

## What Is Respiratory Care?

This issue of RESPIRATORY CARE begins the first new volume after a change in editorship. It ushers in a new, expanded Editorial Board and other changes as well, some of which are described in the accompanying editorial by Assistant Editor Kris Williams. It thus seems appropriate to review the mission and goals of RESPIRATORY CARE, the Journal, in the context of respiratory care, the profession, and respiratory care, the subject area within health care.

### Respiratory Care, The Profession

According to the American Association for Respiratory Care (AARC), respiratory care is “a health care specialty under medical direction in the assessment, treatment, management, control, diagnostic evaluation, and care of patients with deficiencies and abnormalities of the cardiopulmonary system.”<sup>1</sup> The AARC further defines this health care specialty as follows:<sup>2</sup>

Respiratory care is a life-supporting, life-enhancing health care profession practiced under qualified medical direction. Respiratory care services provided to patients with disorders of the cardiopulmonary system include: diagnostic testing, therapeutics, monitoring, and rehabilitation. Patient, family, and public education are central to the mission of the profession. Respiratory care services are provided in all health care facilities and in the home.

Thus, respiratory care the profession is distinct from physical therapy, nursing, and other health care professions, and respiratory care practitioners (RCPs) are not physical therapists, nurses, or physicians. By current estimates, there are about 100,000 RCPs in the United States. Their professional association, the AARC, has approximately 38,000 members and in 1996 celebrated the 50th anniversary of its founding. Through the National Board for Respiratory Care, RCPs can be credentialed either as Registered Respiratory Therapists (RRTs) or Certified Respiratory Therapy Technicians (CRTTs), depending on their level of formal education in the field; there is currently a strong movement to require an associate degree (two years of post-secondary education) as the minimum entry level preparation for the profession.<sup>3,4</sup> To work as an RCP currently requires a professional license in 42 of the 50 United States, Washington DC, and Puerto Rico.

Respiratory care as a distinct health care profession developed in North America and at the present time exists in that form in only a few other places, notably Central America, the Philippines, and Taiwan. In most areas of the world there is no single health care profession whose practitioners are dedicated and specifically trained to deal with all aspects of the care of patients with respiratory problems.

### Respiratory Care, The Subject Area

The term respiratory care also refers to a collection of principles, skills, and patient needs that have arisen because of the nature of respiratory disorders and their effects on individuals. In the introduction to his 1971 book, *Intensive and Rehabilitative Respiratory Care*, Thomas L. Petty used the term not to identify a specific allied health profession but to refer to a multidisciplinary approach to the management of patients with respiratory problems:<sup>5</sup>

The development of an organized team-approach for management of patients with acute respiratory failure has been a major advance of today's medicine and has provided the arena for systematic physiologically oriented care. The disciplines of internal medicine, surgery, anesthesiology, nursing care, inhalation therapy, and physical medicine and rehabilitation all come to bear on problems presented by each individual case.

The context of Petty's description was the management of patients with acute respiratory failure, but its central feature—care that is systematic, based on physiology, and drawn from the expertise of multiple disciplines—applies to other settings as well. Respiratory care is not synonymous with critical care medicine, nor with pulmonary medicine or anesthesiology, although each of these medical specialties includes areas that coincide with aspects of the respiratory care profession and with elements of what American RCPs do.

Respiratory care the subject area is defined by the needs of patients. In the United States, many aspects of the subject area and the profession overlap. For example, in many acute care hospitals the care of a patient with acute respiratory failure would include the following components, each carried out by an RCP (under medical direction and increasingly according to a pre-established patient-driven protocol): arterial punc-

ture and blood gas measurement, endotracheal intubation, initiation and adjustment of mechanical ventilation, endotracheal suctioning, administration of aerosol bronchodilators, and chest physical therapy. If the patient required transfer to another hospital, or intrahospital transport for diagnostic tests or therapeutic interventions during the period of critical illness, an RCP would assist and usually accompany the patient. After extubation (by an RCP) and transfer out of the intensive care unit, the patient might undergo pulmonary function testing (by an RCP), and subsequently enter a pulmonary rehabilitation program in which an RCP played a central role. Following discharge, the patient might be visited at home by an RCP to assist with oxygen therapy or other care.

Whether all of the functions listed above would be carried out by RCPs depends on regional practice patterns and local hospital policy. For example, in the hospital at which I am Medical Director of Respiratory Care, RCPs do not routinely draw arterial blood specimens or perform endotracheal intubation. Everything mentioned falls within the notion of respiratory care as a subject area, though, regardless of who does it. World-wide, most patients with respiratory disorders are cared for in health care systems without RCPs. In most places, intubation would be carried out and mechanical ventilation adjusted by a physician, whether intensivist, pulmonologist, or anesthesiologist; a nurse would suction the airway and administer aerosol medications; chest percussion and postural drainage

would be done by a physical therapist; the ventilator would be maintained and serviced by an equipment technician or clinical engineer; pulmonary function testing would be by a respiratory physiologist; and pulmonary rehabilitation would be under the direction of a pulmonologist or physiatrist. Although the players may vary, the needs of patients are the same, and those needs are encompassed within the subject area of respiratory care (Fig. 1).

### RESPIRATORY CARE, the Journal

Which of the above scenarios does this Journal serve? The answer, with certain reservations, is both. RESPIRATORY CARE is not an ‘allied health’ journal per se, although it is the official journal of the AARC. It is also the only peer-reviewed scientific publication dedicated specifically and exclusively to respiratory care as a subject area. Its contents and intended readership are determined primarily by the latter, although at present most of each month’s copies are sent to members of the AARC.

A central feature of this Journal is the unifying role played by technology—for example, mechanical ventilation, artificial airways, aerosols, oxygen therapy, respiratory monitoring, and pulmonary diagnostics—as applied to the respiratory system. In this sense RESPIRATORY CARE is also “the Journal of Applied Respiratory Science.” The name could be changed

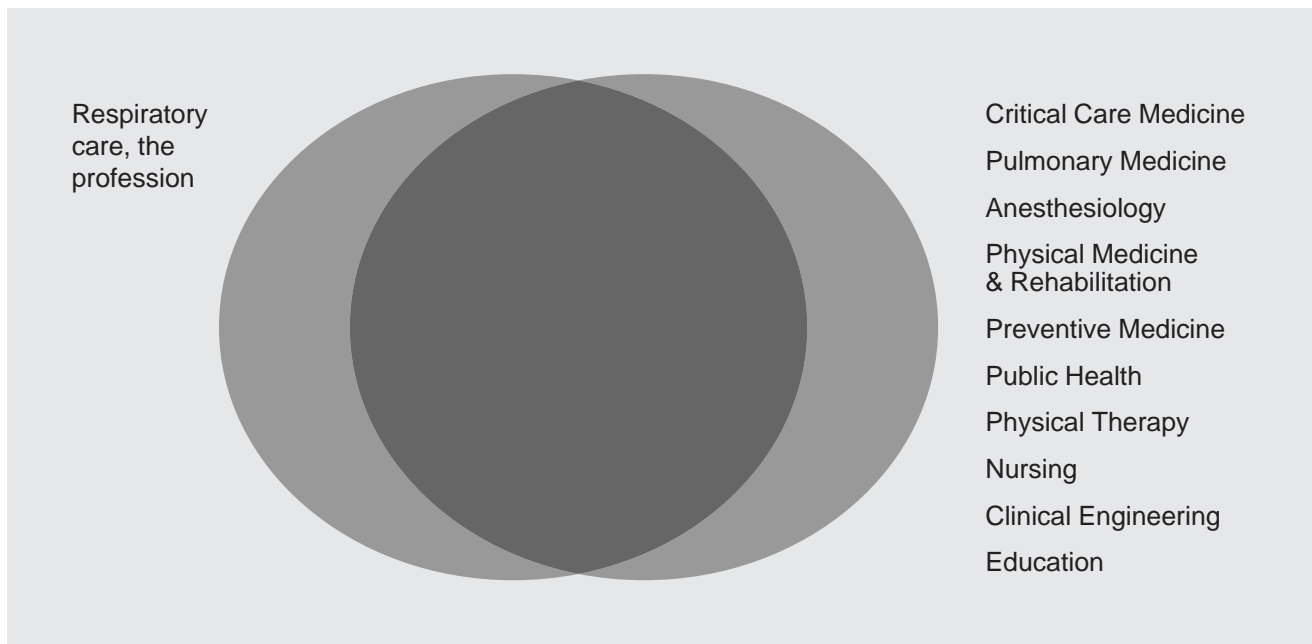


Figure 1: Conceptual representation of the distinction between respiratory care as a separate health care profession (represented by the left-hand oval), and respiratory care as a content area within each of the 10 disciplines represented by the right-hand oval. Respiratory care, the medical subject area, and RESPIRATORY CARE, the Journal, are properly concerned with the overlapped area of the two ovals. Both ovals contain areas that do not overlap and are outside the focus area of the Journal; in the case of the respiratory care profession (left-hand oval) the non-overlapping area would include such things as administrative, credentialing, regulatory, and economic aspects of the profession.

were it not for the fact that there are additional areas included under the term 'respiratory care,' such as patient outcomes, psychosocial and educational issues, and other things perhaps better described by 'care' than by 'science.'

This Journal is not primarily targeted at research into the nature of disease, but rather at topics for the clinician participating in the evaluation and care of patients with respiratory problems, particularly as these areas involve technology. Its overall goal is to be the leading journal for applied clinical pulmonary medicine, respiratory-related critical care, rehabilitation, and home care. Specific goals include augmenting the number and quality of submitted and published research papers, increasing the Journal's readership among physicians and other clinicians (including RCPs), increasing international participation both in reading and in contributing to the Journal, and enhancing the Journal's established role as a source for valuable teaching and reference documents.

The Journal's success will be measured by these things, and by increasing recognition by such institutions as the National Library of Medicine and its *Index Medicus*. Ultimately, however, this journal will succeed to the extent that it improves the care of patients, through more effective and

safer devices and techniques, through more efficient use of resources, and through the better education of clinicians.

**David J Pierson MD**  
Editor-in-Chief  
RESPIRATORY CARE  
Seattle, Washington

#### REFERENCES

1. American Association for Respiratory Care. Statement of Principles. AARC Position Statements. Dallas, TX: AARC, effective Nov 1978.
2. American Association for Respiratory Care. Definition of Respiratory Care. AARC Position Statements. Dallas, TX: AARC, effective Nov 1987.
3. Kacmarek RM. Respiratory care practitioner: carpe diem! *Respir Care* 1992;37(3):264-269.
4. Hess D. Respiratory care at the crossroads—evolution or extinction? *Respir Care* 1996;41(6):534-543.
5. Petty TL. Intensive and rehabilitative respiratory care. Philadelphia, Lea & Febiger, 1971:v.

---

Correspondence: David J Pierson MD, Editor-in-Chief, RESPIRATORY CARE, 600 Ninth Avenue, Suite 702, Seattle WA, 98104-2038.