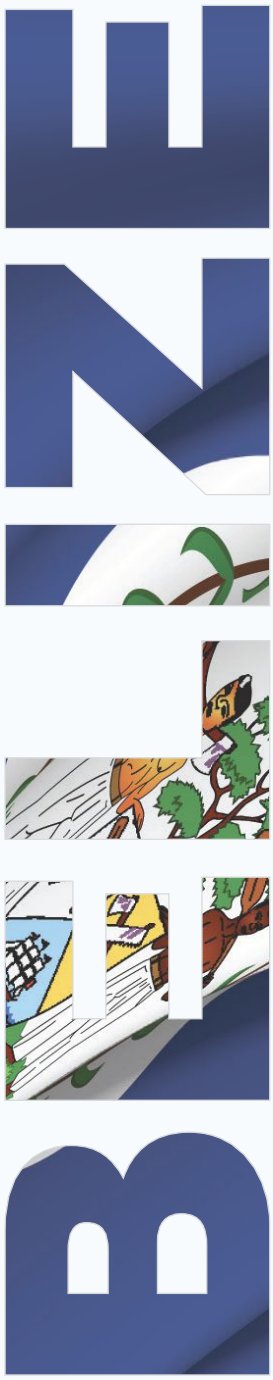
Dave Crotwell met with respiratory physiotherapists for a valuable information exchange.

an ERT. Two hours later, the patient met stability criteria and was extubated. This was the first time they had used a standardized ERT as a tool for extubation readiness in their ICU. The respiratory physiotherapists took the initiative to change practice just one day after I spoke to them about ACT techniques and the benefits of using a standardized extubation readiness assessment.

The Children's HeartLink staff did great work with the hospital team related to continuous process improvement (CPI) and helped guide them on some CPI projects they could start right away. Children's HeartLink has a focus of helping partner hospitals evaluate their current practices, develop performance metrics, implement changes in practice, and measure the outcomes related to those practice changes. As clinician partners with Children's HeartLink, our role is to support and advise the partner hospitals on opportunities for improvement they can work on with their existing resources. While this was only a seven-day trip, I felt really good about the work SCH and Children's HeartLink accomplished with the partner hospital. I plan to continue my relationship with Barbara Alves, one of the Brazilian physiotherapists at Hospital de Messejana now that I am back in Seattle. To date, I have been sharing information related to NIV mask interfaces and ventilation strategies. Children's HeartLink and SCH have more trips to Fortaleza planned for this fall and spring, and skilled respiratory thearapy staff will accompany our physician and nursing colleagues. I hope this is the beginning of a wonderful partnership, and I look forward to working with them to improve the care at Hospital de Messejana. ■

About the Author

Dave Crotwell, RRT-NPS, FAARC, is director of respiratory care services at Seattle Children's Hospital in Seattle, WA.



Improving Health Care in Belize

by James Ciolek, BS, RRT

Working hard to deliver modern respiratory care

In late 2015, my wife Becky and I were given the opportunity to travel to Belize in Central America. We are both registered respiratory therapists, and our trip had a mission: to observe how respiratory care was being performed, share medical knowledge, and report back. I approached this trip with apprehension: "What do I have to offer? Why me?" Becky (ever the pessimist when it comes to flying) approached this trip with apprehension, too: "I know that the plane will crash. Why me?"

A tropical experience

About the size of New Hampshire, Belize is bordered by Mexico to the north, Guatemala to the west and south, and the Caribbean Sea to the east. During our visit, the weather ranged from flooding rains to tropical heat. The local schools were closed on Monday due to the storm that moved through Central America on Oct. 19. This weather system strengthened in the Pacific and became Patricia, the F5 typhoon that hit the west coast of Mexico on Oct. 23.

The humidity was an experience. Condensation appeared on your glass of iced lime juice and formed an ever-growing puddle. There were flies and mosquitos as well, but these pests were minimal in Belize when compared to the insect population of our native Texas.

In Belize, the economy is based on tourism, crude oil, marine products (such as fish and cultured shrimp), sugar, citrus, and bananas. Oil prices are currently down, unemployment is high, and the average income is $3,000 per year. Of the 347,000 people in Belize, only 120,500 are in the workforce.

Before September 1981, Belize was called British Honduras. British influence is ever-present, from the style of government to the names of places, and the average Belizean speaks English. Elections are free. An election occurred the week after our visit. The people of Belize appeared to be determined to vote. Individuals had strong opinions and, just like in the United States, everyone complained about how the taxes are spent. One method of taxation is a flat 12% sales tax.

While the coastal Caribbean beauty of Belize City cannot be denied, the city has no apparent building code. However, Belize has one of the strictest building code enforcement agencies in the world. The enforcers are called hurricanes. Don't ask *if* a storm will strike, ask *when*. Since 1930, there have been 16 hurricanes that have affected Belize, eight of which were major hurricanes that either made landfall in Belize or passed close enough to cause damage or loss of life.

Structures are built based on one of the following three philosophies:

1. This building will be blown away, so any material can be used.

2. This building will survive most storms, so it is built with wood on a firm base.

3. This building is hurricane-proof, so all floors, walls, and roof are solid, reinforced concrete. These strong, structures are often four or five stories tall, but they are gradually sinking into the pile of mahogany wood chips and empty rum bottles that were used to fill the swamp to create the "reclaimed land" that Belize City rests upon.

There are no street signs in much of the city. I did see two stop signs, but there are no speed limit signs. The hotel we stayed in was located in an area that contains a mixture of structures and people. Properties ranged from the very nice, to the abandoned, to the vacant lot. Our wonderful eight-room hotel was adjacent to the residence of the prime minister of Belize.

Bedside education took center stage during the trip.

Belizean clinicians listen as Jim Ciolek explains a key concept.

These two respiratory therapists cover the entire hospital.

Health care in Belize

The hospital bed density in Belize is 1.1 beds for every 1,000 people. There are three hospitals in the Belize district. The other five districts have various medical facilities. Local folk medicine is commonly practiced. In 2015, Belize ran out of anesthesia medication for three months.

All of the critical/serious respiratory cases in the country are transferred to just one of the hospitals in Belize City, the Karl Heusner Memorial Hospital. This main receiving medical center was built in 1995, and its newest wing, where we spent four days, opened in November 2015.

We spent our day learning about Belizean medicine and the other three days sharing what we hoped would be helpful. We learned a lot. In the areas we observed, the hospital beds were arranged in wards of to four to ten patients. Only some sections of the hospital were air conditioned; the emergency department and the ICU step-down wards were among the areas that were not. Imagine patients, just out of the ICU, in humid care areas at 90 degrees plus!

Belize is up to date in certain technologies. Belize has more than adequate computer systems and Internet access, and the hospital had a wonderful overhead projector for presentations. I was in the classroom while nurse-educator Marilyn Aspinal did an in-service training on the adult high-flow nasal cannula. The country has benefited greatly from international donations. We heard about donors from Sweden, Taiwan, Turkey, and the United States. It is probable that this list of nations is now much longer. This collection of new and refurbished equipment has created a warehouse of devices. The assortment is overwhelming. The staff needs to become familiar with various adult and neonatal ventilators, CPAP machines, monitoring equipment, and more. The recent equipment donations from Sweden were accompanied by a team of trainers who came later. This training is highly valued by the staff. Otherwise, the devices could not be used at all.

While we were in the ICU, the nurses initiated several mini-lectures on basic ventilator waveforms. They asked all the right questions regarding the value of waveforms, modes of ventilation, and breath types. The gratitude of these nurses was humbling.

The nurse in charge of the accident and emergency department pleaded with us to somehow help with one of the largest concerns in Belize: asthma. The department has an eight-patient area dedicated to quickly responding to the flood of asthma patients who often come in every time a new weather front hits the city. Belize has air compressors for the patients to take home. Albuterol is in short supply, and plastic hand-held small-volume nebulizers (SVNs) are in critically short supply. Asthma patients suffer, and some die, due to a shortage of SVNs.

Clinicians know about how peak flow measurements can track asthma, but they do not have peak flow meters. More patient education is needed. The workers in Belize are doing all they can.

About the Author

James Ciolek, BS, RRT, is a clinical instructor in the respiratory care program at Tarrant County College in Fort Worth, TX. His wife Becky Ciolek, RRT-ACCS, CPFT, is an instructor in the respiratory care program at Weatherford College in Weatherford, TX.

The modern mechanical devices are there. They all have pulse oximeters. Yes, 50-PSI oxygen is available in much of the facility. All too often, however, the other supplies are not available. During at least three weeks in October 2015, arterial blood gases (ABGs) were not performed because there weren't any cassettes for the bedside ABG device. Ventilator circuits and in-line suction devices are used sparingly, and reuse after cleaning is common, whenever reuse is possible.

A positive outlook

Despite these downsides, there is much hope and progress happening in Belize. The respiratory care personnel delight in any help they can get to create what is possible with what is available. Just as the AARC and its affiliate state societies are defined by their members, not their buildings or assets, the medical community of Belize is defined by the number of dedicated people who work in it, not its buildings or equipment.

How many respiratory therapists (RTs) are there in Belize? There are only two. As expected, they both work at the main hospital where respiratory cases are transferred. Bertha Pacheco-Gonzales received her medical training in Guatemala at the Escuela Nacional de Terapia Respiratoria, Universidad de San Carlos de Guatemala. Prior to that, she completed the physical therapy program at Escuela Privada de Terapia Fisica y Terapia Ocupacional Universidad Francisco Marroquín. She has been working at the hospital for years. With no backup and always on call, her stamina, ability to cope with frustration, and sane personality are beyond my comprehension.

Runiria Pop, a native Mayan-born in Belize, studied in Mexico City at El Colegio Nacional de Educación Profesional Técnica México for four years and completed a technical degree. She started working at the hospital in Belize in September 2015. I pray that this worthy and intelligent person will persist in the future.

A mix of up-to-date technology, limited supplies, and the need for continuing education met us in this Central American nation.

These two professionals work as fast-moving consultants. They cover the entire hospital. The physician often communicates the "goal for today" instead of specific orders. The doctors rely on the skills and opinions of the respiratory therapists. Respectful communication is ever present. Dr. Hildalgo, an ICU specialist, addressed me as "amigo" from the start. He invited, "What can we do better? Please tell us."

The RTs perform constant visual checks on the adult and neonatal ventilators. They handle all of the artificial airways. When they suction these airways, they tend to lavage. Why? They might not be back anytime soon, because the RTs spend much of their time "putting out fires."

Because two people cannot cover the hospital around the clock, the nurses must learn the tasks of the RT. A significant part of the Belizean mindset is focused on behaving as a close family would. This is somewhat beyond working as a team. The RTs perform as many treatments as possible, but they do not have the computer-generated list of patients and tasks that we work with in the United States. The nurses are the glue that keeps patient care going when no RT is available. Does this always work? No. I hope that more RTs will become available in the future.

A partial success

We considered this trip a partial success. We were able to collect information regarding what is and what is not needed. We now know the appropriate person to whom we can send supplies, but challenges remain. Identifying and effectively deploying donated equipment is one of those challenges. The hospital opened a new wing dedi-

Becky Ciolek teaches a class during her visit to Belize.

cated to pediatrics and neonates in November 2015, and the equipment that was donated to the new area was donated to that area only. Equipment could not be removed from that area due to an agreement with the donors. The RTs and Becky quickly saw that three Vision BiPAPs, an Emerson cough assist device, and other equipment belonged in the adult arena. Fortunately, Becky talked to the administrators, who were readily available, and this adult equipment was taken to the adult ICU storage area.

Becky also presented a strong in-service training on the Vision BiPAPs and on BiPAP in general, and we delivered several well-received lectures on asthma and asthma drugs, chest x-rays, and ABG interpretation. We answered many questions during lectures and at the bedside, and Becky was able to figure out and teach the Bear 1000. Becky also did a training lecture on (wait for it!) that little green machine we call the Bird Mark 7. Believe it!

(continued on page 56)

International Respiratory Care Update

by John D. Hiser, MEd, RRT, FAARC

When our members think about the AARC International Committee, most of them think about the International Fellowship Program. That makes sense because the program has been so successful and it is one of the more visible things we do. It's something that we've been successful in achieving every year for the last 26 years, but when you think about AARC's international activities, *it's more than that*.

Our mission is to promote communication and fellowship among respiratory care professionals around the world through cooperation, dialogue, and educational exchanges. Included with our mission statement are 20 goals that we are continually striving to achieve, such as development and coordination of the art and science of respiratory care worldwide, interaction and cooperation among multi-national colleagues, and enhancing awareness and understanding of the profession.

I am very happy to announce that we have achieved every single one of these goals at least once and have achieved a majority of the goals every year. Some of the goals are long-range goals, such as assisting in establishing the profession, assisting those seeking to establish professional associations, and helping those seeking to gain legal recognition. Although we don't see these goals achieved every year, we have been successful in the past, and I know we will achieve these in the future.

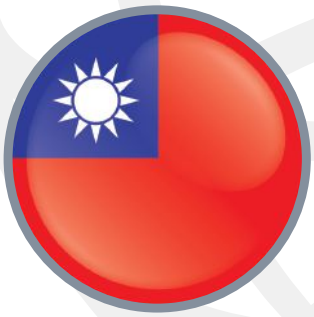
Other goals are a little easier to accomplish and have been achieved almost every year. These include providing assistance in establishing seminars, programs, and schools and helping educational programs gain International Education Recognition System approval through the International Council for Respiratory Care (ICRC).

The editors thank *AARC Times* Guest Editor John D. Hiser, MEd, RRT, FAARC, for his special contributions to our December international issue.

About the Author: John Hiser, MEd, RRT, FAARC, serves as chair of the AARC International Committee and was AARC president in 2005. He is the respiratory care program director at Tarrant County College in Fort Worth, TX.

We continue to add new countries and new international governors to the ICRC and have seen numerous speaker/student exchange activities and medical mission trips each year. We now have over 850 international AARC members from 60 countries. We also continue to have AARC publications translated into other languages and have articles written for *AARC Times* and *Respiratory Care* on a regular basis.

The Association continues to receive reports from around the world that demonstrate the achievement of the international goals of the American Respiratory Care Foundation, AARC, and ICRC. Here are some of these activities.



Taiwan Celebrates RTSROC Annual Meeting and Associated Activities

By Chia-Chen Chu, MS, SRRT, FAARC Governor for Taiwan, International Council for Respiratory Care

On December 13, 2015, the Respiratory Therapy Society of the Republic of China (RTSROC) held its Annual Professional Congress to correspond with the recognition and celebration of the AARC's Respiratory Care Week activities promoting respiratory care. This rich tradition dates back to December 21, 2001, the inaugural date of the third reading of the Respiratory Therapist Law by the Taiwan Legislature, which established official government recognition of the RT profession and the organization's designation as an official Society.

China Medical University BS Degree Students and Faculty Celebrate RC Week in Taiwan

The Taiwan government's recognition of respiratory care as a profession could not have been accomplished without the tireless, decade-long efforts of the predecessor organization, the Respiratory Care Association of the Republic of China (RCAROC). The association was established on April 1, 1991, as a professional group committed to quality improvement in clinical care and the promotion of the respiratory therapy profession.

Recognition by the government was an immense and significant step forward in ensuring the improvement of respiratory care for patients in Taiwan who are afflicted with pulmonary disease. Therefore, by decree, the anniversary of the event is recognized as Respiratory Therapist Day in Taiwan. Every year the RTSROC Annual Meeting is held in conjunction with the celebration of this day, and the respiratory therapy department of China Medical University (CMU) organizes Respiratory Care Week activities to promote the profession. In 2015 the president of the ICRC, Jerome M. Sullivan, PhD, RRT, FAARC, was invited to participate in the RTSROC Annual Meeting, celebrate Respiratory Therapist Day, and partake in Respiratory Care Week activities. The CMU staff met with Jerome Sullivan.

Cairo, Egypt: Experts Gather at Ain Shams University for Internationally Recognized Neonatal Respiratory Care Conference

By Rania El-Farrash, MD, Assistant Professor of Pediatrics and Neonatology and 2014 AARC International Fellow

AARC leaders Brian Walsh and Natalie Napolitano were part of the faculty for the educational program in Egypt.

Soon after the unanimous vote by the ICRC to welcome Egypt as a member of the council, Ain Shams University sponsored an IERS-approved Neonatal Respiratory Care Conference. The seminar was convened February 7–9 and offered an intense educational experience, with 14 contact hours of lecture demonstrations and 4 hours of animal laboratory hands-on educational activity.

The Level I IERS program featured an experienced cadre of distinguished Egyptian physicians and professors specializing in neonatal and pediatric medicine. Two leaders of the AARC were prominently featured as contributing faculty in the clinical program: Brian Walsh, MBA, RRT-NPS, RRT-ACCS, AE-C, FAARC, Harvard Medical School research coordinator in the department of anesthesia, division of critical care; and Natalie Napolitano, MPH, RRT-NPS, AE-C, FAARC, who is the AARC's Neonatal-Pediatrics Specialty Section chair and is a research specialist at the Children's Hospital of Philadelphia.

Included in the comprehensive seminar were presentations on the basics of mechanical ventilation, advanced modes of ventilation, ventilator-associated pneumonia, management of bronchopulmonary dysplasia (BPD), cardiac implications of BPD, and disease-specific ventilation strategies.

Update from the Respiratory Care Division at the West China School of Medicine at Sichuan University

By Professor Liang Zongan, Chairman RC Division, Sichuan University and 1999 AARC International Fellow

The West China School of Medicine, West China Hospital (WCH) of Sichuan University, was established in 1914. It is one of the largest single-site hospitals in the world and the leading medical center of West China, treating complicated and severe cases with 4,300 beds, 44 clinical departments, and 16 non-clinical/laboratory departments.

WCH is ranked second on the Most Popular 3A Hospital List, and in 2014 more than 4.9 million patients visited the outpatient department, 130,000 operations were performed, and 220,000 patients were discharged from inpatient departments. The hospital has the largest student clinical skills training base in China, supervising 165 doctoral candidates and 325 master's degree students. In the past two years, WCH has established long-term cooperative relationships with more than 30 internationally renowned institutions, including Harvard University, Massachusetts General Hospital, and The Mayo Clinic.

In 1997, I launched a four-year respiratory care (RC) training program with the help of Loma Linda University. I am currently responsible for the RC program and chairman of the RC division.

In 2000, WCH officially enrolled undergraduate students in the four-year respiratory care program awarding a Bachelor of Science degree upon graduation. Admission

to the RC program is limited to 20 students per year. This is the only undergraduate teaching institution in China offering a Bachelor of Science degree in respiratory care, and the curriculum is in accordance with what is taught in the United States. Students complete general medical courses as well as specialized courses such as lung function, respiratory physiology, and mechanical ventilation. The educational program concludes with a clinical practice course lasting 48 weeks.

Since its inception, our RC division has trained over 200 respiratory therapists, who now work in 47 hospitals and a number of medical device companies across the 16 provinces. Many of the early graduates have assumed leadership roles as clinical directors and instructors in the RC division.

In 2015, West China Medical School of Sichuan University formally established the RC division and admits candidates for master's and doctorate degrees in respiratory care. Undoubtedly, Sichuan University plays an important role in the development and prosperity of respiratory care throughout China.

At present, respiratory care in China is confronted with many challenges. First, China does not have an approved respiratory therapist licensing examination, although there are some examinations for the graduates from Sichuan University. Therefore, there is no relevant professional qualification certification or credential, and this is where further effort must be expended. Second, the undergraduate education for respiratory care is inadequately supported from a faculty perspective. The teaching faculty was initially composed of physicians, and although some professional respiratory therapists have joined the undergraduate faculty over time, the current faculty still cannot meet the teaching needs. There is a shortage of experienced faculty, and the hope is to have sufficient professional respiratory therapists to take on the teaching work. Third, the RC curriculum, teaching methods, and materials need expansion and revision, and there is a need to include further education and training in scientific research analysis and methodology.

Overall, the Sichuan University RC program's goal is to foster the development of additional Chinese professional respiratory therapists, in part through the establishment of an international training center at WCH. Our RC program will continue to support and encourage international cooperation and communication to assist in the establishment of international standards in RC education, evaluation, research, and credentialing.

Mexico Holds Two International RC Conferences

By Héctor León Garza, MD, FAARC, ICRC Governor of Mexico, Mexican Association of Respiratory Therapy

Respiratory care professionals in Mexico organized two international conferences this year. On September 28–30 we presented the XIII International Respiratory Care Congress in conjunction with the Respiratory Therapy Congress of the National Institute of Respiratory Diseases (INER). Dr. Sarai Toral Freyre, president of the Mexican Association of Respiratory Therapy, coordinated the conference.

Earlier in September, the Federal Association of Respiratory Therapists hosted an International Congress for Respiratory Therapy on September 5–6. This conference was organized by Juan Carlos Perez, RT, and featured international leaders, such as Dr. William Cristancho and Ariel J. Garnero, RT.

Mexico continues its interest in and recognition of the Latin American Board for Professional Certification in Respiratory Therapy. CLACPTER is the only certifying body for respiratory therapists and respiratory health care professionals in Mexico. New countries are interested in joining CLACPTER, among them the Dominican Republic, El Salvador, Nicaragua, and Uruguay. This is another opportunity to advance the Latin

Mexico held two conferences this year.

American Respiratory Therapy Certification Program as the only certifying body to meet this need in Latin America.

The Latin American Board for Professional Certification in Respiratory Therapy, whose leadership and professional prestige has promoted the growth of the organization, conducted its annual meeting in conjunction with the annual AARC International Congress in San Antonio, TX, on October 16, 2016.

Dr. Alberto Lòpez Bascope has fostered a Web Respiratory Care Program since 2015. It continues to grow, with new presentations ranging from basic to advanced respiratory care topics. In October, Dr. Bascope received the Héctor León Garza, MD International Achievement Award at the AARC 2016 Congress in San Antonio.

Update on Respiratory Care at the Hôpital Sacré Coeur in Milot, Haiti

By Daniel D. Rowley, MSc, RRT-ACCS, RRT-NPS, RPFT, FAARC University of Virginia Medical Center Charlottesville, VA; and Natalie Napolitano, MPH, RRT-NPS, AE-C, FAARC, Children's Hospital of Philadelphia, Philadelphia, PA

Hôpital Sacré Coeur (HSC) offers medical care and treatment to infant, pediatric, and adult patients in Milot, Haiti. Specialty services where respiratory care is provided include the neonatal intensive care unit (ICU), pediatric acute care, and a combined pediatric and adult ICU. Respiratory therapists from the United States have been assisting the hospital in improving its respiratory care services for a number of years.

Following a progressive didactic respiratory care training curriculum delivered by volunteer Registered Respiratory Therapists (RRTs) from the United States, we transitioned to clinical education where respiratory therapists work directly with HSC physicians and nurses to help them develop skills and confidence in applying the art and science of respiratory care practice.

Over the past couple of years, respiratory therapists have been committed to improving respiratory care by training HSC staff in basic and intermediate clinical skills for the administration of oxygen therapy, bubble CPAP, and airway management. We have also assisted the staff in identifying when noninvasive positive pressure ventilation (NIPPV) and invasive mechanical ventilation may be beneficial to relieve respiratory distress and hypoxemia.

Our focus has now shifted to the clinical application of respiratory care that is guided by evidence-based literature, consideration of human resource and equipment availability, and cultural norms. While working clinically with HSC staff, we identified opportunities to help them standardize specific respiratory care interventions with the introduction of oxygen therapy, noninvasive ventilation, and invasive mechanical ventilation clinical practice guidelines (CPGs). Examples of CPGs were shared with physician staff and then edited and implemented to meet their patient care management goals while remaining good stewards of limited medical equipment resources. Specific to the neonatal ICU, respiratory therapists introduced a bubble CPAP assembly and an oxygen clinical practice guideline.

Moving forward, we will focus on meeting the immediate needs of HSC medical staff. Our vision is to be able to send two RRTs to Milot, Haiti, for a one-week stint each month to work with HSC staff in neonatal, pediatric, and adult clinical environments.

HSC is affiliated with the CRUDEM Foundation, and all prospective RRT volunteers must complete a formal CRUDEM volunteer application, have a telephone interview with us, and pass a mandatory criminal background check before they can be invited to participate in a preassigned respiratory care training mission at HSC. We believe our continued commitment to quality respiratory care training delivered by highly qualified respiratory therapists has resulted in meaningful and sustained respiratory care improvement at HSC. If you are interested in volunteering for one of our future respiratory therapist teams, please feel free to email us for more information. Daniel Rowley: ddr8a@virginia.edu; Natalie Napolitano: NapolitanoN@email.chop.edu.

Prince Sultan Military College of Health Sciences Third Respiratory Care Student's Symposium, Al Khobar, Saudi Arabia

By Mohammed Al Ahmari, PhD, RRT, CTTS, Chairman, Respiratory Care Program, and ICRC Governor for Saudi Arabia

Students gather to participate in the simulation laboratory competition.

On April 14, Prince Sultan Military College of Health Sciences (PSMCHS) held the Third Respiratory Care Student's Symposium, continuing the success of the previous two symposia.

All of the annual symposia have been organized and conducted by RC students, giving them the opportunity to organize, chair, and present scientific lectures and workshops. This year, the symposium received the national attention of respiratory colleges all over Saudi Arabia. Five universities and colleges participated in the event, which led to the largest number of attendees ever.

The students also hosted the Third RC Student's Competition, similar to the AARC Sputum Bowl. Leading RC departments from different hospitals ran the competition. It was an exciting event for all the attendees. Eight groups from four different RC schools participated in this year's competition.

In addition, the first Respiratory Care Educational Video Award was presented. This award encourages students to innovate new methods of public education by creating short videos targeting the general community to educate them about respiratory care topics such as asthma and smoking. More than a dozen videos were submitted, and the winning educational video was from PSMCHS students. Actually, there were no losers that day. All of the teams were winners by being involved in such an amazing scientific event.

Early Months of 2016 Witness a Busy Time for Respiratory Therapy Faculty at Manipal University, Karnataka, India

By Ramesh Unnikrishnan, MSc, RRT, RT Department Head, Assistant Professor-Senior Scale, and 2015 AARC International Fellow

The faculty and students in the respiratory care department at Manipal University, in Karnataka, India, were very busy earlier this year, not only attending to their RT program but also attending seminars and providing community outreach training programs in basic life support, pulmonary function, and leadership. They also met with

Students and faculty of the RT Bridge education program from the Sultanate of Oman at The Chest Research Foundation in Pune.

Nurses' training at Kasturba Hospital in Manipal, Karnataka.

ICRC Governor for India, Professor Vijay Deshpande, MEd, RRT, FAARC. Here were some activities in India this year:

February 18–20: ICRC Governor for India, Professor Vijay Deshpande, MEd, RRT, FAARC, visited the Manipal campus and interacted with RT students and faculty. He presented a lecture to the students and met with faculty to discuss the future plans of the Indian Association of Respiratory Care (IARC). Professor Deshpande met with IARC President Dr. Anitha Shenoy and discussed the future directions of the IARC and *Indian Journal of Respiratory Care*.

March 5: The department of respiratory therapy organized an introductory workshop on leadership in collaboration with the 5th semester RT Bridge program Oman nationals. Faculties from the respiratory therapy department also participated in the program.

March 16–19: Faculty from the department of respiratory therapy and students from the RT Bridge program participated in a training program on basic and advanced pulmonary function testing at The Chest Research Foundation in Pune, Maharastra.

AARC Executive Director Thomas Kallstrom Accepts Invitation to Attend Chinese Thoracic Society Forum

John D. Hiser, MEd, RRT, FAARC, AARC International Committee Chair and Program Director, Respiratory Care, Tarrant County College, Fort Worth, TX

AARC Executive Director Thomas Kallstrom, MBA, RRT, FAARC, accepted the invitation of Professor and Chairman Dr. Chen Wang, MD, PhD, FCCP, to participate in the Chinese Thoracic Society (CTS) Respiratory and Critical Care Annual Forum. They held the CTS Forum in Changsha, China, February 26–27, where Kallstrom delivered his presentation on "Ventilator-Associated Pneumonia" to the assembly.

This was a unique visit to China, as both Dr. Wang and Kallstrom hope to strengthen the

Thomas Kallstrom presents in the plenary session of the Chinese Thoracic Society Annual Forum.

connection between the AARC and CTS to promote the development of respiratory therapy in China and around the world.

Kallstrom made rounds and presented lectures in a number of hospitals in Beijing prior to his participation in the CTS Annual Meeting. He visited Xi Yuan Hospital and China-Japan Friendship Hospital, where he toured ICU wards and presented lectures to ICU physicians and directors on "Respiratory Therapy in the USA: Past, Present, and Future." In his presentations Kallstrom also highlighted the AARC's international affiliations with countries around the world. He made similar presentations at Peking University International Hospital and Peking University People's Hospital, where he also made rounds in the ICU wards and visited the hospital's history museum.

The unique nature of this visit was underscored by Dr. Wang, who noted that the mutual goal is to strengthen the connection and establish long-term relations between the CTS and AARC, thereby promoting the development of respiratory therapy in China. Plans are being made for a delegation of doctors, nurses, and RTs from China-Japan Friendship Hospital to participate in an RT learning exchange visit to the United States for a period of two to three weeks in the fall. The importance of this exchange is reinforced by Jingen Xai, MS, RT, director of the department of respiratory and critical care medicine at China-Japan Friendship Hospital, who says, "A learning partnership between CTS and AARC will play a very important role in the development of respiratory therapy in China, and also the improvement of patient care by promoting the globalization of respiratory therapy."

Dr. Hallaceli, Visionary Leader and Faculty Member at Mustafa Kemal University, Helps Develop Respiratory Therapy in Turkey

By Arzu Ari, PhD, RRT, PT, CPFT, FAARC, Associate Professor in the Department of Respiratory Therapy at Georgia State University, Atlanta, GA, and ICRC Governor for Turkey

Under the leadership of Dr. Hasan Hallaceli, Mustafa Kemal University in Hatay, Turkey, offered an education program entitled "Patient Assessment and Clinical Applications in Respiratory Therapy Education Program" on May 28–29, 2016. The IERS approved the program, the second one at Mustafa Kemal University.

As the program coordinator and administrator, Dr. Hallaceli joined me in the presentation. I taught 14 hours of educational activities including lectures, live demonstrations, case studies and interactive workshop on patient assessment and respiratory care procedures. The program was very well received by the participants and university officials. The pre-post exam results showed a significant increase in participants' knowledge.

Dr. Hallaceli (left) and Arzu Ari.

As a physical therapist who specialized in orthopedics, respiratory therapy is not Dr. Hallaceli's specialty but he still believes in the importance of developing respiratory care in Turkey and made every effort possible to ensure that the program was a success at Mustafa Kemal University. Through his vision and hard work at two separate respiratory therapy programs, Mustafa Kemal University received its first IERS recognition in Turkey in 2010 and then again in 2016.

Respiratory Care Activities at the Institute of Pulmonary Medicine and Research at Sri Ramakrishna Hospital Coimbatore in Tamilnadu, India

By Mohan Thekkinkattil, MD, AB, DPPR, 2007 AARC International Fellow

Dr. T. Mohankumar, MD, AB, DPPR, is a well-known name in the field of pulmonary medicine after 30 years of work in India. Under his leadership, the Institute of Pulmonary Medicine and Research has been actively involved in various activities. On World COPD day, November 18, 2015, he led a patient awareness campaign with volunteers from Sri Ramakrishna College of Physiotherapy. The purpose of the campaign was to educate the public and patients about the progression of the disease, its symptoms, medications, self-management, and complications management using pamphlets and other means. A free spirometry camp was conducted to screen people for COPD.

Sri Ramakrishna College of Physiotherapy volunteers held a public awareness campaign on COPD.

In August, three scientific papers were published in international journals regarding treatment for stress incontinence in COPD, the influence of different body positions in pulmonary function tests, and the effects of the CORNET device in treating the pneumonia patient. In addition, medical camps are regularly held for the benefit of poor patients.

Tarrant County College Hosts Taiwan RT Students

By John D. Hiser, MEd, RRT, FAARC, Chair, AARC International Committee, and Program Director, Respiratory Care, Tarrant County College, Fort Worth, TX

For the seventh year in a row, Tarrant County College in Fort Worth, TX, hosted respiratory therapy students from China Medical University in Taichung, Taiwan. The students shared lecture, lab, and clinical experiences and also visited several alternative care sites during the three-week visit to America. They also visited the AARC Executive Office to learn how the AARC serves its members around the world. This year's students were Chen, Kuei-Ru (Maynie) and Huang, Jia-Yi (Jimmy). ■

RC Currents

California RT Students Welcome Tokyo Students for Cultural Exchange

Earlier this year, students from Tokyo College of Medico-Pharmaco Technology (TCMPT) in Japan visited students at California College San Diego (CCSD). The visiting students are in the second year of a three-year clinical engineering technology program. Takashi Kudoh, the instructor from TCMPT, coordinated laboratory activities through interpreter Tomoko Ohkubo-Kuo. Terry Davis, retired dean of the School of Health Exercise Science and Athletics from Southwestern College, worked with AARC member Henry Oh, RRT-NPS, MT, CBiol, FRSB, associate dean and director of respiratory therapy at California College, to arrange the respiratory therapy laboratory workshop and cultural exchange.

The students from Tokyo are training to become clinical engineering technologists. They work in operating rooms and intensive care units, operate ventilators and heart-lung machines, and are members of the medical team with doctors and nurses. Graduates of the program take a national examination to be able to practice their profession.

The students toured the college then joined the CCSD respiratory therapy students in the classroom to establish a mutual cultural understanding and a positive learning environment. They went to the laboratory to observe several kinds of ventilators connected to real pig lungs. Eric Coolong, RRT, a teaching assistant/tutor, oriented them on the operations of the ventilators and briefly discussed the different waveforms.

The next activity was pairing each visiting student with two respiratory therapy students to perform vital sign checks and assessments, taking turns doing these procedures on each other. Everyone communicated well through signs and body language.

At the conclusion of their visit, California College presented each visiting student with a certificate in recognition of their participation in the respiratory therapy laboratory workshop. The certificates bear their Japanese names in English. The visiting students gave the California College students souvenirs in appreciation of their hospitality.

"The success of this cultural exchange between the respiratory therapy students from California College and the clinical engineering technology students from Japan is a result of joint cooperation and mutual understanding despite the language barrier and cultural diversity," said Henry Oh. "It shows that superb education and camaraderie have no barriers." California College students learned basic greetings and body language in Japanese. Likewise, the Japanese students learned that a handshake means appreciation upon receipt of a certificate. ■

AARC New Members List Is Online

The "New Members" column can be accessed at http://c.AARC.org/new_members. Current AARC members are encouraged to check this site on the first of each month to view the names of individuals who have been approved as "Active Members" of the Association. ■

Submit RFPs for Congress 2017

The AARC Program Committee wants to hear about the speakers and topics you'd like to see on the program for the 2017 AARC Congress in Indianapolis, IN, next Oct. 4-7. Go online now to www.AARC.org to submit your requests for proposals. The RFP deadline is **Dec. 31**, and there will be no extensions. ■

▶ STUDENT CORNER

Preparing for a Final Exam

Charity Bowling, MA, RRT

Students often express that they stayed up late and were anxious prior to taking a final exam. With better time management, students might reduce some of the apprehension they experience.

Start the review process early by asking for clarification of any missed questions on previous tests. If necessary, make an appointment with a faculty member to review the missed items. Understanding why you missed something will help you make better choices on the final exam.

Outline chapters that are to be covered in class on a weekly basis. Take notes on the material you have just outlined during the lecture and compare the lecture notes to your outline. Doing this helps fill any gaps that may have been overlooked and can eliminate material that is not required!

Study groups are a great way for students to prep for a final exam. Break up the material to be covered and ask each of your study buddies to pick a section that they feel they know best. Create questions out of the material and quiz each other. Forming groups early on helps build on the curriculum being taught weekly and reduces the stress of studying at the last minute.

Don't study all in one night! By breaking the content into bite-sized pieces, you have a better chance of retaining the material. Try studying for an hour or two, taking a break for a few hours, and then studying an additional 1-2 hours during each study session.

Finally, when taking the exam, skip any questions you don't know. When you reach the end of the exam, go back and look at the questions you skipped. If it's a multiple choice exam, eliminate the answers you know are incorrect and narrow it down to two responses. If need be, then just guess! •

Charity Bowling is the respiratory care program chair at Ivy Tech Community College in Indianapolis, IN.

RT Student Members: Send Us Your Stories

AARC Times is always looking for good stories from AARC student members that relate special experiences and give the RT student's perspective on the respiratory care profession they have chosen as a career.

If you have a story to tell, please contact *AARC Times* Editor Marsha Cathcart at cathcart@aarc.org and include in the subject line, "Student Member Story." Be sure to give us your full name, AARC member number, a brief description of the story subject, and why you would like to have it published. Then attach a Word document of the story. We hope to hear from you soon! ■

Blame the Microbes

Could the microbes found in a baby's gut during the first month of life mean the difference between asthma and no asthma at age four? Yes, report researchers from University of California San Francisco and the Henry Ford Health System, who used high-throughput genetic analysis to map the gut microbes found in stool samples collected from 130 infants at around one month of age.

Results showed that babies fell into one of three distinct groups, each characterized by different types of bacterial and fungal species in the gut. Infants in the smallest of these three groups (11 of the 130 infants) were three times more likely to develop atopy and asthma, and the size of this at-risk group was strikingly consistent with the rate of allergic asthma in the general population. The study was published in a recent edition of *Nature Medicine*. ■

Always on Duty

Munira Mohamed is glad she could put her RT training to work helping a man who collapsed at the Newark, NJ, airport last summer.

Munira Mohamed, RRT, was just getting back into the country after visiting family in Stockholm, Sweden, last summer when she noticed the man ahead of her on the escalator in the Newark, NJ, airport. The escalator was crowded with people heading to customs and he seemed to be having trouble keeping his balance.

"He seemed very uneasy walking," recalls Mohamed. "I kept my eye on him. I was thinking, 'I hope he doesn't collapse while on the escalator.'"

That's exactly what happened a few seconds later—luckily, he was at the top of the escalator by then. Mohamed rushed to his side and immediately checked for a pulse. It was faint, but it was there. Then she checked his respiration and found agonal breathing. After quickly consoling the man's daughter and assuring her she was there to help, the AARC member got up to ask another bystander to go ask an agent for the nearest automated external defibrillator (AED) and to call 911.

As she made her way back to the man, she heard someone saying he was a physician. "He checked the pulse and he didn't feel a pulse, and we started doing compressions," says Mohamed. Soon a paramedic stopped to help as well, and the three of them worked as a team to revive the man, with Mohamed at the head taking care of the breaths and the physician and paramedic doing the compressions.

The AED machine was delivered to the scene shortly thereafter and Mohamed placed the patches and found a mask with a filter. "We continued with CPR 30 compressions and two breaths," she says. "The gentleman was shocked three times before we got a heart rate." By the time the paramedics arrived, they had achieved a regular rhythm and a heart rate of 110 beats per minute. The man was loaded onto a stretcher and whisked off to a waiting ambulance.

Mohamed, the doctor, and the paramedic spent a few moments chatting about how lucky the man was to have had three health care professionals in such close proximity when he collapsed, then headed their separate ways. For Mohamed, that meant boarding a flight for the final leg of her journal back home to Minnesota, where she serves as a respiratory therapist at St. Francis Medical Center in Shakopee. When she related her airport adventure to friends, family, and coworkers, she was pleased to receive many "good job" and "right place, right time" comments.

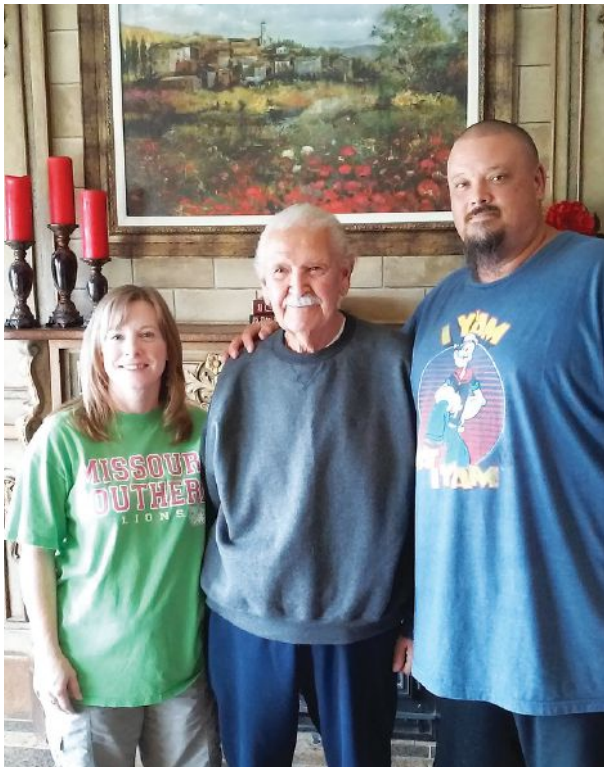
In her head, however, this respiratory therapist couldn't help but think, "I stopped because I'm an RT, and if I see something like that, I'm always on duty." ■

Contribute to Our "Transitions" Column

The AARC "Transitions" column is devoted to sharing news about the passing of AARC members.

You can submit news about your colleagues' recent passing by going to http:c.AARC.org/transitions. Please provide any information about the member's recent obituary so that we can share it with the membership and pay tribute. ■

Making Aging Veterans Feel at Home



Jennifer Jones and her husband Tom, right, have welcomed Korean War veteran Ed Patron into their home.

Aging veterans of service who don't have family members who can care for them are often left with no choice but to go into a nursing home. A Medical Foster Home Program sponsored by the U.S. Department of Veterans Affairs aims to reduce the number of vets who need to go that route. Jennifer Jones, BS, RRT, and her husband Tom are among those who have graciously opened their homes to these American heroes. Their involvement grew out of some hard times of their own. "We became involved with the VA Medical Foster Home program during the summer of 2014," explains the AARC member. "The hospital I worked at in Mount Vernon, MO, with over 500 employees, was being closed. That meant over 500 people, including myself, were going to be without jobs in a few months."

A former security guard at the hospital, her husband was working as the primary caretaker for up to nine boys at a time at a local Children's Home, and that background combined with her experience as a respiratory therapist made them confident that they could take care of an aging vet in their home.

They contacted the VA Medical Foster Home Program coordinator in their area and got the ball rolling. After passing a host of home inspections and upgrading their fire alarm system, they were assigned their first vet in October 2014. A 67-year-old Vietnam vet who served as a mechanic in the Army, the long-time smoker came to them wearing oxygen 50% of the time and using nebulizers on a frequent basis.

"While with us, he quit smoking, stopped needing oxygen, and reduced his nebulizer usage down to QID and began an inhaled steroid BID," says Jones, who now works full-time at Mercy Hospital in Aurora, MO, and as a PRN at Mercy Hospital in nearby Springfield. His health improved so much, in fact, that he was able to move out and live independently again after only a few months. "He continues to keep in touch with us by telephone, text message, and the occasional card," she says.

A second vet came into their home the following January. Also 67 years old and a Vietnam-era vet, he suffered from COPD. Jones and her husband took special care to monitor his condition, including oxygen saturation, oxygen usage, need for breathing treatments, and work of breathing. Improvement wasn't in the cards, however, and he passed away just a couple months later. The death hit both Jones and her husband hard, and they even briefly contemplated quitting the program.

They're glad they didn't. Their third and current veteran, 83-year-old Ed Patron, entered their lives last March and has been a joy to have around the house, says Jones. While he suffers from dementia and diabetes, his medical issues are fairly easily managed, and he enjoys walking on their property in rural Verona and pitching in to help with chores like pulling weeds in Tom's garden. The Jones have also loved learning more about his service in Korea, where he worked as a tank driver and is credited with saving the lives of 84 men. "He has four bronze stars and an array of other awards and medals," says Jones. "It is an honor to have him live with us."

Jones and her husband credit the VA Medical Foster Home Program with improving the quality of life for aging vets at a time in their lives when they would otherwise see a rapid decline. "There is absolutely no need for our veterans to be stuck in nursing homes when there aren't really health issues that warrant that type of care," she says. "My husband and I strongly believe our veterans deserve the very best that we can give." ■

Transitions

Douglas C. Albright, MEd, RRT, passed away in July. A member of the AARC since 1987, he served as director of respiratory care at Penn State Health–St. Joseph's Medical Center in Reading, PA, and played an active role in the Pennsylvania Society for Respiratory Care. ■

Telemedicine Programs Benefit Kids with Asthma

Not all children with asthma have access to an allergist. Could telemedicine improve the availability? The answer is yes, according to Children's Mercy Hospital researchers, who compared a telemedicine program wherein a respiratory therapist or nurse operated telemedicine equipment for an allergist during remote visits, and then compared outcomes for those children with those from kids who attended an allergy clinic at the Kansas City hospital.

The investigators followed the kids in both groups for six months. Children in the telemedicine group were assessed using digital stethoscopes and otoscopes. Asthma control improved in both groups of children. "We were encouraged because sometimes those with the greatest need for an asthma specialist live in underserved areas such as rural or inner-city communities where allergists aren't always available," noted study author Chitra Dinakar, MD. "The study shows these kids can get effective care from a specialist, even if they don't happen to live close to where an allergist practices."

The study was published in the *Annals of Allergy, Asthma and Immunology* last fall. ■

Why Organ Transplant Patients Shouldn't Smoke

Patients who need an organ transplant are advised to stop smoking at least six months prior to the transplant, but little is done to encourage continued abstinence among these individuals after the surgery.

A new study out of Switzerland suggests greater vigilance is needed. Researchers there found that people who continued to smoke or resumed smoking after a transplant were 40% more likely to develop new heart disease, and they also had higher rates of cancer and were more likely to die during follow up. The findings were based on a review of 73 previous studies on transplant patients and were published in a recent edition of *Transplantation*. ■

Mild COPD Needs More Attention

Recent results from the ongoing COPDGene study suggest preventing lung function decline in people with COPD will require much earlier identification and treatment of the condition.

Researchers arrived at that conclusion after analyzing data from the first 2,000 COPDGene participants who returned for a follow-up visit five years after joining the study. Participants were grouped by COPD severity based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, and the study also identified participants with preserved ratio impaired spirometry (PRISm). These patients do not meet the GOLD criteria for COPD, but they have reduced FEV_1 (<80% of expected) and a normal FEV_1/FVC ratio (>0.70%). Among the results:

- Across all groups, including those without COPD and those with PRISm, exacerbations and severe exacerbations were common, with 36.7% reporting events during the past five years.
- Among those with COPD overall, exacerbations were associated with an FEV_1 decline in excess of that predicted by aging and other time-dependent factors.
- Those with mild COPD (GOLD 1) experienced the greatest FEV_1 decline. Each exacerbation was associated with an additional 23 mL/year decline. Each severe exacerbation was associated with an additional 87 mL/year decline.
- Those with moderate (GOLD 2) or severe (GOLD 3) COPD experienced statistically significant but smaller declines in FEV_1 with each exacerbation compared to those with mild COPD.
- Smokers without COPD with an acute respiratory event and those with PRISm with an exacerbation of any severity did not experience FEV_1 decline. A similar result was observed among those with very severe COPD (GOLD 4), which the authors believe likely reflects survivor bias.
- Current and intermittent smokers experienced a steeper FEV_1 decline than former smokers, 9 mL versus 2 mL.

The researchers noted that because medicines used to prevent exacerbations have rarely, if ever, been studied in those with mild COPD, a randomized trial in this group may be warranted. The study was published in a recent edition of the *American Journal of Respiratory and Critical Care Medicine*. ■

Strange But True…

Bagpipe lungs: Dirty bagpipes have been pegged as the cause of a British man's death. While he was alive, physicians thought his severe respiratory symptoms were being caused by allergies, but when they tested his bagpipes on a hunch after he passed away, they found they contained a fungus known to trigger a rare condition called hypersensitivity pneumonitis.

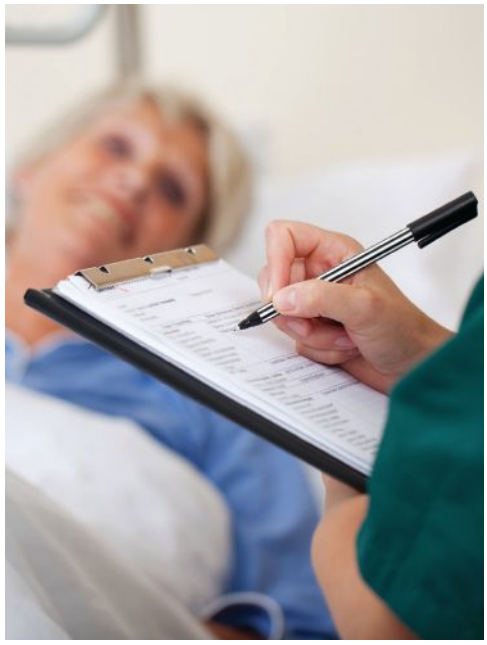
That's one big ball: The Allegheny Health Network out of Pennsylvania decided to raise awareness of asthma last summer by blowing up the world's largest beach ball at a local regatta. The ball measured 40 feet in diameter and stood some four stories tall. ■

Nothing New Here — Electronic Cigarettes Not Proven as Smoking Cessation Aid

Two years ago the *Cochrane Review* published a study based on the current evidence on the value of e-cigarettes in smoking cessation. That review concluded that electronic cigarettes containing nicotine are better at helping people quit smoking than electronic cigarettes not containing nicotine, but nicotine-containing devices could not be proven superior to the nicotine patch.

According to a new review in the same publication, nothing has changed. No additional randomized controlled trials were available to include in the update, and observational data from an additional 11 studies found no serious side effects from using electronic cigarettes for up to two years. The most commonly reported side effects were throat and mouth irritation.

The authors believe subsequent reviews may shed more light on the issue. Right now, a number of randomized controlled trials are in the works, and their results may help clarify the real value of e-cigarettes as an aid to stop smoking. ■



Sometimes a Readmission Is a Good Thing

The Centers for Medicare and Medicaid Services (CMS) have targeted six areas for readmissions penalties: heart attack, pneumonia, heart failure, stroke, COPD, and coronary artery bypass. Federal penalties for excessive readmissions have led most clinicians to believe readmission is a bad thing that should be avoided at all costs.

Maybe not, say Johns Hopkins researchers who looked at hospital-wide readmission rates at nearly 4,500 facilities and compared them with those facilities' mortality rates. Hospitals with the highest rates of readmission were actually more likely to show better mortality scores in patients treated for heart failure, COPD, and stroke.

"High readmission rates could stem from the legitimate need to care for chronically ill patients in high-intensity settings," study author Daniel J. Brotman, MD, was quoted as saying. "It's possible that global efforts to keep patients out of the hospital might, in some instances, place patients at risk by delaying necessary acute care." Dr. Brotman and his colleagues published their findings in a recent edition of the *Journal of Hospital Medicine*. ■

Industry Watch

NRPA says to keep parks tobacco free

The U.S. National Recreation and Park Association (NRPA) has issued a position statement calling for a ban on the consumption and use of tobacco products in all public parks and recreation centers across the country. The organization believes prohibiting tobacco use at these places will protect visitors, especially children, from unhealthy behavior and exposure to secondhand smoke, as well as prevent millions of cigarette butts and filters from being left behind by tobacco users.

Lurie Children's Hospital receives NIH grant

Ann & Robert H. Lurie Children's Hospital of Chicago has been selected to participate in the National Institutes of Health (NIH)-funded prematurity-related ventilatory control (Pre-Vent) study consortium. Physicians and researchers at Lurie Children's Hospital will partner with investigators from other leading national hospitals to expand knowledge of neurorespiratory maturation in premature infants. Lurie Children's Hospital's site-specific study will investigate how autonomic, neurologic control of breathing matures in infants born at less than 29 weeks of gestation. The hospital will receive approximately $2.5 million over five years to pursue its site-specific study, as well as other program-wide projects.

Corbus completes enrollment in cystic fibrosis study

Corbus Pharmaceuticals Holdings, Inc., has completed subject enrollment in its Phase 2 clinical study of Resunab for the treatment of cystic fibrosis. The company expects to report top-line results early in the first quarter of 2017 in the international, multi-center, double-blinded, randomized, placebo-control trial, which is supported by a $5 million development award from the Cystic Fibrosis Foundation. The objectives of the study are to evaluate Resunab's safety, tolerability, and efficacy in adults with cystic fibrosis without regard to underlying genetic mutation or infecting pathogen.

Monaghan reports good results for Aerobika®

According to Monaghan Medical Corporation, results from a real-world study evaluating the efficacy of the Aerobika® device in reducing COPD exacerbations show a clinically significant reduction in exacerbations in as little as 30 days of treatment when used as an add-on to usual COPD medications. "Adding the Aerobika® device to our current COPD treatment protocols could significantly improve patient outcomes while decreasing the burden on our health care resources," says Brian Carlin, MD, FCCP, FAASM. The findings were presented at the European Respiratory Society International Congress in London.

Mallinckrodt patents upheld

According to Mallinckrodt Pharmaceuticals, the U.S. Patent and Trademark Office has upheld the validity of commercially significant claims related to five patents covering gas delivery systems, as well as methods of using such systems related to INOMAX® (nitric oxide) gas for inhalation. "INOMAX is protected by comprehensive intellectual property covering both the drug and INOmax delivery systems — patents which extend late into the next decade and beyond," Michael-Bryant Hicks, Mallinckrodt senior vice president and general counsel, was quoted as saying.

BD launches next-gen diagnostic system

Becton, Dickinson and Company (BD) has launched its next-generation wireless rapid diagnostic system for detection of influenza A and B, respiratory syncytial virus, and group A strep, with new traceability and secure patient health record documentation features and functionality. The company says the new wireless BD Veritor™ Plus System provides health care providers and laboratorians in physician offices, clinics, hospitals, and integrated delivery networks with objective, lab-quality immunoassay test results within minutes. It will also streamline the point-of-care diagnostic workflow, enabling providers to

quickly review patient results to assist in determining the appropriate treatment in a single consultation.

Study says naloxone can be given via nasal spray

Research published in *The Journal of Clinical Pharmacology* finds the U.S. Food and Drug Administration (FDA)-approved intranasal formulation of naloxone, NARCAN® (Naloxone HCl) nasal spray (4 mg) delivers approximately the same amount of naloxone as a 2-mg intramuscular (IM) injection. Plasma concentrations were detectible within 2.5 minutes, and maximum concentration levels were achieved as rapidly as with the IM injection. There were no differences in safety profiles. "We are excited to have this data published demonstrating the concentrated formulation in NARCAN® Nasal Spray (4 mg) achieving a rapid and effective exposure of naloxone. This is increasingly important due to the dramatic rise in overdose cases of highly potent opioids, such as fentanyl, which require higher concentrations of naloxone," according to Adapt Pharma CEO Seamus Mulligan.

FDA grants Fast Track designation for AEROSURF®

According to Windtree Therapeutics, Inc., the FDA has granted Fast Track designation for the company's AEROSURF® (lucinactant for inhalation) for the treatment of premature infants with respiratory distress syndrome (RDS). The novel, investigational combination drug/device product is being developed to deliver aerosolized KL4 surfactant to premature infants with RDS, potentially reducing the need for invasive endotracheal intubation and mechanical ventilation to administer surfactant therapy.

DMD drug receives accelerated approval

The FDA has granted accelerated approval for Sarepta Therapeutics' Exondys 51 (eteplirsen) injection for the treatment of patients with Duchenne muscular dystrophy (DMD). Exondys 51 is specifically indicated for patients who have a confirmed mutation of the dystrophin gene amenable to exon 51 skipping, which affects about 13% of the population with DMD. "In rare diseases, new drug development is especially challenging due to the small numbers of people affected by each disease and the lack of medical understanding of many disorders," explains Janet Woodcock, MD, director of the FDA's Center for Drug Evaluation and Research. "Accelerated approval makes this drug available to patients based on initial data, but we eagerly await learning more about the efficacy of this drug through a confirmatory clinical trial that the company must conduct after approval."

Neuraltus launches study on ALS drug

Neuraltus Pharmaceuticals, Inc., has initiated a second Phase 2 study of its investigational treatment, NP001, in patients with amyotrophic lateral sclerosis (ALS). The randomized, double-blind, placebo-controlled, multicenter study will enroll up to 120 ALS patients in North America with evidence of systemic inflammation. Patients will receive either 2 mg/kg of NP001 or a placebo over a six-month period. The study is designed to evaluate the change from baseline in the "ALS Functional Rating Score Revised," which measures key activities of daily living and function for patients with ALS. Secondary objectives include a change in pulmonary function as measured by vital capacity readings.

ProterixBio joins industrial advisory boards

ProterixBio, Inc., has joined the industrial advisory boards of the COPD Foundation and the SPIROMICS Consortium, reflecting the company's commitment to develop novel clinical applications for pulmonary diseases. "The COPD Foundation is dedicated to improving the lives of all those affected by COPD and we are grateful to ProterixBio for their generous sponsorship which will enable us to help the research and patient community alike," COPD Foundation CEO Craig Kephart was quoted as saying. The SPIROMICS Consortium is conducting the Subpopulations and Intermediate Outcomes in COPD Study, a joint NIH- and industry-funded multi-center trial of COPD patients designed to guide the future development of therapies for COPD.

Intrexon and CRS Bio to focus on CRS

Intrexon Corporation has entered into an exclusive channel collaboration with CRS Bio, Inc. that will focus on the targeted delivery of antibodies for the treatment of chronic rhinosinusitis (CRS) with and without nasal polyps. The project will utilize Intrexon's ActoBiotics™ technology to block inflammatory mediators in the nasal passage, leading to improved breathing and quality of life. "Chronic rhinosinusitis affects more than 10% of the EU and U.S. population, and often cannot be cured by current therapies," notes Claus Bachert, MD, PhD, from Ghent University Hospital in Belgium. "The ActoBiotics™ platform for local delivery of innovative therapy is perfectly suited to develop new approaches for CRS." ■

Brief submissions and photos for this column may be sent to *AARC Times* Editor Marsha Cathcart at cathcart@aarc.org.

Special Advertising Section

Industry Update

Featuring information on products and equipment from manufacturers

The View from Over the Hill (Or… Better Over the Hill than Under It!)

by Debbie Linhart, BS, RRT

Here I am, "retired," a word that derives from the ancient Aramaic "re," meaning I thought about this over, over, and over again, and "tired," which is what I was. Actually, that's not completely true. I was getting too tired on shifts I worked, but I *never* got tired of my patients. I miss them dearly… and my co-workers — I miss them, too.

Privileged to be an RT

I always considered it a privilege to be a respiratory therapist. We often see our patients and their loved ones on one of the worst days of their lives. What we say and do and how we do it can have a huge impact on their attitudes, their hope and cooperation, and, ultimately, their outcome. A few moments of kindness, listening, or attention may seem small to us but huge to a person in crisis. Always striving to do the best I could for each patient gave me a sense of participating in the well-being of my little corner of the planet, a sense of purpose and belonging.

I am fortunate to have remained in contact with two former patients. Gayle was a recent high school graduate with asthma and I was her respiratory therapist when we met in 1974. I remember drawing her blood and explaining the oxyhemoglobin dissociation curve to her after doing her ABG. We have been bridesmaids for each other's weddings, and this year makes 40 years she's been a respiratory therapist herself.

The other is Verna. Verna was my patient when I was a new nurse's aide in 1967, and we have been friends ever since. She is my guardian angel, my cheerleader, my anchor, my other mother. No wonder I made health care my life, if these two women are examples of the amazing people I've had a chance to know.

I worked in health care for 50 years and in respiratory care for 42. I had been involved with the fantastic people in the Illinois Society for Respiratory Care since 1979, so retirement has left a huge hole in my life that I'm still working to fill.

about the author…

Debbie Linhart is a past president of the Illinois Society for Respiratory Care (ISRC). She was the 2008 recipient of the ISRC Legacy Award for lifetime contributions to respiratory care in Illinois, the 2010 recipient of the ISRC President's Award for outstanding officer of the year, and the 2012 recipient of the AARC Outstanding Affiliate Contributor Award.

Keeping busy

What to do, what to do? It helped that while I was considering when to retire, I was also considering what I might enjoy doing once I did retire and making connections to ease the transition. My first goal was to lose ten pounds, and I can honestly report I have only 15 pounds to go and I'll be there!

I'm enjoying spending more time with family and friends and getting to know my four-and-a-half-year-old granddaughter better. She's currently trying to convince her parents to legally change her name to "Elsa" like the princess in *Frozen*. Her parents are telling her to "Let It Go."

I'm also getting my house in order. There are such major remodeling and renovations being done that when my son came to visit he actually drove past my house because he didn't recognize it!

I am the new president of the Winfield Library Friends, am a village appointee to a committee developing a riverwalk in our community, am active at my church, and am involved in my high school alumni association. I am also a member of the Art Institute of Chicago, which was recognized as the number one museum in the world in 2014. I enjoy taking the train

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(continued from page 24, Cover Story)

programs that will place them on par with similar programs offered in the United States.

It was my pleasure to work with the late Dr. Louis Sinopoli to help our international RT colleagues design a set of standards that reflect contemporary education accreditation best practices. These standards allow us to determine whether an education experience warrants approval by the IERS. The result has been the approval of more than 170 high-quality RT programs that have helped educate international practitioners to better care for patients with respiratory disease and injury.

How does the IERS benefit the nations that take advantage of it, and how does it benefit RTs here in our country?

When quality education and training in respiratory therapy is strong outside of the United States, it makes RTs even stronger here at home. This is particularly true when the benchmark for measuring the quality of international RT education is grounded in the quality of education provided in the United States. The standards to which many of our colleagues aspire are fashioned after our scope of practice, professional association, education and credentialing systems, accreditation process, and importantly, our inclusion as key members of the health care team.

Our international counterparts want what we have attained, and they speak highly of our important role in U.S. health care. By qualifying for approval by the IERS, with the ICRC and AARC endorsing the quality of their educational programs, these international RT practitioners benefit by growing in influence and stature in their home countries. This makes every one of us as respiratory therapists stronger and more influential in our everyday professional interactions.

How did it feel to receive last year's international achievement award?

It is always special to be recognized by your peers for doing work that you enjoy. To receive the Hector Leon Garza MD International Achievement Award is especially important to me because the namesake of the award is a close personal friend I have worked with on the ICRC and known for over 30 years. Dr. Hector Leon Garza is a giant in respiratory care, not only in Mexico and Latin America but also throughout the international respiratory care community. There is a rich tradition surrounding the Garza Award, and I feel fortunate and proud to have received it and cherish the honor. ■

(continued from page 54, Reflections)

downtown, spending the day exploring exhibits, listening to lectures, and eating lunch in the Chicago loop.

Making the most of life

And the future? I hope to always recognize, appreciate, and make the most of the blessings in my life, past, present, and yet to come. Over the years, I have seen many people struggle for each breath and it has taught me just how full and rich my life is even on my quietest days. I hope to find new purposes, and new ways to participate in the well-being of my little corner of the planet along the way. ■

65 or over? Been an AARC member for 20 years or more? Then you qualify for a significant price break on annual dues through our new senior membership category. Call (972) 243-2272 to take advantage of the offer.

(continued from page 27, Expansion of Respiratory Care in China)

ventilator workshop that focused on using scalar graphic waveforms to identify and optimize patient–ventilator synchrony. Drs. Liu and Ma then invited us to round with them in the ICU to discuss patient care management strategies.

The following morning we traveled across town to The Fudan University Children's Hospital, where we were joined by the hospital's CEO and pediatric ICU staff. They indicated significant interest in wanting respiratory therapists in their ICU, so we delivered a presentation outlining the training, roles, and responsibilities of respiratory therapists in the United States. We answered questions about how they may best move forward with having some of their staff receive respiratory therapy training. This would allow them to employ designated respiratory therapists in the pediatric ICU using a clinical practice model similar to that being used in the United States.

Since our return to the United States, we have connected administrative staff at The Fudan University Children's Hospital in Shanghai with key stakeholders within the respiratory care community. Partnering with SRRSH's respiratory care department in Hangzhou, with AARC International Council for Respiratory Care (ICRC) President Jerome Sullivan, PhD, RRT, FAARC, with AARC Executive Director Tom Kallstrom, MBA, RRT, FAARC, and with us, The Fudan University Children's Hospital will develop a strategic plan to become the first respiratory therapist training center in China with specialized training in pediatric respiratory care. Their vision is to be the leader in pediatric respiratory therapy training in China. Our trip to provided great teaching opportunities and many unique cultural and professional experiences for us. It is encouraging to see such positive growth among the respiratory therapy community in China. With effective networking among AARC International Fellows, the Chinese Thoracic Society, hospital administrators, and critical care clinicians throughout China, this sustained commitment to improve respiratory care, while collaborating with the ICRC and AARC, will undoubtedly broaden a shared vision to improve respiratory care throughout China. ■

(continued from page 35, Improving Health Care in Belize)

Here's what you can do

We are not asking for donations of equipment or money. The funds to cover the equipment gaps are taken care of by a group of Christian organizations. Among the people within these organizations are George Robertson and his son, Josh. They take a special interest in Belize. George is a RT who trained at Tarrant County College in Texas during the 1980s. He is active in establishing the hospice movement in Belize, working with an anesthesiologist named Dr. Beatrice Thomas. She sat at my left while at dinner on a Sunday evening. The next day, she met with the highest government officials to discuss the hospice movement and the care of the dying in Belize.

What can you do? You can save lives in the following three ways:

- Belize needs asthma educators who speak English. English is the national language. Are you willing to travel and teach patients and staff? This extended trip could send the educator beyond Belize City. The beautiful countryside awaits you.
- Belize desperately needs one or more biomedical equipment technicians to travel to Central America and assess the maintenance and repair situation. The person(s) will need to gather the needed manuals and supplies when back in the United States and then go back to Belize, make the repairs, and do the maintenance.
- Are you a competent neonatal RT? Belize needs you. The RTs would love to have someone to talk to about premies and ventilation. Please consider a teaching trip.

Interested? Contact me at james.ciolek@tccd.edu. ■

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