Letters to the Editors are welcome and encouraged. Letters must raise points of current interest or address topics that have been previously addressed in the American Journal of Critical Care. Keep your letter concise. Letters are subject to editing. Include your name, credentials, title (optional), city and state, and telephone number (for verification, not for publication). Address to Kathleen Dracup, RN, DNSc, School of Nursing, University of California at Los Angeles, Factor Building, Box 956918, Los Angeles, CA 90095-6918, or fax, (310) 794-7482, or e-mail, AJCC@sonnet.ucla.edu.

To the Editors:

I appreciated the topic addressed in the Cardiology Casebook column titled “Statin Therapy in Congestive Heart Failure” (2005;14:338-340); however, I am concerned with several points in the case. When listing the medications the patient was taking, the authors noted that enalapril was prescribed at a dose of 50 mg twice a day when in fact the recommended dose, and doses used in the clinical trial for heart failure, is 50 mg daily. In reality, enalapril should be administered at a target dose of 20 mg twice a day.

If utilizing evidence-based medicine, the answer to the first question, “Which one of the following medications is vital to the management of CHF (congestive heart failure)?” should be angiotensin-converting enzyme inhibitors, β-blockers, and aldosterone receptor blockers. These medications have all been shown to improve morbidity and mortality. Diuretic therapy in CHF has never been shown in clinical trials to improve mortality, though it has been shown to provide symptom relief. Therefore, when asking what medication is vital to CHF management, I think that the answer provided is incorrect. Stating that a diuretic is the “best and most effective therapy in treating CHF” is based on symptom relief and not on long-term outcomes such as mortality.

In the discussion on lipid management, the authors stated that low-density lipoprotein (LDL) levels as low as 50 have been shown to reduce coronary events and mortality. The reference listed for this data was a study of a rat with heart failure. The current recommendations for humans, based on the National Cholesterol Education Program (NCEP) guidelines, is a goal of 70 or less in very high-risk patients—and I believe the patient discussed in the Cardiology Casebook was high risk. No prospective, randomized clinical trial data exist that identify an LDL goal of 50. The recent PROVE-IT and TNT trials clearly demonstrated benefits for lower LDL levels in the 70 range. The recent update from the NCEP with the high-risk goal of 70 stemmed from these trial results.

Rebecca L. Angerstein, MA, MSN, BC, CCRN, CNS
Norton, Ohio

The Authors Reply

The insightful concerns in Rebecca L. Angerstein’s letter are appreciated. Our responses to her concerns follow. First and foremost, in order of clinical significance we consider the control of the sodium ion (Language barriers are significant impediments to providing quality healthcare and contribute to stress for healthcare providers. These authors developed a translation tool, the Focused Accessible Spanish Translator (FAST), to be used to communicate with Spanish-speaking patients. The FAST was designed to be concise, easily accessible, portable, and contain the phrases that nurses and physicians must use in their daily practice. In this study, the authors assessed the effect of the language barrier on nurses and physicians in their institution and determined the effectiveness of the FAST at bridging that barrier.)

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importance of treating the etiology of CHF by improving coronary circulation or correcting valvular abnormalities. Nevertheless, in patients with CHF, natruresis and reducing cardiac demands by modifying activity will initiate cardiac compensation regardless of etiology. Compensation can be accomplished with diuretics, Na+ restriction, and reducing demands for cardiac work in patients in whom direct improvement in myocardial function is not possible (eg, the elderly in whom CHF is most frequent and where surgical revascularization is deemed to be too risky). We would strongly disagree with any report in the literature that disregards the major role of Na+ and the significance of a low Na+ diet and diuretic therapy in attaining cardiac compensation in CHF, a view that is contrary to the long established principles in treating CHF. The use of diuretics is the cornerstone of successful therapy for CHF.

The Physicians’ Desk Reference (PDR) 2005 clearly indicates that eplerenone dosage can be 50 mg twice a day. Regarding the question ofenalapril dosage, each patient requires dose titration starting with 5 mg daily. Many cannot tolerate a 40 mg daily dose of enalapril. This is emphasized in the cardiac and renal literature; in addition, precautions in the dosage of enalapril are stressed in the PDR 2005.

The serum levels of low-density lipoprotein cholesterol (LDL-C) for which statin therapy is indicated has had an interesting history over the years. In answer to concerns regarding therapeutic guideline references for statin therapy, the following can be gleaned from the literature. The HMG-CoA reductase inhibitors (statins) were approved by the Federal Drug Administration in 1987. In 1990, the recommended therapeutic aim for LDL-C was 135 mg/dL for those with no history of coronary disease and 100 mg/dL for those with a history of coronary disease. In 1995, 100 mg/dL was the recommended goal for LDL-C regardless of the past history.

The following are guidelines used to refine treatment for atherosclerosis (from the NCEP Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults):

1990 - goal for LDL-C 130 mg/dL
1993 - ATP-II goal for LDL-C with coronary heart disease <100 mg/dL
   ATP-II goal for LDL-C without coronary heart disease and less than 2 risk factors <130 mg/dL
   ATP-II goal for LDL-C without coronary heart disease and 0 to 1 risk factors <160 mg/dL
2001 - ATP-III without coronary disease <130 mg/dL
2005 - LDL-C 70 mg/dl goal in treating hyperlipidemia.

Isolated reports have shown that an LDL-C level of 60 mg/dl offers greater protection, endothelial cell repair, and can be achieved without undue side effects of an increase in statin dosage. Note the continued downward trend in target levels of LDL-C over 15 years of statin therapy. LDL-C levels of 40 to 50 mg/dl are the author’s (Dr Lemberg) goals for patients with multiple coronary disease risk factors or high hs-CRP and 15 years experience in the use of statins in treating hyperlipidemia. Our personal recommendations to our readers regarding the optimal LDL-C level for prevention and treatment of atherosclerotic heart disease: “STAY TUNED,” “lower is better,” and the lowest therapeutic level for LDL-C has yet to be established.

Finally, the rat, an unduly maligned but very useful laboratory animal, has served the medical profession admirably and has been employed extensively for years in numerous pharmaceutical dosage safety tests! (reference PDR 2005, as well as in every annual PDR of previous years).

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Louis Lemberg, MD
Kathyrn Buchanan Keller, RN, PhD

To the Editors:

Your editorial titled “Doctor of Nursing Practice—MRI or Total Body Scan?” (2005;14:278-281) was a thought-provoking, well-balanced essay on a very important topic. I would add another perspective that argues against the development of yet another nursing degree. I act as an expert witness on a variety of legal
cases involving nurses and other healthcare professionals. Often, the key issue is scope of practice and a lack of understanding of who is responsible for which facets of patient care. It is alarming that the word “nurse” has become so generic and meaningless that patients can mistake a nursing assistant for a nurse practitioner. Even other healthcare professionals can lose sight of the responsibilities inherent to each level of “nurse.” Often, it seems as though all women working in the healthcare setting who wear white uniforms or scrubs are referred to as “nurses” despite their true professional title (LPN, RN, NP, CNS, etc). These distinctions are not there to make us feel more important; they are there to identify responsibilities, define limitations, and protect the patient. The lack of distinction between roles can result in tragic consequences for patients. But the consequences also accrue to the individual nurses, physicians, and providers who must also endure the lawsuits when things go awry. To make the advanced practice continuum even more confusing with yet another degree would be ill-advised. I can’t tell you how many times patients—and other healthcare professionals!—look at the title on my name pin with pure puzzlement: How can I be a nurse (RN) and a doctor (PhD)?

We have done a poor job in making distinctions between nursing levels in the past. We might be better served by clarifying and explicitly naming the levels to ourselves, patients, and other healthcare providers before we engage in discussions about adding another title.

Mary Caldwell, RN, PhD
San Francisco, Calif

To the Editors:
As a 2003 graduate of the Rush University School of Nursing DNP (doctor of nursing practice) program and a CCRN for more than 30 years, I was surprised and disappointed to see an American Journal of Critical Care editorial with such bias.

The editorial reads as if work toward the DNP has gone on behind closed doors without input from academia and/or practicing nurses. According to the American Association of Colleges of Nursing Web site, “Over the past 2 years, AACN [colleges] and the Task Force on the Practice Doctorate held a variety of forums and invitational meetings to collect input on the DNP from stakeholders. Last year, AACN (colleges) and the National Organization of Nurse Practitioner Faculties jointly sponsored a forum attended by the majority of APN practice organizations. . . . Two DNP task forces continue to seek opinions and commentary from stakeholders as they move forward with this new vision for nursing education.”

Regional meet-
directly and have had that discussion. Patients have come to accept seeing a nurse practitioner in place of a physician for routine checkups and office visits because of being seen quickly. Would a nurse who is a DNP be called Doctor, and how confusing will that be to patients?

Is the proposal to replace the MS degree or is it just for the nurse practitioner? As an RN returning to school for my BSN and hopefully my MSN, I will be interested in following this debate.

Janette Kottong, RN, PCCN
Albuquerque, NM

To the Editors:
I totally agree with your editorial. We have confused the public, healthcare, and above all nurses ourselves with the many entry levels into nursing. Let’s not continue to do so. Just because a group of advanced practice nurses thinks this is the way to go, doesn’t mean the rest of us agree. Our voices should be heard also. Advanced practice nursing should not forget what is truly “nursing.” Some think that advancing the practice of nursing means crossing over to the practice of medicine. If you want a doctorate, get a PhD.

Kathleen E. Hubner, MSN, RN, CNRN
Indianapolis, Ind

To the Editors:
I read with interest your editorial on the doctor of nursing practice. As an advanced practice nurse with a PhD, I am one of the very few who has been able to successfully blend a research degree with clinical practice. Most of my colleagues with PhDs have found comfort in the world of academia and have chosen to focus on research and teaching. In fact, having been a faculty member, I struggled for some time with the notion that academia is where I should return.

However, since then I have come to terms with my true strengths: the ability to make a difference as an advanced practice nurse and promote clinical research at the same time. I completed my MSN in 1981 and started my first job as a clinical nurse specialist in critical care. In those days, the role was quite new, and I spent my first 2 years explaining to nearly everyone in my path just exactly what was a clinical nurse specialist and my job duties. Since that time, all of the advanced practice nursing roles have evolved into respected and valued members of the health team.

I am pleased that a doctorate is being considered as the entry into advanced practice. However, I am concerned about perceptions of our team members and the public as well. Because of the fundamental nature of the PhD as a research degree, I cannot suggest that it be considered as the terminal degree for advanced practice nurses. I am suggesting, however, that if we consider a clinical doctorate in nursing that there be only 1 type of clinical doctorate, whatever we choose to call it. Most of our nursing colleagues do not know the differences between any of the nursing doctorate degrees: DNP, DNSc, DNS, DSN, DN, and ND. I am embarrassed to admit that I don’t know the differences either. I wouldn’t want our advanced practice nurses of the future to struggle with public confusion as we all have struggled with the entry into practice issue.

Linda L. Morris, PhD, APN, CCNS
Chicago, Ill

To the Editors:
Thank you so much for addressing the American Association of Colleges of Nursing proposal to implement the doctor of nursing practice (DNP) as the preparation for advanced practice nursing. This is indeed an important issue that all nurses need to learn about and discuss with their colleagues. A preliminary draft of the DNP essentials document can be found on the Colleges Web site at http://www.aacn.nche.edu/. In the next several months, regional hearings will be held around the country to solicit input from all those who would like to attend.

We believe the DNP will help improve patient outcomes, clinical practice, and the stature of the profession. Advanced practice nurses at the DNP level will be educated to deliver excellent care and also to evaluate the outcomes of that care within the context of evidence-based practice and current healthcare systems. The lack of parity and respect that nurses receive from other healthcare workers is frequently cited as the primary reason why nurses leave the profession and why prospective nurses decide not to enter the profession. The DNP not only gives advanced practice nurses comparable credentials to other healthcare practitioners, it also emphasizes interdisciplinary collaboration within the proposed curriculum.

Regardless of the titles we have accumulated behind our names thus far, our patients see us as nurses. Patients expect their nurses to be adequately prepared to care for them regardless of their role. This can be seen in the public’s widespread acceptance of the nurse practitioner role: There was some initial confusion on the part of the public at first, but they quickly became receptive and trusting of these nurses.

Many advanced practice nurses would like to further their education but wish to remain in clinical practice and not become researchers. The curriculum proposed
by the Colleges for the DNP includes areas currently not addressed in a traditional advanced practice program. This additional content in the areas of evidence-based practice, outcomes evaluation, systems implementation, program evaluation, and technology will prepare our nurse leaders for the future. The complexity of healthcare systems in the future will require that nurses possess a greater repertoire of skills than the current advanced practice curriculum provides.

The nursing profession has evolved tremendously during the past 150 years. Change will be required to meet the challenges of the next 150 years. In the words of Florence Nightingale (1872), a pioneer of our profession, “For us who Nurse, our Nursing is a thing, which, unless in it we are making progress every year, every month, every week, take my word for it, we are going back.”

Rhonda McLain, DSN, RN
Jacqueline Moss, PhD, RN
Birmingham, Ala

To the Editors:

Thank you for your recent editorial on the doctor of nursing practice (DNP). Its timing is important. Here in Florida, the battle between the Florida Medical Association and advanced practice nurses is huge. The arguments of the Florida Medical Association do not even approach validity: decreased safety without direct supervision, prescribing scheduled drugs would further drug abuse, and other such preposterous statements that should embarrass the presenter, yet with the funding available to them the issues are acted upon with extreme voracity. I agree with and understand the advantages and disadvantages of the DNP. However, other disciplines are demanding doctoral preparedness, which I feel should be mandated for all “providers.”

Your statement that “consumers will soon know all of their healthcare providers as ‘doctor’ ” would not apply to nurse practitioners with a master’s degree in nursing. There is already an issue of nurse practitioners with a master’s degree in effort to gain professional respect opens the door for making up a new doctorate degree for nurses. Many situations and questions leap to my mind, but before I can consider them, I am compelled to get past an image of “rearranging deck chairs on the Titanic.”

If nurses seek a new doctorate in an effort to gain respect from physicians and other healthcare providers, they are not likely to get that respect. Any lack of respect regarding the nursing profession probably isn’t based on initials, and therefore adding initials won’t address the problem. Changing the perceptions of not only healthcare professionals but also of society takes time, work, and unity of purpose.

Until nurses can speak with one voice, until they can provide the data that prove their worth, and until the word “nurse” means similar things to all people, problems of respect and questions about place in the scheme won’t be answered. Push to have nurses as professors in medical schools, by all means. Work to show medical students and interns that nurses are professional members of the team, absolutely. Simply making up a new degree in an effort to gain professional respect opens the profession up to charges of, well, making up a new degree in an effort to gain professional respect.

Nursing isn’t, and never has been, about “bean counting” or making money. Nursing is about patient care, first and foremost, and providing the best possible care should be every nurse’s goal. I just don’t see how the DNP gets you there.

David Blackman
Chesapeake, Va

Bonnie Marting, MSN, ARNP
Juniper, Fla

To the Editors:

As the husband of a nurse, your editorial about the doctor of nursing practice (DNP) makes me worry, and not just that I’ll hear about it at the dinner table for years to come. Nursing as a profession faces difficulties that are much more fundamental than a few more initials after a nurse’s name. There are those who believe that professional nursing is in danger of marginalization, if not outright extinction. Yet, instead of a grass-roots movement to solidify the place of professional nursing in the healthcare firmament, there is discussion about a new doctorate degree for nurses. Many situations and questions leap to my mind, but before I can consider them, I am compelled to get past an image of “rearranging deck chairs on the Titanic.”

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David Blackman
Chesapeake, Va
LETTERS TO THE EDITORS
Linda L. Morris

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