

Preface



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Guest Editors

I wish to thank my many teachers and role models who instilled in me the drive to teach the noble art of medicine—the many generations of students, residents, and fellows who have allowed me to practice those skills. And most importantly the love and support of my wife and children who allow me the opportunity to care for patients. A special thanks to my friend and colleague Richard Carlson for allowing us to edit this issue of the *Clinics*.

Peter J. Papadakos, MD, FCCM

I would like to thank my wife, Barbara, and children, Bryan, Kevin, and Katie, for their love and understanding while I pursue an academic career. My wife is the foundation of our family, and I greatly appreciate her. I would also like to acknowledge my parents. Clearly, their guidance and sacrifices enabled me to achieve my career goals. Lastly, I would like to thank my colleague, Dr. P.J. Papadakos, who has been a friend and role model. I greatly appreciate his teaching and the opportunities he has given me in academic medicine.

Joe Dooley, MD

The last decade has generated a growing fund of knowledge on how ventilator management can greatly impact patient outcome. The concepts developed by ARDS Network have been broadly accepted and placed into clinical practice, not only at university centers, but has filtered down to community hospitals. We are educating our students, residents, and fellows not only on the clinical aspects of ventilation but also in the growing fund of

knowledge of the basic science of mechanical ventilation and how it may generate not only physiologic responses in the lung but may also be part of a greater systemic inflammatory response.

It is not only our goal in the issue to review the basic aspects of mechanical ventilation, such as modes of mechanical ventilation, ventilatory monitoring, and weaning from ventilation, but we wish to also develop discussion on some of the common controversies such as alveolar recruitment and stabilization. This issue also addresses some of the cutting edge concepts of mechanical ventilation such as therapist-driven protocols to standardize our care within specific disease groups. More and more, we use the education and expertise of respiratory therapists to provide a comprehensive team approach in patient management. Introduction of computer-based closed loop ventilation will also surely change the face of critical care practice as we allow technology to aid us in the 24/7 environment of the modern ICU.

We have also started to address three major complex patient disease groups in this issue: massive chest trauma, the complex environment of the neurologic ICU, and the fast-track world of the cardiovascular patient. Aspects of each of these may have implications in the care of other less specialty-based patients. No issue of a monograph on mechanical ventilation can be complete without focusing on a major question in our society, that of end of life. We are hopeful that this issue will be useful and spur broad-based discussion on how to wean mechanical life support during that highly emotionally charged period.

The full scope of the science and technology of mechanical ventilation has grown to such an extent that no single issue of the *Clinics* can fully address the topic, but we are hopeful that this issue acts as a base for further reading and research.

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