

ACCE News

January 1994

President's Message for the December 1993 ACCE Newsletter

Joseph F. Dyro, Ph.D., CCE

Gazing northward from the 19th story of the University Medical Center at Stony Brook (note the recent name change) in the direction of Bridgeport Hospital and membership chairman, Frank Painter at Novamed, the wide expanse of Long Island Sound stretches before me. The Sound, the sea, the ocean, bodies wide and deep, some parts known, much unknown. Clinical engineers are in the maelstrom and surrounded by high seas in the vast, deep ocean of health care. The tack we take through the rough seas is crucial in ensuring a safe voyage to a peaceful harbor. Let's admit it, though, smooth sailing would be a bit dull, wouldn't it? Plumbing the depths to learn more about where we are gives us more knowledge to sail the best course. Never stop learning, never be complacent, especially when the storm is raging. Take the initiative, good advice in times when many are speculating about change and about how you will be affected by it. This is the time to lead, to take the initiative; not the time to follow in a thick fog behind those whose vision is not one bit sharper than yours. Kipling's words ring loud and true like a captain's bell: "If you can keep your wits, when all about you, others are losing theirs and blaming it on you..." Clinical engineers are made of stronger stuff that will keep us from foundering, that will keep us on a steady course. Let us not be the Helen Trents of this world dashing ourselves against the rocks of despair.

What an exciting time it is. Great opportunities abound. Clinical engineering has such enormous potential, solidity, and energy. I am greatly encouraged by the accomplishments of my fellow ACCE members. Starting with the Board, I thank them for the care and thought, the time and energy that resulted in the recent Bylaws revisions. Thanks go to the Committee chairmen who have diligently worked to fulfill their respective commitments. The many members who have distinguished themselves by innovative methods to promote and enhance the profession of clinical engineering give me reason to know that the future will continue to brighten.

The Bylaws revisions approved by the Board were passed in a recent mail ballot. Thanks go to all those who took the time from their busy schedules to review the proposed changes and to send in ballots. Most of the membership voted. Elections for officers and members-at-large will be held around the first of the year. Look for ballots to be mailed to you.

The Public Affairs Committee, under the able leadership of Wayne Morse, has developed a fine brochure describing the College. These brochures will be used to publicize ACCE and especially to reach out to clinical engineers who have as yet not affiliated themselves with the College. Please contact Wayne for further information on the brochure. Frank Painter and his membership committee are working on innovative strategies to increase our membership.

The long, arduous labors of our indefatigable and enormously patient Chairman of the Advocacy Committee, Denver Lodge, and his helpful and concerned committee members were rewarded at the last Board meeting. The Board endorsed the Advocacy Committee's proposal to institute the ACCE Advocacy Awards Program. For a full description of this innovative approach to promote the profession see the companion article in this newsletter. Thank you Advocacy Committee. Now let us see a huge wave of applications. We will all look forward to our General Membership meeting in May when the awards will be made.

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Al Jakniunas represented the ACCE at the Second Partnership Conference of the Health Care Institutions and New Independent States sponsored in part by the American International Health Alliance (AIHA). AIHA was a sponsor of the Second Advanced Clinical Engineering Workshop in Boston this past spring. Al has filed a report which appears in this newsletter.

Binseng Wang, Yadin David and I were privileged to be members of a team of Biomedical Engineers who reviewed the National Institutes of Health Biomedical Engineering and Instrumentation Program (BEIP) this past October. We were joined by Joe McClain of Walter Reed Medical Center in an extensive study of the Applied Clinical Engineering Section of BEIP. The review of this important program by several members of the ACCE underscores the role all members have in promoting clinical engineering through program review. The Board has had some discussion on the part the ACCE can play in the review of clinical engineering departments. We would welcome your comments and suggestions relating to peer review.

I am pleased to report that member, George Johnston, and his good wife, Arlene, are alive and well in the Land of the Pharaohs. George is demonstrating the flexibility and adaptability of the clinical engineer as he develops a teaching curriculum for the management of a waste treatment plant on the outskirts of Cairo. This roving CE ambassador without portfolio will be at the General Meeting in May with his usual travel log and collection of amazing tales. Don't miss the show. From other parts of the world comes word that Manny Furst has successfully completed an assignment arranged through the Pan American Health Organization (PAHO) and the ACCE to advise Queen Margaret Hospital in the Bahamas on establishing a medical device management system. PAHO is a sponsor of ACCE Advanced Clinical Engineering Workshops and is actively promoting clinical engineering in the Americas through the tireless efforts of ACCE member, Antonio Hernandez. Along the lines of consulting, look for Manny's Round Table at the May 1994 AAMI meeting on networking among clinical engineers for fun and profit.

The conference on Development, Assessment and Maintenance of Medical Instrumentation in Trieste, Italy, in September (see related story in this newsletter) gave me a good opportunity to interact with

clinical engineers from around the world. A great deal of interest was seen in the activities of the College. I am pleased to report that I met with the founders of the Italian equivalent of the ACCE on the eve of their inaugural event. Our discussions that night and during the following days helped to get that organization off to a good start. After the conference, I donned my hat as a member of the Board of the Clinical Engineering Division of the International Federation of Medical and Biological Engineering. A great deal of the discussion fell to the role of the CED in supporting the upcoming World Congress of Medical Physics and Biomedical Engineering, August 21-26, 1994 in Rio de Janeiro.

Encouraging and rewarding news recently came to me from Lucio Flavio de Magalhaes Brito of Brazil and Pedro Tonarelli of Uruguay, participants in the first Advanced Clinical Engineering Workshop. Flavio and Pedro have applied the principles learned at the Workshop to their work as clinical engineers in their respective countries with great success. Awareness of clinical engineering and its benefits is spreading around the world. See the accompanying story in this newsletter. Flavio also reports that another Workshop participant, Carmelo Felice of Argentina, is forming a clinical engineering department in a pediatric hospital in Tucuman and plans to establish a Clinical Engineering Division within the Argentinean Society of Bioengineering.

Mark your calendar now for the General Meeting of the ACCE to be held in Washington, D.C. on May 24, 1994. Keep your correspondence coming in to ACCE News editor, Dave Simmons. Send success stories or send your perspectives on the development of the profession in an era of changing patterns of healthcare. May you all have a healthy and prosperous New Year.

ACCE

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Development, Assessment and Maintenance of Medical Instrumentation, Trieste Conference:

Reported by Joseph F. Dyro, Ph.D., C.C.E.

The Clinical Engineering Division of the International Federation of Medical and Biological Engineering (CED-IFMBE) held a conference on Development, Assessment and Maintenance of Medical Instrumentation in Trieste, Italy on September 16-17, 1993. The conference was held in cooperation with the Italian Association of Medical and Biological Engineering (AIIMB), the Center for Research and Study on Medical Devices (CRSTBS), ACCE, the Division of Strengthening of Health Services of the World Health Organization (WHO-DSIIS), and the Biomedical Equipment Assessment and Management - ECC Research Project (AIM-BEAM). Some 140 attendees from 22 countries heard lectures on four principal themes: (1) Development of medical instrumentation from research to industry; (2) Medical instrumentation assessment: technical, economical and clinical approach; (3) Medical instrumentation management; and (4) Clinical engineering departments organization and university programs. An exposition of medical instrumentation was arranged complementing the formal technical presentations. Medical instrumentation companies demonstrated their products, systems, and services.

The location of the conference was the Area Science Park of Trieste, one of the most important multidisciplinary science parks in Italy with over 800 employees. The Park operates under the aegis of the Italian Ministry of University and Technological Research in association with the National Research Council. Many laboratories develop and utilize sophisticated scientific instrumentation in such fields as physics, biotechnology and computer science, all of which have applications in medicine. One of the labs, CIVAB, offers models and products for the efficient management of medical equipment to the Italian health care system.

Chairman of the conference, Diego Bravar, and his

fine staff ensured that every organizational detail was attended to in the most professional manner. The warm hospitality shown to all attendees complemented the superb technical presentations. I was impressed by the advances in clinical engineering practice, training and organization in the many countries represented at the conference. Bravar, who is also chairman of the CED, has been on the forefront of the development of clinical engineering in Italy. Many of his students and associates have established top notch departments and have recognized the need to develop the profession within their country. The formation of the Italian College of Clinical Engineering, announced at the meeting, stands as a commitment to this effort.

I delivered three papers: The American College of Clinical Engineering; The role of the biomedical engineering technology advancement (BETA) program in promoting economic conversion; and organizing the clinical engineering department for effective medical devices technology management. The first presentation described the College, its mission, organization and accomplishments. The second paper described the BETA program at Stony Brook. BETA's mission is to strengthen the regional economy through the formation of collaborative agreements between industry and the University in the area of medical devices development. The third paper reviewed the Department of Stony Brook and how it is poised to take advantage of emerging opportunities in the changing health care climate.

A great deal of interest was shown by the participants in ACCE. It was clear from the presentations and from the discussions that took place that the ACCE definition of clinical engineer enjoys widespread acceptance and serves as a solid guideline for recognizing the appropriate role and qualifications of a clinical engineer.

Brito and Tonarelli Advance Clinical Engineering in Brazil and Uruguay

Reported by Joseph F. Dyro, Ph.D., C.C.E.

It is most encouraging to see the fruits of one's labor. Reports on clinical engineering advancement have been sent to me from Lucio Flavio de Magalhaes Brito of Brazil and Pedro Tonarelli of Uruguay, participants in the first Advanced Clinical Engineering Workshop. Flavio and Pedro have applied the principles learned at the Workshop to their work as clinical engineers in their respective countries with great success. Both have been quite explicit in crediting their success to the knowledge gained during the Workshop. Brito was featured on the cover page of CIPA the journal of the Internal Commission for Accident Prevention. The journal's feature article, an interview with Brito, provided him the opportunity to describe clinical engineering and its vital role in hospital safety. Brito also presented a paper on the Definition of Clinical Engineer at the 2nd Brazilian Congress of Hospital Engineering in Sao Paulo, June, 1992. He credits the work of ACCE in developing the definition. He also presented a review of Hospital Safety Program, a piece this reporter wrote for *John Webster's Encyclopedia of Medical Instrumentation*. The Ministry of Health was quick to realize the significance of this and commissioned Brito to write the terms of reference for a Hospital Safety Manual. Brito's advocacy work continues. I just received a copy of the Journal of the Medical Association of Brazil with his front page article on Clinical Engineers. This in-depth article fully describes the importance of clinical engineering in health care organizations. It also details Brito's work in establishing a course on Clinical Engineering at the Electrotechnical and Energy Institute of the University of Sao Paulo State.

Pedro Tonarelli writes that he was tapped by the Ministry of Public Health to coordinate the acceptance and installation of over \$30 million of medical devices for the largest hospital in Uruguay, Hospital Pereiro Rossell. He owes his selection to his participation in the Advanced Clinical Engineering Workshop. Tonarelli has made the case for clinical engineering well and has been given two clinical engineering positions to fill in his engineering department within his organization, CASMU. He is devel-

oping a clinical engineering seminar for biomedical engineering students at the University. Congratulations to Brito and Tonarelli. Their work should serve as an inspiration to us all to carry the message of clinical engineering to the sectors of the health care world that would benefit from such knowledge and in so doing would promote the profession.

Second Partnership Conference of Health Care Institutions and New Independent States **October 21-22, 1993**

Reported by Alfred Jakniunas

Under a cooperative agreement with the United States Agency for International Development (USAID), the American International Health Alliance (AIHA), has established twenty-one health care partnerships in ten republics of the former Soviet Union. These participants allow American providers to assist their counterparts in the New Independent States (NIS) of the former Soviet Union. The partnerships allow American providers to assist in addressing significant mortality and morbidity issues, improve care organizations, and introduce market oriented solutions to hospital and health delivery systems and financial problems. The NIS has been devastated by the fragmentation of the central economies, hyper-inflation, and political instability.

Meeting their health care challenges successfully will be a key test of local, regional and national governments and the new democratic, market-oriented institutions in the NIS.

The goals of the AIHA's NIS programs have been as follows:

- (1) Closing the health care knowledge gap so that preventive and curative techniques which have been successful elsewhere can be adapted and disseminated;
- (2) Improving the efficiency and productivity of existing health providers through better clinical and administrative managerial organizations; and
- (3) Training of health policy makers and administrators at all levels of government.

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The current AIHA program which has twenty-one active partnerships in the U.S. consists of 47 hospitals, health care systems and medical schools; NIS participants include 42 hospitals and health systems and 12 medical universities.

One of the goals of the conference was to assess the results of the partnerships to date. Some of the initial results have shown reduction of hospital patient stays, increase in performance of complex operations, and increase in productivity. There are already signs of transfer of new technologies to decentralized centers. If this continues, the need for technical instrumentation support will increase.

Utilization of modern equipment, although limited, has been identified in selected projects. Medical devices, such as infant incubators, cardiopulmonary heart-lung bypass units, diagnostic ultrasound units and pulse oximeters have been introduced on a limited basis.

Some of the US government agencies are participating indirectly by providing information through existing programs which complement partnership efforts. The World Bank produced reports on the Ukraine, the Baltics, and NIS. Support exists for lectureships, fellowships and undergraduate exchange programs.

Perhaps the most challenging project which AIHA has undertaken to date is implementing an electronic mail system. Trip reports are entered on a computer template. Once the report is saved to a file on disk, the partnership representative can send trip reports to AIHA in Washington. Information stored in the database will provide information on emerging trends and patterns.

ACCE will continue to monitor activity in this area for the benefit of members who wish to seek opportunities on the international front.

National Engineers Week

Tom Bauld, Ph.D.

The time is fast approaching for the annual celebration of National Engineers Week in February 1994. Contact the National Committee at NSPE Engineers Week Headquarters, 1420 King Street, Alexandria, VA, 22314 (703) 684-2852. Promotion and marketing opportunities are available. Plan a celebration of

Clinical Engineering at your institution or in conjunction with a local society's monthly meeting. Write to your Governor and request a Proclamation for Clinical Engineering Week. Demonstrate your contributions to healthcare and create publicity. Remember, your local Public Radio and Public Television stations are able to get your message out. Also consider local access cable channels.

National Engineers Week was founded in 1951 by the National Society of Professional Engineers. It is always celebrated at the time of George Washington's birthday. Our nation's first President was a military engineer and land surveyor.

Since 1951, and beginning with President Truman, U.S. Presidents have sent special messages of appreciation to the engineering profession in recognition of the week. Recognition includes the selection of an Engineer of the Year.

At its beginning, Engineers Week included a few scattered government proclamations, dinners and speeches. It has since grown to involve tens of thousands of engineers in a variety of community outreach activities such as technology and education exhibits at shopping malls to presentation of student scholarships.

In Southeast Michigan, the first Engineers Week Biomedical Symposium was celebrated in 1993. The program began at one location with a day of four concurrent sessions in addition to technical training seminars throughout the week.¹ This year it will involve six (6) local hospitals with multiple sessions and technical seminars during the week of February 20-26. In addition, other technical training classes are scheduled from February through April.

The Michigan Society for Clinical Engineering, in conjunction with the University of Michigan, Botsford General, William Beaumont, St. Mary, Providence, and Henry Ford Hospitals, will be presenting seminars on topics such as: The Impact of Government Regulations in Healthcare/SMDA, Principles of Laser Safety and Operation, Minimally Invasive Surgery, and Mathematical Modeling in Cardiology Research and giving tours of various facilities, like the William Beaumont Hospital Co-Generation Plant. Technical training includes PC Troubleshooting and service schools presented by Cincinnati Sub-Zero, Nellcor, Datascope, Physio-Control, RSTI, and SECA Scale.

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¹ In an Executive Declaration, Michigan governor, John Engler has also proclaimed the week as Clinical Engineering and Biomedical Equipment Technology Week.

For more information, contact Chris Peters and Jahan Azizi at 313-936-5056.

Editorial

David Simmons, Sc.D., C.C.E.

An ancient Chinese saying goes: "May you live in interesting times!"

Eight presidents have held office since the early days of what we now know as Clinical Engineering. In the past thirty years our profession has grown along with the general health care system of this country. Both have seen many changes. But what next? At no time in the past thirty years have we entered such a period of imminent change. We hear about something called "Virtual reality." We are entering a period of "Virtual Uncertainty." A long string of metaphors come to mind but space prevents us from citing them here. The reflection is interesting.

Anticipation. A word; yes. However, anticipation of what may happen to, with, and within this country's Health Care System as a result of the proposed Clinton Health Care Plan has already caused many changes. Some from fear; some from anticipation.

Within 24 hours recently I happened to review the Implementation Plan for two major multi-hospital health care systems; one private sector and one government. The similarity of verbiage is striking. Both talk about "restructuring" (the new buzz word for reorganizing and consolidating departments, services, resources, and staffing flexibility, innovation and advanced planning lace both documents. Reducing staff and overhead are major tenants of both restructuring documents. Competition - a word used between private sector hospitals for years now includes competition with government hospitals as well. Transition, total quality improvement and

"profound change" round out the list of words and phrases that are to be found in the business and operational plans of individual hospitals and multi-hospital groups alike.

Anticipation of what might happen has caused more change and impact, real and anticipated, than could have been imagined just a year ago.

But what about us?

A few clinical engineers have already felt the impact of restructuring towards a managed health care system. Many others are feeling the pressure of financial constraints and staffing limitations.

Each of us will focus on our own challenges in this time of uncertainty. There is no single best approach or way to meet the challenge. It is, however, important to do some anticipation of our own.

- Anticipate smaller budgets and find ways to do more with less.
- Anticipate no increase in staff but find ways to prioritize work tasks.
- Anticipate delays and deferrals of major equipment purchases; both new and replacement purchases. Therefore, find ways to use and maintain existing equipment longer.
- Anticipate reorganization and find ways to justify current staff and planned reductions and budgetary limitations.

In a word; the future belongs to those who plan for it. Anticipate. Be proactive. Do those things that will demonstrate value and quality to our organizations. We began with a Chinese saying, so it is appropriate that we finish with one. **THIS TOO SHALL PASS.**

Healthcare Reform

Tom Bauld, Ph.D.

Healthcare reform is about to occur. After a lengthy debate and compromising on various features and payment schemes, some form of national managed care will begin to be implemented. All of us need to understand as much as possible and prepare for changes that may occur. The entire 1336-page "Health Security Act", stock number 040-000-00634 costs \$45.00. The 132-page "Report to America", stock number 040-000-00633-8 explains the bill in plain English and costs \$5.00. Both documents are available from the Government Printing Office at (202) 783-3238. Enjoy the reading. Your thoughts and action on how it might affect your operations are necessary for our profession.

FDA Issues

Tom Bauld, Ph.D.

The recent settlement of 61 million dollars by C.R. Bard was an example of a manufacturer selling an unapproved product and lying to the government about the experimentation it was doing on humans.

Considering the very low number of device problem reports submitted by healthcare institutions (about a 1:20 ratio compared to reports submitted by manufacturers), it is very possible that the potential financial penalties for healthcare facilities could occur after the formal evaluation of reporting has occurred.

There is still no announced date for the release of the Final Regulations about Device Problem Reporting.

Device Tracking in the Implant/Explant area as well as determining whether implants have prematurely failed is occupying a lot of our effort. University of Michigan Hospitals are concerned about the amount of resource it consumes. Does anyone else out there consider this a problem? We just reported the acquisition of our first two infusion pumps back to the manufacturer from whom we purchased them. Are you using HIMA, ECRI or manufacturers forms or have you developed your own forms?

Total Quality Update

Tom Bauld, Ph.D.

It would seem helpful for all of us who are involved in Total Quality efforts to provide an update on what is occurring in our departments.

As an example, at the University of Michigan Hospitals, we have been working on a Total Quality program since 1987. My department is in the Facilities Services Division, which decided that all staff members would receive 16 hours of Team Member training. No other Division has yet made that commitment.

I personally have received training as a Team Leader and a Facilitator, each requiring a week long course. Currently, I am a Team Member on our department's Training Initiative Team and I am a Facilitator for a cross functional (multi-departmental) Stat Medications Turnaround Team. In our department, there is an MMS Quality Improvement Team and, in addition, several of my staff serve on a Stockroom Quality Improvement Team.

The most satisfying and productive role I have is that of the Team Member in the Training Initiative Team. The group meets weekly for an hour and a half, is a smoothly working team with dedicated and highly motivated members, and has formalized, standardized, and simplified our training activities. As an example of the accomplishments of the Team and our Training Coordinators, we have scheduled factory service schools to be held at our institution every other month through August of 1994.

Let us hear from you. What is happening at your institution that can help your peers?

Clinical/Biomedical Engineering Department Activity

Tom Bauld, Ph.D.

Recently, University of Michigan Hospitals decided to implement semi-automatic defibrillators for the offsite clinics in our system. These are defibrillators with analysis software that examines the ECG and advises the operator whether ventricular fibrillation (VF) or ventricular tachycardia (VT) is present, and if so, shock the heart. We purchased nine defibrillators which have a memory module that records the ECG waveforms and information about the patient's rhythm and the delivered shocks. Rather than buying a download interface device at each location, we volunteered to be the central point for the data. Each site will send us their module following a cardiac arrest and we will load that information into a database and produce a written report to send back to the clinic. While waiting for the return of their memory module in the mail, they will use a spare module. We can then produce summary reports for review by our CPR QA Committee as well as reports of each clinic's activity levels.

What are your latest achievements?

ACCE members need to communicate their activities to their peers. This is one of the main reasons we formed the organization, to help each other, to share ideas, and to promote our achievements.

This Newsletter is everyone's vehicle for communication, but that opportunity has not been realized yet. Please contribute to the next issue.

Announcements

The Thirteenth Southern Biomedical Engineering Conference will be held on April 16th to 17th, 1994 at the Engineering Research Institute of the University of District of Columbia in Washington, D.C. Suggested topics for the presentations include Computers in Medicine, Bioinstrumentation, and Clinical Engineering, just to name a few. Contact Jafar

Vossoughi, Ph.D. at (202) 282-2388 for more information about the conference and about the submission of abstracts for presentation. First deadline for abstract submission was November 1, 1993.

The Rio '94 World Congress on Medical Physics and Biomedical Engineering will be held in Rio de Janeiro, Brazil, from the 21st to the 26th of August, 1994. Deadline for abstract submission for both oral and poster presentations was November 20, 1993. All presentations will be in English and topics include such diverse subjects as Artificial Organs, Health Information Systems, Clinical Engineering, Medical Imaging, and Technology Assessment. For more information, contact Joe Dyro at (516) 444-1420. Joe is a member of the Clinical Engineering Division Board of the IFMBE. The Board is coordinating all sessions on clinical engineering.

The Chinese Medical Equipment Application and Repair Association Annual Conference will be held in Huang Shan City in October, 1994. Xiang Ju Wu, an ACCE member in Beijing, is a member of the Board of Directors of the Association. Those interested in more information may contact Steve Friedman at Stanford University Hospital, (415) 725-5001. Steve has been invited to attend this meeting and would like to gauge the interest of members of ACCE in participating in this event.

ACCE Advocacy Awards Program

Denver Lodge

The ACCE Advocacy Committee has great news. In a special session called on September 30, to discuss ACCE advocacy issues, the ACCE Board formally approved and adopted an ACCE Advocacy Committee initiative establishing an ACCE Awards Program. This program will commence immediately and will establish annual ACCE awards for both "Professional Development" and "Professional Achievement," in the advancement of the profession of clinical engineering!

The awards, described below, will be presented annually at the ACCE at the General Membership Meeting in 1994. We encourage ACCE members to apply either for yourself or on behalf of others for achievements in promoting clinical engineering.

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ACCE Professional Development Award

In the past, clinical engineers have written papers and presented speeches directed at their peers, and not at non-engineering, non-technical healthcare professionals, such as administrators. The Advocacy Committee maintains that to better advocate our profession, we must direct our communication to other professionals, particularly those in non-engineering environment.

ACCE Professional Development Awards will recognize accomplishments of professional advocacy and will be a stimulus to our members to increase efforts, promote awareness and appreciation of clinical engineering within other healthcare professions.

This award will recognize ACCE members and others for their outstanding promotion of the profession of clinical engineering in writing or in speaking aimed at non-engineering health professional audiences.

ACCE Professional Achievement Award

ACCE maintains that clinical engineers perform work for which they are uniquely qualified. ACCE maintains that certain duties and responsibilities are the exclusive domain of the clinical engineer. Characterizing this uniqueness and exclusivity is necessary for professional stature.

ACCE Professional Achievement Award will stimulate activity by ACCE members to clearly define the unique capabilities of clinical engineers. This award will recognize ACCE members and others for their work in defining the exclusive limits for the practice of clinical engineering. They will be recognized for identifying unique functions, roles, activities, duties and responsibilities of clinical engineers.

A. Eligibility Criteria:

Only clinical engineers who are ACCE members are eligible for an ACCE Professional Development Award and an ACCE Professional Achievement Award. Anyone who is not a clinical engineer is eligible also. Self-nomination and nomination of others is permitted. ACCE Board members are eligible, but may not vote if they are also members of the Advocacy Committee which determines the awards.

B. Acceptance Criteria:

1. Publications or transcripts of presentations may be submitted to the ACCE Advocacy Committee at any time. Awards made at the General Membership Meeting will be based upon nominations received during the calendar year preceding the meeting.

In the first year of the ACCE Advocacy Awards Program (1994), awards will be considered for papers published or presentations made at any time before the end of 1993. Any article or presentation submitted will be considered by the Advocacy Committee only once.

2. To be considered for a Professional Development Award, each publication or presentation submitted must have been presented in a distinctly non-engineering, health related publication. [i.e., not at meetings such as AAMI, ASHE, ECRI, ACCE, ICC, IEEE/EMBS, and IFMBE; and not in publications like the Journal of Clinical Engineering, Biomedical Instrumentation & Technology, Second Source, and Health Devices; but rather at administrative, government policy, medical, or health related meetings such as those of the AHA, JCAHO, FDA, AMA, ANA, ADA, CAP or RSNA, or in periodicals such as Hospitals, Healthcare Executive, Modern Healthcare, Healthcare Forum, Hospital & Health Services Administration, JAMA, Critical Care, RN or AJN]. The committee will determine assessment of the perceived contribution toward facilitating a better understanding of the value and efficacy of the clinical engineering profession in the eyes of other non-engineering health professionals, in accordance with the eligibility and acceptance criteria outlined above.

To be considered for a Professional Achievement Award, each publication or presentation submitted must have identified some unique task performed by clinical engineers by virtue of their qualifications. Nominees must show that such task should not be performed by any other person. Nominees must define unique functions, roles, activities, duties and responsibilities of clinical engineers, and which, if performed by non-clinical engineers, could raise issues of professional competency.

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Articles can appear in industry journals, including engineering publications like the Journal of Clinical Engineering or Biomedical Instrumentation & Technology, and these presentation can be made at technical and engineering meetings of such organizations as AAMI, ASHE, IEEE/EMBS, and IFMBE.

3. Each publication or presentation must make use of the title "Clinical Engineer" and/or the term "Clinical Engineering." Terms used must be consistent with the ACCE definition of clinical engineer.

Content of material presented must be deemed by the Advocacy Committee as presenting accurate information, bringing increased awareness to the profession, and making a positive contribution to the understanding of clinical engineering.

C. Award Description

In the first year of the ACCE Advocacy Award Program (1994), the Professional Development Awards and the Professional Achievement Awards shall each consist of two \$300 cash awards and three \$50 cash awards. One of the \$300 awards (issued this year only) may go to some historical publication or presentation, made prior to the existence of the ACCE, and the other \$300 award will go to a publication or presentation made since the ACCE was formed in 1991. The committee will assess the nominee's contribution in promoting a better understanding of the value of the clinical engineering profession. Each cash award will be accompanied by an engraved plaque. The number of awards and value may change at the discretion of the ACCE board.

Nominations for the 1994 ACCE Advocacy Awards must be received before March 31, 1994.

ACCE ADVOCACY AWARD NOMINATION

The author(s) name(s):

The candidate is an ACCE member: Yes No

The candidate is a clinical engineer: Yes No

This nomination is for the following (circle one):

ACCE Professional Development Award

ACCE Professional Achievement Award

Give the title of the publication or presentation:

Describe where the article was published or the presentation given:

Give dates of publication or presentation.

Attach one copy of article or presentation transcript.

Send to: Denver A. Lodge, Chairman
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