ACCE News

**Newsletter of the
American College of Clinical Engineering**

President's Message:

ACCE Members should seriously consider attending Healthcare Management Systems Society (HIMSS) Meeting in Orlando, FL

On February 22-26, 2004, the Healthcare Information Management Systems Society (HIMSS) will hold their annual meeting in Orlando FL. As many of you have already experienced, Clinical Engineering and Information Technology are becoming strong, inseparable partners because individual pieces of medical equipment are continuing to dovetail into computer-integrated clinical informa-

Ray Zambuto is President of Technology in Medicine in Holliston, MA and *President* of ACCE

tion and management systems.

This has profound implications for Clinical Engineers in the potential broadening of the scope of our work and it also can add new complexity and opportunities to the budgeting and reporting relations within the hospital. The HIMSS meeting is an ideal place to learn first-hand what is really going on in IT, meet and hear the movers and shakers, and become thoroughly prepared to address the new issues with others in your organization.

ACCE is actively involved at this year's HIMSS meeting through our HIPAA and IHE Task Forces (our IHE Task Force is sponsoring a Round Table Discussion on Clinical Engineering in the IHE on Wednesday February 25th). As an aid to exploring engineering-oriented opportunities and activities at the HIMSS meeting, and as a networking event, ACCE is holding a Breakfast

Meeting the same day as the Roundtable. The Breakfast Meeting is being co-sponsored by HIMSS for attendees who have an interest, passion, or focus on clinical engineering and its role in information system design, implementation, and support.

This is a great opportunity for engineering-oriented attendees to kick off or extend their IT portfolio and I urge you to take advantage of the opportunity by putting this meeting on your calendar. Registration information is available at www.HIMSS.org. The breakfast meeting is limited, and will be by invitation only, so if you are planning on attending, please let me know as soon as possible.

*- Ray Zambuto
(rzambuto@techmed.com)*

Certification Update
- First Exam Given

For the first time in several years, clinical engineers are able to take steps toward becoming certified. Several candidates were accepted for the first AHTF written clinical engineering certification that was given on November 22nd at locations across the United States. The examination results have been reviewed by the Professional Testing Corporation (PTC) as one of numerous ways to ensure a psychometrically defensible examination process. PTC will send the results to the Commission in late December and the Commission will then provide the examination candidates with their individual exam scores. Those candidates that pass the written examination will be scheduled for an oral examination in the spring. The Board of Examiners is working to make the oral examination process as fair and valid as the written examination. This includes advisement from PTC in defining the goals, methods, and processes in addition to writing the questions for the oral exam. In parallel with this activity, the Board has begun work on the second certification examination. The application is being reworked based on the experiences of the first round of applicants and a full one-third of the next written examination will contain questions not previously contained in the first exam. Through this diligence, the AHTF is ensuring the ability to identify competent clinical engineers through psychometrically defensible examination well into the future.

- Caroline Campbell
(*CCampbe2@clarian.org*)

Clinical Engineering Certification FAQs

I've recently responded to a number of questions from members who were inquiring about certification. I felt the others might have similar questions and so am sharing the following Q&A:

1. The CE Certification brochure states existing CCEs have until October 31, 2002 to apply for recognition under the new program but recent articles have mentioned a January 31, 2004 deadline. Which one is correct?

   Because the advertising / information campaign about the new program went slower than we hoped and fewer than expected applied for recognition, we extended the deadline. We should have been more aggressive in the information campaign. Since we are applying for NOCA certification (National Organization for Competency Assurance) they specify that there only be one way to obtain certification. We had to first run the recognition program, cut it off at some point and then start certifying people by testing. The original deadline was 10/31/03, just prior to the written exam. But since the oral exams will be given in February/March, we felt that extending the recognition program to January 31, 2004 was OK under the circumstances. It's just that after that we

   will be unable to recognize anyone else and still be eligible for NOCA certification.

2. Why is the new certification valid only until June 30, 2004? I know it is "free" but renewing it only after 6 months seems like overkill.

   We offered "no cost" recognition until June '04 in an attempt to uncomplicate the financial process. In June we will begin to charge $25 per year in three year blocks for CCE renewal. We need the money to run a valid certification program. We are definitely doing that now. The exam questions are appropriate, professionally analyzed and very well worded. It is nearly a perfect exam, but we had to hire a professional organization to help us with the questions, guard the confidentiality of the exam, prepare the exams, administer them in 30 cities nationwide and help us with the post test analysis. This ain't cheap! Also, the ACCE Healthcare Technology Foundation offered to pay for the first round of professional assistance, so we could forgo renewal fees until June. Then the CCE community will be paying a small amount to support a valid process.

3. Why it is necessary to submit a 3 year journal if my

ICC certification is current and was renewed recently? Especially since the two journals are almost identical, why not accept the other one?

Try it. Fill out the cover page of the HTCC CCE recognition application and attach your AAMI renewal worksheet. This may not work because the point system may not be the same, but you can try. It just might work though, because you will have the CE Board of Examiners reviewing your application and they can probably recognize that you

Frank Painter is a Clinical Engineering Consultant with Technology Management Consultants in Trumbull, CT and ACCE's Certification Committee Chair

should be recognized.

4. Can you or someone tell me how many have "recognized" their ICC certification so far?

Federal Government Advances Professional Recognition of Clinical Engineering

On December 6, 2003, President Bush signed a bill designating 31 federal jobs, including Biomedical/Clinical Engineering from the standard administrative positions (Title 5) to Allied Health Professional positions (Hybrid Title 38). While this sounds like yet another bureaucratic line item, this bill can potentially launch a new era for Clinical Engineering.

For the Department of Veterans Affairs this bill enables the following:

√ Creation of a national professional review board. This board will define standards and professional qualifications for the field, rather than Human Resources. Additionally, the board will help define appropriate (and hopefully higher) pay scales.

√ Professional certification/licensing can be used as an advancement incentive.

√ Hiring qualifications and flexibility. New hires will need to be board qualified. If there is an opening and a willing, board-qualified candidate, that person can be directly hired without much of the normal overhead of government hiring logistics.

What is the implication for our profession?

This is official government acknowledgement at the highest level of Biomedical/Clinical Engineering as a health care profession. This bill also now sets the stage for:

√ Professional recognition similar to other health care professions (Physicians, nurses, etc).

√ Performance standards and qualifications set by a professional board, rather than administrators.

√ Use of licensing and/or certification as a competence standard and hiring criteria.

In short, many of the professional freedoms (and responsibilities) of physicians, dentists, nurses, etc. may be ours.

*- Paul Sherman
(Paul.Sherman@med.va.gov)*

Paul Sherman is Biomedical Engineer with the VA Center for Engineering and Occupational Safety and Health

Highlights of Membership Committee Activities

ACCE's Membership Committee has made progress on several major issues this past year. These include:

1. Revised member application and proposed by-laws changes to make membership more accessible to professionals in healthcare related healthcare fields who are interested in joining ACCE.

2. Implemented an annual review of Associate and Candidate members to encourage qualified members to advance their membership status

3. Implemented a review process in an effort to allow greater financial assistance to existing and prospective members

4. Implemented a process to ensure that individuals who receive an annual membership as an award are set at the appropriate membership level (so they will be eligible to renew their membership when their free term ends) .

One of next year's goals is to evaluate the application process of Fellow.

*- Dave Francoeur
(dave.francoeur@trimedx.com)*

Midwinter Orlando Warm-up Ahead at HIMSS 2004:
An Integrating the Healthcare Enterprise (IHE) Project Update

Clinical Engineers will have an opportunity to meet IHE participants and designers and to discuss ways that we can help enhance the IHE program on February 25, 2004 during the HIMSS Annual Conference in Orlando, FL. I will be leading a Roundtable that afternoon to continue our discussions on the ways that Clinical Engineers can help the IHE project continue moving towards being a daily reality for hospitals and healthcare providers. This past year, ACCE members have participated in meetings in Chicago and San Diego, and have been part of the IHE Strategic Plan-

Elliot Sloane is assistant professor of Decision and Information Technologies at Villanova University and past president of ACCE

ning Committee's regular monthly telephone meetings. We are being asked to share our systems and engineering perspectives at these meetings. We are helping this internationally-based community chip away at the complex issues associated with the design of an interoperable Information Technology (IT) standard. That standard will

eventually allow virtually all healthcare computer systems to share critical patient data and to streamline healthcare's workflow processes. Not only will this improve efficiency, but patient safety will be improved at the same time.

The IHE program has received quite a few important boosts in the past year from many sources. The core Information System IHE designs (www.himss.org/ihe) have been perfected and finely tuned to dovetail with the Radiology System IHE design (www.rsna.org/ihe) this past year. That effort was enhanced by a contract signed between the IHE organization and the HL7 organization to adopt HL7 as the core information coding infrastructure within IHE (www.ihe.org). HIMSS, RSNA, and HL7 have worked hard since Spring to set up and run multiple manufacturer-focused sessions to get them ready to run demonstration projects and RSNA and HIMSS. ACCE members will receive a special private tour of the IHE demonstration site at the HIMSS conference immediately after the above-mentioned Roundtable, as well as an introductory tutorial on the IHE and HL7 architectures that are the bedrock of the whole system.

In addition, this summer a formal IHE project was launched by the American College of Cardiology (ACC), which will be the

first IHE system designed to reach outside of the hospital setting to specialist's offices. This is likely to put renewed emphasis on HIPAA-related patient data security and it will likely depend on sound patient medical record integration planning, too. The Cardiologist's requirements will also push the IHE design outside of the fixed-installation, in-hospital systems commonly found in the Radiology department.

There were two other important IHE developments this year: A Laboratory-focused IHE initiative has been spearheaded in France (www.gmsih.fr/ihe), and an IHE initiative is underway in Japan. All in all, 2004 is shaping up to be a busy IHE year, and ACCE has a key role in the planning and implementation of the IHE programs!

If you can make it to Orlando for even a few days, you will find the HIMSS conference is a huge, invaluable, and delightful event (last year's attendance was nearly 20,000 strong!). John Hughes, Ray Zambuto, Steve Grimes, Bryanne Patail, Mark Bruley, Steve Juett, and Steve Haupt are among the friendly faces that've been turning up at the HIMSS conference, and we hope that YOU will come this year too. ACCE has an important role to play, and I think that you will quickly see that you have a lot to

Perspectives from ECRI: *A Key Patient Safety Role for Clinical Engineering*

The Institute of Medicine just published a report entitled "Keeping Patients Safe – Transforming the Work Environment of Nurses." A key recommendation in the report addresses the need to provide on-going education and training of nursing staff to address continuous growth of new technology. This is such an important recommendation and points to a critical role of the clinical engineer that is too often overlooked or de-emphasized.

Many clinical engineering departments spend well over 80% of their resources and energies on inspection and repair of medical devices. The biggest part of that effort is spent on inspection and preventive maintenance procedures (i.e., trying to catch looming device failures before the failure occurs and causes an injury or other problem). However, over ECRI's many years of investigating medical device-related problems we have found that less than 25% of the problems we hear about are from device failures and a much smaller percentage of the problems could have been prevented by inspection and preventive maintenance. Conversely about 75% of the problems we hear about are due to user error, frequently because the users do not understand how to operate or fully understand the risks of using their devices. I am not trying to say that inspection and preventive maintenance is not important or shouldn't be done.

It's just that for many hospitals, some priorities needed to be shifted such that user training for medical devices receives much more consideration. And, clinical engineers have to play a prominent role in that effort by helping to establish training-related policies, implement training programs, and actually conducting some of the training.

The process of ensuring that clinicians are effectively trained in the technology they are expected to use needs to start early on in the technology life cycle. For example, many hospitals fail to carefully consider utilization in the equipment planning process. As a result far too many hospitals have equipment that is underutilized. If clinical staff does not use technology enough, they can't become proficient. Have you ever seen a clinician struggle to figure out how to use a device because it has not been operated in months? It happens all the time. Also, many hospitals fail to plan for training when budgeting for equipment acquisitions. And, in cases when training is actually considered, there is rarely a plan to include the cost of retraining to help reinforce what was originally learned. Clinicians are bombarded with so much information, that a one-time in-service on how to use a device will go in one ear and out the other. Repetition is key.

Once equipment is in place, important new information

Jim Keller is Director of ECRI's Health Devices Group, ECRI, and a Member at Large for ACCE's Board

about the technology often comes to light. Each hospital's training program needs to have a process in place for how this new information is disseminated to the end users (i.e., ongoing education). For example, ECRI just published a hazard report about a new fire risk with anesthesia carbon dioxide absorbers. Has your anesthesia staff been informed about this problem? Does your hospital have documentation to show that this was done? ECRI has many more examples of how hospitals and clinical engineering programs can improve training and general clinician understanding regarding the use of medical devices. The ones mentioned above are just a few ideas to help you get started with developing a new program or improving an existing one at your institution.

Feel free to call or e-mail me at ECRI if you would like to discuss this topic or if you would like to obtain a copy of our article on anesthesia absorber fires. I can be reached at jkeller@ecri.org or (610) 825-6000, ext. 5279.

The Christmas Tree and Clinical Engineering

Thud! My head struck the desk as I slumped over. "Can things get worse?" My cry was instantaneously answered as if by an Echo. Yes, my Nemesis, Wang BinSeng, was calling me, his Narcissus. How did he know to call me just at the moment that I felt I was the center of the world and that this world was dishing out more than I could take?

Earlier, while feverishly struggling to meet a 5 PM deadline, I heard screams from a distant corner of the house. I scrambled down the stairs to see what was once a beautifully decorated Christmas tree, now horizontal and with decorations a shambles, atop my daughter. She looked rather like the Wicked Witch from the West's sister, sans ruby slippers, crushed under Dorothy's house. My wife and I extricated her from the holiday heap. What happened? Why did it fall over? Why didn't you leave it alone? Why were you trying to reposition it? It tipped over by itself. Why didn't you set it up right in the first place? The peaceful air now reeked with acrid accusations. The culture of

blame reared its ugly head. After fixing the stand, setting up the tree again, and cooling off a bit, but still shaken, I slinked back to my cave. Now late with my paper; my forehead met the desktop with that resounding thud.

BinSeng was an angel in disguise. While his soothing voice offered a Merry Christmas to me and the family and as I told him about the tree's collapse, I grasped the significance of that event and even the incidents that began the week before in West Newbury, Massachusetts, at the Beaver Brook Christmas Tree Farm. The ride on the tractor-pulled wagon to the best trees paused only for us to enjoy a cup of delicious Woodman's clam chowder at the farm's refreshment stand. Our tree selected, sawed, and sledged to the bundling machine that would compress and bound it with string in one operation. We waited our turn to watch our tree get pulled through the machine's annulus by the pull of a stranded steel cable on a motor-driven reel. Snap! The grappling hooks attached to the tree, being pulled through the annulus, detached and flew back under the tension on the stranded cable striking my first born, apple-of-my-eye, at the knees. The father of the tree farm's owner, a physician, rushed to her side, examined her, and did the right thing all in keeping with the season and with good patient-doctor rela-

tions. He looked me square in the eye and said, "The tree is free." He added, "If further medical care is necessary, we have insurance." I did an incident analysis, taking photographs of the scene and conducting several interviews of tree farm's personnel.

A few days later, the tree now upright in an aged, poorly maintained tree stand, the family festooned the fir with baubles and lights. "Say, Dad, these lights don't work." No problem. The stand of lights taken to the bench, basic troubleshooting ensued, and a repair was affected. Now, all was well and there was peace on earth. That is, until the collapse the following day.

So what can we draw from this? The clinical engineer in me was visited by three spirits in the form of marvelous opportunities to exercise CE skills: incident investigation at the farm, trouble shooting and rectification of the lights, and root-cause analysis (RCA) of the tree collapse. RCA revealed that the tree stand had received inadequate maintenance. Over the years, the four legs of this heavy duty stand had deformed under the weight of various trees and no longer served to support the tree as designed. Slight movement of the tree while turning it to expose the tree's best side was sufficient to initiate the eventual collapse. In future years, the stand will be

From the Penalty Box:

Well the year 2003 is almost over and not much progress has been made on making hospitals a safe place to be. If we can believe the press about 100,000 people a year die because of preventable medical mistakes. Another 100,000 die because of infections they picked up in hospitals. Close to another 100,000 suffer injuries from falls and another 100,000 injure their backs. I look at these numbers and say "What the hell are we doing to make hospitals safer?" Even given the exaggerations of the general press, remember 10,000 people dying a year from defective medical devices? That claim proved to be not even a WAG but a very uninformed guess by someone who had no experience in healthcare. But it did give our profession a goal to shoot for. So now we say to the 200,000 that die every year in hospitals "Not my job". What about the 200,000 injured? "No power cord we don't touch it."

I was recently in a hospital where I saw a device that the manufacturer sent out a notice on in 1968 to no longer use. In 2003, which is 35 years after the manufacturer said pull it from service this hospital was still using it. Being an old pack rat I pulled the letter from my files and sent it to both the engineer at the hospital and the administrator. The response from the administrator was that the information was turned over to the engineer for action and the response from the engineer was he would look into the device.

How are we as a profession going to handle the challenges of HIPAA, all the computer based equipment, remote diagnostics and what is coming our way if we cannot tell a hospital in simple terms, "this unit is not safe, we will not fix it and it has to be replaced". One engineer said to me that we are too concerned about getting old equipment out of service and to keep costs down they have to keep them running. He pointed out that the DC-3 is still flying and that plane is 60 years old or more. My response to him was "would you want to fly that plane?" I have and it was not a great feeling.

At another hospital I observed a device that was so covered with stickers and tape it was hard to tell the color of the chassis. Maybe the device worked well but it presented a picture to the patient that it was held together with stickers and tape. When I asked the engineer about the condition of the devices the response was "we test them someone else cleans them". This is the same person that has his car detailed several times a year and trades it in every 3 years.

My wife has had more than her share of medical problems and many of her problems can be traced to devices not being calibrated and repeatable. It seems that no two blood pressure units in the doctor's office give the same blood pressure. But getting 40 points difference between rooms in 15 minutes is a little extreme. Then when the medicine is prescribed we spend weeks getting used to the side effects of that prescription.

One of the great personalities of the 20th century, Groucho Marx, once said, "Politics is the art of looking for trouble, finding it, misdiagnosing it and misapplying the wrong remedies". Change the word politics to medicine and it apples to all too much to our profession.

It is time for us, as a profession, to make that push needed to bring a safe environment to the hospitals, clinics and physician offices that we are responsible for. Get rid of the old and outdate equipment, don't put questionable parts on the shelf just in case they are OK, push for better infection control, better user education on devices and cleaner devices. This may sound crazy but in doing so we will probably reduce our long term costs and improve healthcare.

As a side note, my grandson, Conor, got his first penalty and a goal in league hockey so the Harrington line will continue on. I just hope that he has as much fun playing hockey as I did, even with the bum knees and all the other aches and pains I would not have missed it.

I hope your holiday season was great and that 2004 will be productive, safe and peaceful throughout the world.

- *Dave Harrington*
  (*Dave@sbttech.com*)

gain from participating in this conference, and in supporting the successful development of the IHE standard.

We have a great core ACCE IHE task force that includes me, Ron Baumann, Ted Cohen, Steve Grimes, and Atanas Manev. We sure could use your help too, because this project is likely to grow quickly as it successfully encompasses more hospital areas. Clinical Engineers have a bright and essential role in the IT-enabled healthcare enterprise of the 21st century. I hope to see you in Orlando so that you can learn more the whole IHE project (plus you'll learn all about HIMSS, too, and a lot more about the whole healthcare IT field than you ever thought possible!) E-mail me if you are interested in attending.

- Elliot B. Sloane, PhD
(IHEchair@ACCEnet.org).

88 had submitted their applications for recognition as of 10/31/03. The total list is 263 possible renewals. At least that's all the names we could come up with that are CCEs. We have received 10-15 additional applications since 10/31 and we just sent e-mails to about 110 more. The rest we will have to send written reminders to, which is in progress. The Board is in the process of reviewing applications.

- Frank Painter
(frpainter@earthlink.com)

inspected and any maintenance and repair will be made before it is put into service. Trouble shooting the string of lights was fairly straightforward. Appropriately resisting the temptation to use nurse tape offered by my RN wife, I elected to use electrician's tape to secure a wire detached from the base of a lamp. The analysis of the tree farm incident revealed that the tree being bundled was on the big and bushy side, the force required to pull it through the annulus was greater than normal, and the grappling hooks were inadequately secured to the tree. Furthermore, the staff was aware that from time to time such unexpected release of hooks had occurred, but the management had not taken measures to cordon off the area to keep observers out of the hazard zone nor had it posted warnings to apprise the customers of the dangers of fly back.

My Christmas present to all my readers is this. Keep your clinical engineering skills sharp by grasping the significance of all events and applying your skills whether you are on the farm or in your living room!

- the Shadow

HIPAA Update

On December 17, the first meeting of HIMSS *Medical Device Security Workgroup* took place. The Workgroup's proposed charter is to *"evaluate the issues of security threats and best practices for securing of medical devices in healthcare organizations. As medical device products move from an electronic base to an IT base their vulnerability to security threats has increased ... the workgroup will develop a white paper, recommend solutions, and identify best practice situations."*

The impetus behind the formation of this Workgroup is the recently finalized HIPAA Security Rule <u>and</u> a recognition by influential members of the healthcare information technology community that data maintained and transmitted by medical devices represent a major and largely unaddressed security issue. HIMSS acknowledgement of the significant role medical devices have in healthcare data security brings a powerful ally to the aid of clinical engineers who are working to insure their devices and systems are compliant with HIPAA's Security Rule by the April 2005 deadline.

The HIMSS Workgroup will now meet on a monthly basis. Representatives of ACCE's HIPAA Task Force will work closely with the group to share insights we have gained over the past several years as well as to gain the benefit of the new Workgroup's technical expertise.

- Steve Grimes
(*HIPAAchair@ACCEnet.org*)

In Memoriam
Al Jakniunas
March 9, 1936 - October 1, 2003

In a joint expression of sorrow, ACCE, the Healthcare Technology Foundation, and PAHO joined the Lithuanian department of BaltMedTech and placed this plaque in the hallway of Vilnius University Hospital ... the site of the ACCE Advanced Clinical Engineering Workshop that was organized by Al Jakniunas. Donations from all over the world continue to arrive at the Healthcare Technology Foundation with expression of sadden sympathy for all of Al's lifetime work.

Alfred Grazutis Jakniunas
Catalytic, caring clinical engineer, died on October 1, 2003

"Do you want to make big money?" Al usually started his telephone calls in this way. He would then launch into one of the many ideas for expanding the horizons of clinical engineering: distance learning, international education, transfer of information, e-books, improving health care in the Baltics and Poland. These were some of the directions this dynamo took. His big heart, welcoming bear hug, jollity, and infectious enthusiasm characterized this man of vision and vitality. Al's face never failed to brighten the most dreary day. Even without saying a word, with facial expressions he communicated volumes. His son, Glenn, commented, "It was not long ago I mentioned to a doctor at Dad's hospital that whenever I see someone who knew Dad, I somehow see a little bit of him in their faces. He, undoubtedly, made a lasting impression on all and I am certain that he will continue to direct our thoughts during difficult times."

Al always extended a big welcoming hand of friendship

Al was born in Lithuania and grew up in the United States. He held jobs in industry and hospi-

tals, eventually attaining the position of Director of Biomedical Engineering at Howard University Hospital. He is one of the pioneers of clinical engineering and helped to establish the American College of Clinical Engineering.

Al could always be found in the midst of his friends who derived much energy from this human sparkplug.

Al was a major force in moving clinical engineering in the Baltic region from the Soviet era to modern Western practices. His significant contributions included the formation and promotion of BALTMEDTECH, a cooperative between clinical engineers in Estonia, Latvia and Lithuania, modeled after the NORDMEDTEK, a clinical engineering cooperative in the Scandinavian countries. He was a major force in organizing the Advanced Clinical Engineering Workshop in Vilnius, a landmark in cooperation among the Baltic countries where Al, together with the World Health Organization (WHO), brought clinical engineers and administrators from all the Baltic countries.

Fellow Lithuanian, Rimantas Baytakys, Director of Clinical Engineering at Vilnius University Hospital, had the following to say upon the news of Al's passing. "Al

Al with Rimantas Baytakys (l) and Jim Wear (r) during the Vilnius ACEW

Jakniunas was a highly skilled professional and a warm and enthusiastic person. His care and attention to our special needs and the time he shared with us was enriching in every way. His contributions have left a major imprint in the history of clinical engineering in the Baltics and will be appreciated forever by the patients in the Baltic countries."

"Why Me!?" ask Al.

Al was well-acquainted with the hazards of international work. While traveling to Moscow five years ago for an Advanced Clinical Engineering Workshop (ACEW), he fell ill. In Moscow, his discom-

Remembering Al Jakniunas

fort rapidly worsened. A workshop participant, Dr. Sergei Barsukov, Deputy-Chief of the A. Vishnevsky Central Clinical Hospital, Ministry of Defense of the Russian Federation, did a physical diagnosis. Six hours of emergency abdominal surgery performed by Dr. Valery K. Zuyev, Deputy Chief Surgeon, MoD RF, and Chief Surgeon of the Hospital followed by a two-week stay in the Intensive Care Unit saved Al's life. While recuperating in a VIP suite, Al reported that doctors, nurses and technicians who provided the best quality of care imaginable, treated him like a five-star general. Valery, Natalia and Ludmila visited with flowers, chocolates and smiles to buoy General Al's spirits. Upon his return to work at Howard University Hospital Al remarked, *"Let there be no doubt as to the high quality of medical care available in Russia."*

Al leads the way to fine dining

Some of the most memorable moments with Al were spent enjoying lively conversation over good food and drink. On more than one occasion, he proved to

me, his Polish friend, that Lithuanians clearly dominate in such departments. Al's capacity for these good things in life was exceeded only by his capacity for kindness and caring. In spite of managing one of the most prestigious and sophisticated teaching hospitals, Al never forgot those less fortunate than him. He tirelessly helped clinical engineers from developed and, especially, developing countries. He enthusiastically contributed to the creation of the first ACEW held in Washington in 1991. One of Al's most enduring contributions is the vision to create the Infratech listserv, sponsored by WHO and the Pan American Health Organization (PAHO), with the support of ACCE. Since its inception, Al gracefully led the management of this listserv, benefiting many users worldwide.

Al describes Infratech to Mexico's Velásquez

Yadin David remarked, "Over the years, Al showed us that we all follow a destiny and wherever this takes us we must think with our hearts and see to it that our deeds made this place better. He did it as a practicing clinical engineer and as a human being never for-

getting where his roots were. He guided us through trips to Russia and to Lithuania to the Infratec concept and to the reasons we work in hospitals. He was a good and honest person. I already miss him ... I feel sad to lose a good friend."

Dave Simmons remembered Al as follows: "I first met Al in 1973 when he attended a seminar at George Washington University that James Wear and I were presenting. Al has been a friend and Associate for 30 years. His commitment to our profession and to improving the human condition were unquestionably of the highest magnitude. Al had undying faith in the greatness of the Human Spirit! He is loved and missed."

BinSeng Wang, a close comrade of Al's, was the first to relay the news about Al to his fellow ACCE colleagues. Al went to Lithuania in September for additional voluntary work and returned very ill. Eventually, he was diagnosed with the Legionnaire's disease. Unfortunately, his body did not react to several antibiotics that were tried. He is survived by his wife, Priscilla, mother, Birute, children, Kaaran Carbajal, Glenn Jakniunas and Heather Passofaro, and two grandsons. Following a Christian mass at Fort Myer Chapel, Arlington National Cemetery, Al's ashes were placed in the Arlington National Cemetery's Columbarium.

- Joe Dyro (dyro@alum.mit.edu)

Attention: Certified Clinical Engineers!!
>>> January 31st Deadline <<<

The Clinical Engineering Certification Program administered by the United States Board of Examiners for Clinical Engineering will recognize the certification of clinical engineers who were previously certified under the program suspended by AAMI and who have remained in professional practice.

Applications are now available to apply for listing with the new program.

Practicing Clinical Engineers who are currently renewed under the suspended ICC / AAMI program, or whose AAMI renewal previously lapsed are eligible to apply for recognition under the new program until January 31, 2004.

To obtain an application for recognition under the new program, or to obtain more information contact ACCE at: certification@accenet.org or (610) 825-6067

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Contact: Izabella Gieras
E-mail: igieras@beaumontservices.com
Phone: 248-551-0549

Calendar of Events

ACCE
AMERICAN COLLEGE OF CLINICAL ENGINEERING

February 22-26, 2004
Health Information Management and Systems Society (HIMSS)
Orlando, FL
Discounted Registration
ends **Jan 26th** .... **Don't Miss It!!!!**

June 5-8, 2004
Association for the Advancement of Medical Instrumentation (AAMI)
Boston, MA

July 26-28, 2004
American Society of Healthcare Engineers (ASHE)
Orlando, FL

September 1-4, 2004
Institute of Electrical and Electronic Engineers – Engineering in Biology and Medicine (IEEE-EMBS)
San Francisco, CA

We're on the Web!
http://www.accenet.org

Newsletter of the American College of Clinical Engineering

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