lights should be maintained regularly and must be covered by a protective shield designed to deflect light away from persons standing beneath them. If a lamp becomes unshielded it should be turned off until it is repaired. People should avoid looking directly into these lights at any time.

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A Matter of Choice?

To the Editor:

We have read with interest the article by Smale et al in the June issue (CHEST 1995; 107:1655-61) regarding endotracheal intubation by paramedics during in-hospital cardiopulmonary resuscitation (CPR). They conclude that paramedics can successfully, and without undue difficulty or complications, place endotracheal tubes during in-hospital CPR. And, based on this relatively small sample size study, they suggest that appropriately trained paramedics may be incorporated into hospital-based CPR teams. We agree that it may help to solve the problems of the scarcity of personnel highly skilled in intubation during CPR in some small or remote hospitals. A well-trained paramedic is probably better than an untrained physician to do the job. However, mechanical training is one thing; medical training is another. A medical technician should not be a substitute for a physician in certain circumstances.

It is generally perceived by most people that endotracheal intubation is a relatively easy and safe procedure. It is true in most cases when there is no problem of difficult airway and when performed by experienced hands. However, in anesthesia, difficult intubation is considered one of the greatest challenges and the major cause of morbidity and mortality. Sometimes, even under optimal conditions in the operating room, with induction and muscle relaxation, an experienced person may fail to intubate. Endotracheal intubation can become disastrous when it fails or results in trauma. Most airway catastrophes have occurred when possible airway difficulty was not appreciated. In order to avoid mishaps, anesthesiologists are trained to recognize a difficult airway and be familiar with some alternative techniques to secure the airway including blind nasal intubation, fiberoptic intubation, retrograde intubation, laryngeal mask airway, and surgical airways. Not only that, they are also trained to be acquainted with pathophysiologic and pharmacologic effects and methods to prevent complications during laryngoscopy and endotracheal intubation such as aspiration in full-stomach patients, myocardial ischemia, or infarction due to increased sympathetic response and myocardial O2 consumption in coronary disease, increased intracranial pressure and intraocular pressure, hyperkalemia following succinylcholine, coagulation problems, pharmacology of adjunct agents for intubation, etc. We realize that, during CPR, securing the airway immediately is of utmost importance and because of time constraints, the risk of irreversible hypoxic damage should always guide the decision algorithm. Nevertheless, no matter what the patient’s condition, completely “out of phase” or not, other than immediate restoration of a patent airway, prevention of complications, if feasible, should always be taken into consideration. Depending on the individual pre-existing diseases and on-going problems, there are various techniques and drugs to choose and precautions to take by a physician. We agree that since the success rate is acceptably high, prehospital field endotracheal intubation by well-trained paramedics should be encouraged. However, it should be reminded that in an emergency situation while the time is critical and stress is mounting, trauma and/or failure during intubation is more likely to occur in less experienced hands. Therefore, in the hospital, even with successful mask ventilation and functioning airway, allowing three attempts or 15 min during CPR, we believe, is not justifiable unless no other qualified person is available.

During CPR, the most experienced and skilled person should be the one to perform intubation. If the choice is someone at the same level of training and/or experience, the physician is the better choice. If paramedics can be trained, why not physicians?

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Respiratory Care Education Includes Intubations

To the Editor:

I found the article entitled "Endotracheal Intubation by Paramedics During In-Hospital CPR" (CHEST 1995; 107:1655-61) to be very informative. Difficulties in maintaining a qualified staff for the purposes of intubation have been present for several years, especially in medically underserved areas. I would, however, like to take this opportunity to point out what I believe to be inaccurate statements as they relate to respiratory care practitioners (RCPs).

In the article, I found two statements especially troublesome. The first statement deals with the qualifications of RCPs. In the article, the statement is made that RCPs are not trained to intubate. The fact is that in over 300 of the 400 accredited respiratory care education programs (100% of registry programs), intubation is taught as part of the standard curriculum. In many instances, this education is complemented by actual practice under supervision during clinical rotations. Hospitals considering utilization of RCPs would, therefore, not necessarily incur significant financial burden to train RCPs for this procedure.

The second statement refers to an apparent unwillingness for RCPs to work evenings and nights. We are not aware of any data

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