ACCE News

Newsletter of the American College of Clinical Engineering

January / February 2009 Volume 19, Issue 1

President's Message

Well, here we are in 2009! The time, as usual, is flying by and I barely have a chance to lift my head up long enough to reflect on those passing moments. Like most, I'm frantically trying to stay 'on top of things' and usually something needs to grab my attention to snap me out of my usual routine (review this incident report, finish reading that article, etc…). Something like our beautiful new newsletter format. Great work, Ismael Cordero!

This month marks the 2nd year that I've lived in Rome. In these two years, I've learned how to use a new language to navigate around in a new city and culture. In that time, I bought a house, got married (twice, but to the same guy both times), saw the birth of my first nephew, and found a full time job working in my field here in Rome (well, just outside of Rome – which is why I had to learn how to drive in some of the notably most chaotic traffic). OK – I got a lot done – no wonder I can't remember what I did last Wednesday or where I packed away those Christmas cards that I only found last week (while looking for an old manuscript).

Obviously that New Year's resolution to 'get better organized' is up for re-evaluation.

The benefit of having gone through so many changes is that everything still feels new. Since I still think that we are in 2007, I don't feel like I've lost any time. Everything seems fresh and new and there is an energy that gives me that little extra push in the morning. The new marriage, new house, and new job all fill me with encouragement and excitement.

Of course the reason that the past two years are such a blur was because it wasn't all that much fun. For me, learning a new language was really tough. I completely underestimated how difficult it would be for me. Completely failing at trying to communicate with construction workers, florists, and the guy at the sandwich shop nearby only emphasized my status as an outsider, a target. And I hated every minute of it. Not only because I had to make a fool of myself before I could get that sandwich

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Our Newsletter Gets a Face Lift

As you can see, the newsletter is sporting a fresh new look. The design was modeled after ACCE's logo and website color palette and also borrows elements from the ACCE banner that was first displayed at the 2008 AAMI meeting in San Jose.

This is your newsletter, so any thoughts you may have on how to make it even better will be much appreciated. Please share your ideas and feedback to Ted Cohen tedcohen@pacbell.net and Ismael Cordero ismael.cordero@orbis.org, the editors, or to Jim Keller, the managing editor. Enjoy!

Membership Renewal

It's that time of the year again! If you have not already done so, please renew your ACCE membership on-line at www.accenet.org by clicking on the yellow highlighted link at the top of the homepage and logging in. You may alternately renew by mailing a check or money order to :

ACCE
5200 Butler Pike
Plymouth Meeting, PA 19462
Al Levenson, Secretariat
Secretariat@accenet.org

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President's Message *(Continued from page 1)*

order right, but I had to depend on others to help me –my husband had to take time off of work to take me to appointments because, with exception to those that work in the tourist industry, not that many people in Rome speak English. I had had a great life in Boston where I could talk to people, very intelligent, cultured, engaging people, at work and after, not just to survive, but also to connect and evolve. And now I was a 2-year old just trying to make myself understood.

And don't get me started about the healthcare situation here…believe me, a nationalized healthcare system doesn't always mean a better healthcare system.

But that was then and this is now.

In the end, is the sacrifice worth it? Only time will tell. But the sacrifices and struggles made up to this point have produced some notable fruit. For example, my Italian is now good enough. I'm proud to say that I won a public competition for a research fellowship at "Sapienza" University and the pediatric teaching hospital here in Rome – and that interview was not in English! The wedding was beautiful – some of the local town residents called it 'historic'. And I can curse at the crazy Roman drivers now in Italian just like I did to the crazy Bostonian drivers in English. Notable fruit, indeed!

I've been asked, as President, what are my goals for ACCE. What new beginnings do I see for us? And I have to be honest, at first, I was perplexed to find a good response. With the continued fall out from the global economic crisis, people are forced to do more with less. Several of my friends were already doing the work of 2 people before the crisis. Now that workload is increased even more. And with shaky or stressful work situations, family-time is even more valuable and therefore takes priority during our 'free time'. So, I don't want to disrespect our members by insisting that we continue to aggressively grow and expand – at least not in the traditional sense. Those efforts require volunteer time that is difficult to demand in this period. Instead, I want ACCE to use this time to reflect on who we are as a society and how we serve our profession. I want us to continue to improve upon our symposia at the HIMSS and AAMI conferences so that we can continue to invite thought-leaders to share their ideas and experiences. I want us to continue to build on our educational programs like the Teleconference Series and the CCE Review Course, both of which continue to get amazing reviews. I want our members to keep looking to ACCE as a valuable resource, built on the dedication and innovation of our volunteers. We will consider new programs, but only if we know we can produce them with a high level of quality and this will continue to require tough decision making since we won't be able to do everything that we want to do.

I shared some of my personal experiences above to introduce the idea that new beginnings are exciting on the surface, but deep down, there is usually a history of hard work and sacrifice behind them. We are all set for a fantastic 2009, and it is thanks to the many members that sacrifice their time to bring us these events and programs!

My husband and I promised each other that this would be our 'quiet year'… place your bets all, place your bets…

See you soon.

Cheers,

Jennifer Jackson, President, ACCE

jenniferljackson@yahoo.com

CCE Certification: New Applicants and Renewals

1. The next CCE exam will be given on November 7, 2009 in 28 cities around the US. The deadline for applications is September 12, 2009. Please see the website: http://www.acce-htf.org/certification to view the handbook and application for this exam.

2. In 2007, ACCE released the results of the new "Body of Knowledge Survey". The US Board of Examiners for Clinical Engineering, chaired by Patrick Lynch, made adjustments in the mix of questions based on that survey. The changes are included in the 2007 CCE Handbook which is available on the ACCE-HTF website.

3. Renewal: CCE renewal is required once every three years. The CCE Renewal Handbook and Renewal Application Form can be downloaded from the CE certification website: http://www.acce-htf.org/certification. The renewal fee can be paid by check or by credit card on the ACCE HTF website.

4. Any questions can be directed to Cheryl Shaw, the certification program's secretariat, at certification@acce-htf.org.

Perspectives from ECRI Institute

Second Annual List of Top Ten Health Technology Hazards

Jim Keller is ECRI Institute's Vice President for Health Technology Evaluation and Safety and a past Member at Large for ACCE's Board.

For its over forty years of existence, ECRI Institute has developed a tremendous amount of knowledge about medical device safety. This has come from the work of our *Health Devices* comparative evaluation program, investigations from our longstanding international problem reporting system, research and analysis from our accident and forensic investigation services, and our recent experience in running Pennsylvania's Patient Safety Reporting System. We have recently distilled much of that knowledge to publish a guidance article in the November 2008 issue of Health Devices with our second annual list of top ten health technology hazards. Our list is based on serious technology safety concerns that can be prevented with appropriate attention and planning. The list was put together to help raise awareness about these serious problems.

Medical devices and systems are designed to aid in the diagnosis and treatment of a multitude of conditions that patients experience. In the vast majority of cases, these technologies do just that—that is, a device or system is used correctly and it functions as intended. There are exceptions, however. And patients and staff do get injured during the use of medical technologies. Clearly, healthcare facilities should strive to eliminate all health technology hazards. But it simply is not possible to address all potential sources of injury or damage at once. Thus, hospitals should start by focusing on those hazards that warrant the most attention. The items on our top 10 list are those that ECRI Institute believes should be receiving attention at virtually all healthcare facilities.

When compiling our list, we considered both the prevalence and severity of the adverse event. That is, we selected items representing threats to patient (and staff) safety that occur frequently or that could lead to severe harm—or both. We based our selections on our experience in investigating and consulting on device-related incidents, as well as on information found in ECRI Institute's medical device reporting databases and in other problem reporting databases. For each item on the list, our article describes the hazard, presents recommendations for avoiding it, and points to useful articles and PowerPoint presentations with more information on the topic. The top 10 hazards for 2008, listed in order of importance include:

1. Alarm hazards
2. Needlesticks and other sharps injuries
3. Air embolism from contrast media injectors
4. Retained devices and unretrieved fragments
5. Surgical fires
6. Anesthesia hazards due to inadequate pre-use inspection
7. Misleading displays
8. CT radiation dose
9. MR imaging burns
10. Fiberoptic light-source burns

ECRI Institute will be hosting an educational Webinar on alarm safety highlighting the number one item on the list. Information on this Webinar, which is scheduled for February 18, 2009 is available on ECRI Institute's Web site at:

https://www.ecri.org/Press/Pages/Alarm_Safety.aspx.

The guidance article with the top ten list is available for a free download from ECRI Institute's Web site at the following link:

https://www.ecri.org/Press/Pages/Top_10_Health_Technology_Hazards.aspx.

Feel free to contact me at (610) 825-6000, ext. 5279 or jkeller@ecri.org if you would like discuss any of the items covered on the top ten list or if you have any questions about the Webinar on alarm safety.

Jim Keller, is ECRI's Vice President for Health Technology Evaluation and Safety and a past Member at Large for ACCE's Board

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Healthcare Technology Foundation News

Foundation Annual Meeting

The annual meeting of the Foundation's Board will take place in Chicago preceding the HIMMS meeting and ACCE Symposium. The annual meeting is an important opportunity for the Foundation to assess its progress, plan for the future, and elect new officers and Board members. Although the Foundation is a separate entity, it remains aligned with ACCE with respect to interests and programs and ACCE President Jennifer Jackson serves on the Foundation Board. Input from and direct participation by ACCE members is always welcome.

Board Membership

As with all volunteer organizations, the success of the Foundation depends on the service of dedicated and productive individuals. The possible appearance of cliquishness as names reappear in various roles across multiple organizations is actually a result of the relatively few names that people can think of when asked "who can we ask to do…?" Volunteering to serve on the Board or one of its committees is an excellent way to become one of the recognized "doers" and future leaders in our profession. Short of volunteering yourself, suggestions are always welcome.

Patient Safety Brochures

Two patient safety brochures from the Foundation, "Fire Safety & Oxygen: A Patient Guide" and "Can I bring my own medical device with me to the hospitals?" are available from our website as free tri-foldable downloads in both English and Spanish. Limited numbers of printed copies remain available. Co-branding opportunities are also available with prior permission. Please remember these resources if these issues come up in your hospital, or be proactive and bring them to the attention of appropriate personnel. Suggestions for additional brochure topics are welcome, especially if you want to help write one!

The Foundation PSO

The Foundation has re-registered as a Patient Safety Organization using the Final Rule form from AHRQ. We continue to develop our PSO plans and welcome new team members in fulfilling this role of the Foundation..

Awards

Two awards are administered by the Foundation: the Marvin Shepherd Patient Safety Award (co-administered by ACCE) and the Excellence in Clinical Engineering Leadership (ExCEL) award. Further information on these prestigious awards can be found at the Foundation website: http://www.accefoundation.org/.

Donations to the Foundation

Whether you are a year-start or year-end donor, remember the Foundation in your personal and corporate giving. And also remember that "in honor/ recognition of…" donations are welcome. All donations are tax deductible.

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AHTF is an independent, not-for-profit foundation

ACCE News

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ACCE News is a benefit of ACCE membership; nonmembers may subscribe for $60

To subscribe e-mail *Secretariat@accenet.org*

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Commentary: Providing Excellent Service

I recently (and voluntarily) attended an employee workshop on The Essentials of Great Service. Although this workshop was generic in nature, I thought that many of the elements presented could be directly applied to Clinical Engineering.

Knowledge

Appropriate knowledge is the starting point for almost any quality activity. For Clinical Engineering this includes technology knowledge, clinical applications knowledge, and increasingly perhaps computer network knowledge. This knowledge must include the current device inventory, what is coming in the short term, and what is on the horizon. None of what follows can substitute for actually knowing what needs to be known, at least not for long.

Anticipating Needs

While there may be bench work that occurs without extensive interaction with others, Clinical Engineering is essentially a service enterprise, whether hospital employee or contractor based. A key to good service is understanding what the "customer" wants and needs from you, and providing it. In Clinical Engineering what the customer wants is basically medical equipment that meets their clinical requirements and that functions properly all of the time. Meeting clinical requirements is a key element of pre-purchase decision making, training and future planning. Functioning properly is eventually the domain of maintenance and repair, assuming it functioned properly to begin with and had reasonable reliability. What the customer also wants is satisfying interactions with you in terms of your interest in their problems and your desire to address them. Anticipating needs also means looking beyond what the customer says they need to providing a perspective on what you think they also need. In this the "voice-of-the-customer" is just a starting point.

Great First and Lasting Impression

First impressions have a long lasting effect. This can include what might be argued as superficial attributes. For example, professional appearance, whatever that means in your setting, is important in creating and maintaining a good impression of the individual and the department. Yes, it is true that the technical work can probably be accomplished by a slovenly person, but the relationship with the clinical user and others in the hospital may not overcome a poor appearance. Another useful skill is learning the names of the people you deal with. People like this; it makes them feel acknowledged and important. While this also may seem superficial, it is real none-the-less. Appropriate professional behavior, at all times, is also important. It is not just face-to-face interactions that set the tone, but also shop, hallway, cafeteria, parties and other informal interactions that are part of the impression that is made and maintained. This does not mean that one must always be stogy, but it does mean that you are on-the-job at virtually all times that you are in or near the facility, and should act accordingly.

Listening

Actually listening to the customer is another important activity. One component of being a good listener is really paying attention, and asking open ended rather than yes/no questions in order to encourage full disclosure of the issue at

hand. Actually getting to talk to a live person, as opposed to voice mail, can be important here. You hate going through a multi-level automated phone tree when you need something, why would you think that your customers feel any differently? Likewise while e-mail and is obviously valuable, it cannot always replace an effective live communication, especially in the absence of timely feedback. Repeat and verify is another important component of listening. You want to be sure you have the information correctly, and at the same time demonstrate that you were really listening.

Staying Calm and Taking Responsibility

Staying calm when dealing with someone else who is irate is an admirable skill. While the temptation for many (most?) may be to escalate your side of the conversation to meet their outrage and possible rudeness, it is rarely productive, and it can leave a long and painful legacy. And if it needs to be subsequently mediated, the result can be even worse. It is also of value to not deflect a problem elsewhere without knowing yourself that the redirected information provided is correct and that whoever that else-

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International Report

ORBIS Sponsorships Available for ACCE Membership

Thanks to an agreement between ORBIS International (www.orbis.org) and ACCE, funds are available to cover the first year of membership in ACCE for clinical engineering professionals in developing countries who have limited economic means to afford membership. In addition, it is possible to apply for an extension of this support after the initial one-year membership period. Both ORBIS and ACCE are keen to encourage applications for these sponsorships as part of an ongoing commitment to promoting the safe and effective support of medical technologies around the world.

If you are currently an ACCE member and know of a colleague who might be interested in this opportunity, please contact them and encourage them to apply.

Applications may be made for either Individual or Associate membership, as defined in the Membership section of the ACCE website, which also provides detailed application information including a downloadable application form. Applicants should note on the application that they are applying for the ORBIS sponsorship.

If you are unsure whether you qualify for this sponsorship and would like to discuss it, please email me at:

internationalchair@acce.net.

Tony Easty; Chair,

International Committee, ACCE

Providing Excellent Service

(Continued from page 5)

where is will really solve the problem. The customer does not want a runaround, and if your information is wrong their impression of how much you cared and how valuable your effort was will be negative and long lasting. What might be the new classic is this area is "That's not us, call IT."

Doing Something Extra

Effectively completing assigned responsibilities should be the minimum expected performance. Going beyond that to do more is not only valuable to the organization, but helps build the desired relationships and the value of the service. This can be as simple as saying "Let's check all the other ones, too.", or "What kind of in-service should we have to address this issue?"

Serving Yourself While Serving Others

There are many positive aspects of providing good service. One that goes beyond meeting the needs of others and the organization is the personal value of being held in high regard by people throughout the organization. Such high regard can serve you in your annual reviews, promotion considerations, and future endeavors. If people you interact with are asked about you, what do they say? Is it "technically sound but a jerk", or do they say "is always professional and helpful"? This issue also applies to the Clinical Engineering department. Is it held in high regard and valued, or is there an impression that it can be easily replaced, and perhaps should be?

William Hyman, ScD, PE, Secretary, ACCE Healthcare Technology Foundation

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ACCE Clinical Engineering Certification Study Guide

The American College of Clinical Engineering has prepared a Study Guide for the Clinical Engineering Certification examination offered by the Healthcare Technology Certification Commission established under the ACCE Healthcare Technology Foundation. The Study Guide is available through ACCE for $30. To order a copy of the Guide, please make out a check payable to ACCE and send to:

Alan Levenson, ACCE Secretariat
5200 Butler Pike
Plymouth Meeting, PA 19462

Or e-mail Secretariat@ACCEnet.org and include credit card information (name on card, type of card, card number, and expiration date). Applications are now being accepted for the **November 2009** exam. Applications and the applicant handbook can be found at www.ACCEnet.org/certification

The ACCE Study Guide was written by an independent group of clinical engineers not associated with the exam process

The View from the Penalty Box

Here in the northeast the New Year came in with power outages, snow, ice, cold and some very nasty political finger pointing at healthcare costs.

There is very little that clinical engineers can do about the weather but there is a lot that we can and should be doing about healthcare costs. Let me digress a bit before starting on potential ways of getting healthcare cost down. When I entered college- yes the ivy vines were only about 2 feet out of the ground then- now they are over the 4th story of the building- the dean of freshmen told us that we were there to learn 3 things. First was "how little we know", most of Washington DC and the federal government are poster children for this one. Second was "how and where to locate information needed to solve a problem", most of government must have been on a bathroom break when this was discussed. Third was 'what to do with the information when you found it". We engineers are very good at this one. A few years later I got involved with the moon program and the manager pushed what the goal was and that we engineers had to solve the problems to reach that goal. July of this year will mark 40 years since we first walked on the moon as engineers came together and reached that goal by solving problems. For you "youngsters" out there reading this 90% of the calculations were done with slide rulers. If we had access to a computer it used punch cards and we had no text books to refer to. We had no idea if that ventilator would keep the person alive on the moon but it did and we reached our goal and now it is time to set the goal on healthcare costs.

The finger pointing on healthcare costs came about when the local newspaper did some research and found out that a certain group of hospitals were being paid up to 40% more for the same services as other hospitals. While this hospital group is well known they are not the leaders in quality healthcare in the Boston area. They fall about mid point on the ratings. What made it really bad was that a physician at a community based hospital who had privileges at one of these "highly paid" hospitals would transfer a patient into the "highly paid hospital" for the procedure, that they would do, then transfer them back to the local hospital for recovery. That is one way to make your BMW payments. This is going to be a very interesting struggle between the "highly paid" hospitals, the insurance companies, the other hospitals, the politicians and way down the list us poor patients that have to foot the bills. I will keep a watch on this one.

I heard about a person who had an MRI at a hospital outside of his home area for what was thought to be an emergency condition. It turned out not to be an emergency so he returned home. Being an engineer he asked for a copy of the scan and after some begging and pleading he got it. About two weeks later the condition came back and he went to his local hospital, with the scan, but they were not able to read it there. That was strange to me as the manufacturer of the scanner was the same in both places, so he had another scan to the tune of $900.00. But I can take the card from my digital camera go to any Walgreen's drugstore and have printouts of selected images at any other Walgreen's in the country. Question- what is the difference between the drug store technology and the hospital technology? If they can move images around why can't we in hospitals.

In closing this column I would like to use two quotations that have been around for a long time, I am not sure who first said them or wrote them but they apply to the problems of healthcare.

First quotation "I have seen the enemy and it is us" or something close to that.

Second quotation, "lead, follow, or get the hell out of the way"

The goal is reducing healthcare costs while improving healthcare, if we got to the moon we can do this.

Dave Harrington

dave@sbttech.com

Journal of Clinical Engineering – Call for Papers

The Journal of Clinical Engineering, which prints the ACCE News in each issue, is interested in papers from you. If you have an urge to write, and good clinical engineering activities or thoughts to share, please consider JCE as one of your outlets. One type of article not seen in a while is the Department Overview which presents how your department is structured and how it performs its functions. Shorter "Perspective" pieces are also welcome. You can discuss manuscript ideas with fellow member William Hyman, who is one of the editors of JCE. He can be reached at w-hyman@tamu.edu. Completed manuscripts can be sent to William or Michael Leven-Epstein at lecomm1@aol.com.

Workshop on Wireless Technology in Healthcare

Left: Elliot Sloane of Villanova University; Center: workshop participants at the Villanova venue; Right: Rick Hampton of Partners Healthcare . Photos by Tim Gee, Medical Connectivity Consulting.

A Workshop on Wireless Technology in Healthcare titled: "What is needed for safe, secure, and reliable deployment?" was held on December 19, 2008 at Villanova University in Villanova, PA and at Carnegie Mellon University in Pittsburg, PA. Both sites were linked via live audio-video teleconferencing. The event was organized by, among others, Don Witters of FDA, Elliot Sloane from Villanova, Rick Hampton of Partners Healthcare, and Todd Cooper of Breakthrough Solutions Foundry, Inc. . Approximately 50 people participated in the workshop.

While wireless technologies have been used for decades in medical devices, it has only been recently with the advent of wireless broadband technologies that adaptation of wireless for mobile medical devices and applications has skyrocketed. However, most of the wireless protocol and systems now being used were not originally designed with remote home care and health monitoring or high-reliability, secure, life-critical medical applications in mind.

More than any other technology employed in modern medicine, wireless connectivity calls upon the resources of numerous industry groups: medical devices, information technology, RFID, telecommunications and cellular telephone to mention but a few. The disparate nature of these groups leaves several unresolved gaps in the implementation of most wireless medical devices and systems. If these gaps remain unaddressed they could result in undesired behaviors and potential safety risks. These gaps include:

- quality of service (QoS) needed for medical functions
- data integrity, latency, through-put, lost or corrupted data
- wireless coexistence
- security of wireless signals
- electromagnetic compatibility (EMC) of the wireless and surrounding medical devices

This workshop attempted to:

- Identify stakeholders from different industries, stimulate dialog, and develop collaborative efforts
- Raise awareness of the unique characteristics and risks for wireless in healthcare
- Develop pathways to ensure the safe, secure and reliable use of wireless technology in healthcare
- Identify needed tools such as standards and guidance information and make plans to develop them
- Devise strategies for present and future technologies
- Develop mechanisms linking design, testing, deployment, maintenance and regulatory considerations for the safe and secure use of wireless technology in healthcare.

Detailed impressions and comments on the workshop can be found on the excellent blog on medical connectivity run by Tim Gee:

http://medicalconnectivity.com/2009/01/06/workshop-on-wireless-tech-in-healthcare/

Also, in the next few weeks the ACCE website will be featuring a comprehensive report written by some of the meeting organizers that will include the workshop's findings, conclusions and action points.

Ismael Cordero

ismael.cordero@orbis.org

ACCE Advocacy Awards - Call For Nominations

Dear ACCE Friends:

On behalf of the ACCE Board, the ACCE Advocacy Committee is pleased to note the following awards and recent winners. Please take time to nominate worthy colleagues today or contact students to submit their papers. Just email recommended individual(s), justification(s), and or papers to advocacychair@accenet.org by March 2, 2009. Thank you.

Paul Sherman, Vice President, ACCE
Paul.Sherman@va.gov

Award	Recent Winners
Award: Lifetime Achievement Award **Award Criteria:** This award is the highest award given by ACCE. It will be given to an individual based on life long accomplishments and contributions to the clinical engineering profession.	2002 -- 2003 -- 2004 -- 2005 George Johnston 2006 Marv Shepard 2007 -- 2008 David Harrington & Ted Cohen
Award: International Clinical Engineering Award **Award Criteria:** The award will be presented to one deserving international engineer who has advanced health technology management in their country to improve quality, service, and affordability. The individual would typically be recognized by their country's health leaders or global organizations through leadership roles in their country's national and or activities in the region.	2002 -- 2003 -- 2004 -- 2005 -- 2006 -- 2007 -- 2008 Adriana Velazquez
Award: Marv Shepherd Patient Safety Award **Award Criteria:** The award will be given to an individual who has excelled in the "safety" area related to the clinical engineering field. For example, a national investigator of accidents, an inventor of a safety device, or an author of books on medical device hazards, etc. This is a joint Award between ACCE and the ACCE Healthcare Technology Foundation.	2002 Leslie Geddes 2003 Mark Bruley 2004 Jeffrey Cooper 2005 Bryanne Patail 2006 Leonard Klebanov & Larry Fennigkoh 2007 Malcolm Ridgway 2008 Jim Wear & Matt Baretich
Award: ACCE Challenge Award **Award Criteria:** The award will be given to an individual who is not presently an ACCE member, but is eligible for membership, for his/her achievements in the field of medical technology within the clinical engineering (CE) field, for example; an individual who has contributed to the design of a "safe" environment or shown significant activities in technology management and assessment.	2002 L.Lkebanov & J Czap 2003 Luis Cornejo & Sophia Zikherman 2004 -- 2005 Carolyn Mahoney & John Reis 2006 Naida Grunde & Mike Doron 2007 -- 2008 Denise Korniewicz
Award: Tom O'Dea Advocacy Award **Award Criteria:** The award will be given to an individual who has written articles, given presentations, or led efforts that have advanced the field of CE – particularly in promoting the profession to people in other related fields.	2002 Tom O'Dea 2003 Steve Grimes, John Hughes 2004 -- 2005 Joe Dyro 2006 Elliott Sloane & Ray Zambuto 2007 Julie Kirst 2008 Nancy Pressly
Award: Professional Achievement in Technology Award/ Professional Development Award **Award Criteria:** The award will be given to an individual for his/her contributions to the CE profession of a professional or technical nature, such as research or development of a new technique or product, a paper of significance on a technical issue, or 'trailblazing' work in a new application of clinical engineering.	2002 Joe Bronzino 2003 Malcolm Ridgway 2004 -- 2005 Steve Grimes 2006 Matt Baretich 2007 Todd Cooper 2008 Frank Painter
Award: Professional Achievement in Management Award/ Managerial Excellence Award **Award Criteria:** The award will be given to an individual for his/her contributions to the CE profession of a managerial nature, such as a paper of significance, solving of a problem or issue for the profession, or the application of new techniques to CE with measurable positive results.	2002 Kenneth Maddock 2003 -- 2004 -- 2005 Manny Furst 2006 -- 2007 Richard Congdon 2008 Tobey Clark & Ismael Cordero
Award: Student Paper Competition **Award Criteria:** The award will be given to an individual currently a student in a CE or related graduate program that wrote a paper that contributes significantly to the body of knowledge in CE.	2002 -- 2003 Kristi Hinner 2004 -- 2005 Brandi Spencer 2006 Mary Fazio 2007 -- 2008 Raquel Lopez

ACCE

AMERICAN COLLEGE OF CLINICAL ENGINEERING

ACCE Mission

1. To establish a standard of competence and to promote excellence in Clinical Engineering Practice
2. To promote safe and effective application of Science and Technology to patient care
3. To define the body of knowledge on which the profession is based
4. To represent the professional interests of Clinical Engineers

We are on the Web:

www.accenet.org

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Vice President .... Paul Sherman
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Nominations Committee Chair .... Steve Grimes
Professional Practices Committee Chair .... Paul Sherman
Body of Knowledge Committee Chair .... Open
Strategic Development Committee Chair .... Izabella Gieras
Secretariat .... Alan Levenson

Calendar of Events

April 4-9, 2009

HIMSS '09

(discount registration for current ACCE members)

Chicago, IL

April 4, 2009

2009 ACCE Clinical Engineering and IT Symposium in conjunction with HIMSS (separate registration required)

Chicago, IL

April 4-9

ACCE Annual membership meeting and awards ceremony (in conjunction with HIMSS 2009)

Chicago, IL

June 6-8, 2009

AAMI Conference

Baltimore, MD.

June 4-5, 2009

CCE Prep Review Course

Baltimore, MD.

September 7-12, 2009

Medical Physics and Biomedical Engineering

World Congress 2009

Munich, Germany

November 7, 2009

CCE Exam

28 cities in US