ACCE News

Newsletter of the American College of Clinical Engineering

July/August 2009 Volume 19, Issue 4

CCE Exam

The next CCE written examination will be held on Saturday, November 7, 2009 in 29 cities across the United States. The deadline for applications is August 14, 2009 for applicants testing within the United States & Canada and July 17, 2009 for applicants testing outside the United States & Canada.

Arrangements can be made to take the written exam in most major cities around the world by contacting the HTCC Secretariat at:

certification@acce-htf.org.

In this Issue:

President's Message: Italian CE Meeting

I had the privilege to deliver a talk at the Italian Clinical Engineering Society's (AIIC) Annual Meeting this past June. The setting was beautiful: Palermo, Sicily, on the seaside, over the course of two perfect summer days. I already made a note that I have to return there soon and see the area because, despite the seductive sea breezes and the allure of the crystal blue water, I was much too caught up with the talks at the conference.

This was my first international clinical engineering meeting, invited to give 'the American Experience', of which, initially, I had no idea how to impart. What are the differences between American and Italian engineers and which one do I exploit to create an interesting and informative talk? I'd met the Society's leadership. So have some of you. They've been to AAMI, to our receptions, and formally invited us to share in their programs. During her presidency, Izabella Gieras travelled to Rome to represent ACCE. In our conversations, we talked about device maintenance strategies, technology assessment, and the Joint Commission (Joint Commission International for them, but the program is *basically* the same). Above all, they talked about the difficulties getting an official and recognized position in the hierarchy of healthcare leadership. Take away the difference in language, and it is obvious that the approach to the profession is truly the same.

During the meeting, the speakers touched on familiar topics: innovative management of infusion systems, including a wireless component; the integrated management of clinical risk and patient safety; addressing the modern needs of the OR, including best practices for managing the robot (Da Vinci system in this case); and the convergence of biomedical equipment and IT. All of the talks were amazing and I was delighted to be a part of it. Later, on the Thursday evening of the meeting, I was inducted as an honorary member of their Society. For me, it was an Oscar moment and my impromptu speech in very broken Italian hopefully communicated my appreciation as well as my pleasure to see an obvious opportunity for collaboration and learning between the two organizations.

During the meeting, I noted the absence of a topic that is currently hot in our country – that of the convergence of CE and IT professionals. I started conversations about this topic with some of the members. Did they feel the struggle or the competition? And, most didn't. The duties of the IT professional are, for the majority, still that of functional back office support. Hospitals have their clinical systems online and medical devices on networks but the cultural collide hasn't yet occurred. And time will tell if it ever will. One thing I've learned since living here is that the Italian system is very concerned with proper credentialing. An engineer is bestowed with that title only after passing the professional exam. Some American states have a requirement for practicing engineers to have

(Continued on page 2)

President's Report continued

(Continued from page 1)

the PE. In Italy, it is the only way. AIIC has been hard at work proposing legislation to further define the legal definition of a clinical engineer, which one will have to meet if he/she wishes to practice in that space. So, I will be interested to follow the profession's path as clinical IT and medical device systems become more and more intertwined. The Italian Clinical Engineer will (hopefully) have his education, training, and work duties clearly defined by the state so I hope to be a fly on the wall when the time comes to define the practice around these integrated systems.

Most of this enlightenment came on the first day of the meeting. My talk was first thing on Day 2. So, that gave me time to tweak my talk a bit that evening (we've all done it, admit it!). I used an example of a project that I worked on at the Brigham in these past few years. We used many of the tools that found their way into ISO 80001-1. So, it was only natural that I use that project as a case study around this standard. I felt it was something that was close to my heart, current with the American-side of the profession, and international enough to impact the Italians now and soon in the future. I like what I delivered. I did the talk in English though and unfortunately, not all of the audience was able to follow. Next year, it will be in Italian!

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

ACCE News

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ACCE at AAMI 2009: Another Great Success

Under the leadership of President Elect Mario Castañeda, ACCE formally provided two symposia at AAMI in Baltimore this year, *Addressing Wireless Challenges in Healthcare Technology Management* on Saturday morning, June 6, and *Current Economic Issues and Their Effect on Healthcare Technology Management* on Monday afternoon, June 8. Both programs were well attended, with outstanding speakers, and new insights. ACCE Secretary Jim Welch noted that over half of AAMI's presentations this year were led by ACCE members.

ACCE President Jennifer Jackson introduced the Saturday morning program to the crowd of over 200 with opening remarks via skype from her home in Rome, Italy. Some of Jennifer's comments are excerpted as follows:

This year, our symposium is focused on wireless technology management in healthcare as wireless data communication has returned to the forefront of our professions. We are beyond the debate on whether to WMTS or not to WMTS or if your cellular phone policy is adequate. Instead, we are facing a sea change in the way medical data is measured and reported. Cable-less physiological monitoring, tele-health programs, complex workflow procedures are all pieces in the wireless puzzle and we are challenged to modify our practices to ensure that these technologies operate in a safe and effective manner.

Wireless data transmission presents a set of unique challenges with respect to its wired forefather. We inherit all the risks that exist in a conventional wired network plus these additional management challenges. Some of these new threats include: Data thieves eavesdropping more easily on a wireless network via access points. Service integrity is more easily challenged when unauthorized agents or software consume too many network resources. Transmissions are harder to synchronize leaving time-dependent vital signs at risk of corruption. Data from unauthorized devices are transmitted creating a discontinuity in information quality. However, there are options available to manage these risks.

Next keynote speaker was Rick Hampton, Wireless Manager, Partners HealthCare Information Systems, RHampton@Partners.org, who spoke on *The Wireless Universe: Toolkit for Troubleshooting and Problem Resolution*. Key topics addressed by Rick were:

There are many reasons to go wireless including; voice, data, RTLS, and telemetry, Rick also discussed buzz words, use cases, FCC services utilized, wireless toolkits and the need to survey your environment and inventory and understand all your wireless systems including: making a list of systems, owners, frequencies, modulation characteristics and interaction potentials. Each hospital should also work toward creating a wireless strategic use plan.

Leanne Cordisco, HCIT Program Manager, Education Services, Leanne.Cordisco@ge.com, next addressed *Wireless Training for GE Biomeds* (a model for how clinical engineering hospital staff around the US could be trained):

She discussed RF basics, antenna basics, site surveys, RFID/RTLS, 802.11, WMTS, cellular, frequency coordination, and troubleshooting. She also talked about some of GE's lessons learned including: wireless is special; online training was a failure; hands-on exercises are critical for success; reinforcement is necessary, constant learning is required; and wireless is a system, the break/fix box mentality does not work.

The Joint Commission's George Mills, Senior Engineer, Standard Interpretation Group, was the next speaker. George addressed *Wireless Technology from the Joint Commission Perspective*. From the Joint Commission standards he pointed out three areas of concern: medical equipment failure; information management; and risk assessment. His remarks drew many questions from the audience that will receive written follow-up from the Joint Commission over the next several months. George summarized his wireless Joint Commission recommendations as follows: Include in written procedures an action plan to implement

Rick Hampton addresses AAMI's ACCE Symposium crowd on the advantages and pitfalls of wireless medical technologies.

ACCE at AAMI 2009: continued

(Continued from page 3)

if a wireless signal is compromised (e.g. scheduled or unscheduled outages), test corrective actions, document a process to manage interruptions to maintain access to information, conduct an inventory and risk assessment of wireless devices and applications and register Wireless Medical Telemetry Systems (WMTS) with ASHE.

Robert Jarrin, Director, Government Affairs, Qualcomm Incorporated, rjarrin@qualcomm.com made the final presentation - *Deploying Wireless To Extend Healthcare Enterprise To Home: The Continua Health Alliance*. Mr Jarrin discussed the Continua Health Alliance, a non-profit, open industry alliance of healthcare and technology companies world-wide joining together in collaboration to improve the quality of personal healthcare. Continua is focused on using wireless technologies to address issues with the elderly, chronic disease, and overweight populations through health and wellness, disease management, and aging independently. Continua has seven technical Working Groups (WG) that provide technical input to the Use Case WG. The technical working groups have responsibility to define architectural frameworks, identify and characterize high-level functional components and interfaces, survey existing technologies / standards in order to make recommendations and identify gaps, develop Interoperability Guidelines (requirements, standards, influence standards, interpretations / profiles), and provide technical inputs for Interoperability Testing. The Use Case WG identifies and prioritizes market needs; represents the voice of the clinicians, domain experts, and users; and promotes early implementations of Continua interoperability solutions. Architecture issues are addressed via Interoperability work. Results are published as Guidelines, Certifications, and a Recognizable Logo placed on certified devices.

ACCE's second formal AAMI session was a Monday Symposia, introduced by Pat Lynch, and focused on Healthcare Finances. The first presentation *Perspectives from Medical Center Financial Leaders*, with speakers Keith Persinger and Craig Fleischmann from the University of Maryland Medical Center (UMMC), Baltimore. They provided a UMMC Overview on large health systems, Projected Growth versus "Today's World" and the Required Performance Improvement – balancing margin and cash flow. They also discussed the Role of Biomedical/Clinical Engineering in Improving Financial Performance – increased outsourcing versus in-house growth and Building a Sustainable and Supportive Culture.

Key points included: clinical equipment repair and maintenance is a major expense for most institutions; controlling repair and maintenance expense is absolutely critical to the financial solvency of the institution, especially in a poor economy, and controlling expense means not only managing repair and maintenance expense but also providing input into the best use of limited capital funds for equipment replacement. The Finance Department can provide assistance in the elements of an effective financial analysis but the expertise has to come from Clinical Engineering; and the responsibility for managing repair and maintenance expense lies with Clinical Engineering and Procurement (Contracting Department) – not Finance.

Pat Lynch next addressed *Slashing Biomedical Budgets in 2009: Surviving corporate mandates in the recession of 2009. As the leader of* the Federation of Medical Equipment Support Associations www.fmesa.org, Pat has visited many local and regional biomedical societies in the last year to shape this presentation. Excerpts from Pat's presentation include:

Examples of issues: Administration has cut the budget. I cannot train my staff. The boss won't let me hire staff. How can I do the same work with less staff? Administration cut out travel. Other topics that Pat addressed included: The economic crisis and how it affects healthcare and hospitals. How biomeds typically respond to financial pressures and why these responses do not work, lessons from around the country, examples of cost-effective approaches from Pat's and colleagues experiences over 30+ years and a networking solution to self-help. There was also a round-table discussion.

Britton Berek, Director of Regulatory Compliance, ARAMARK Healthcare, closed with *Regulatory Perspectives: Ensuring Patient Safety through Clinical Engineering.* Britt addressed changes in the current regulatory environment and regulatory-driven opportunities for Clinical Engineers: and included the following topics in his presentation: Patient Safety: Joint Commission National Patient Safety Goals; Sentinel Event Alerts; Quality Monitoring ("Never Events" - Error Reduction). Infection Control / Patient Throughput for Medical Equipment; and Pay for Performance; Patient Satisfaction and HCAHPS.

Copies of presentations are available upon request.

Tom Judd

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Commentary: Medical Devices in FDA Safety News

The FDA's Patient Safety News is an online and broadcast monthly video news show aimed at healthcare professionals, but also including some direct to patient information. The current and archived shows since February, 2002 are available at the FDA's web site.[1] Both drug and device issues are covered, and the issues presented may be manufacturer specific, or may address a generic type of product.

Most of the stories reiterate information previously provided as MedWatch Safety Alerts or other forms of FDA safety advisories. One result of this is that there is a variable delay between the initial availability of the information and the presentation on Patient Safety News. For example the July 2009 story on the Disentronic insulin pump cites an April, 2009 recall posted on the companies web site which was followed by a May 2009 FDA posting as a MedWatch safety alert. The May 2009 story on the Baxter Colleague volumetric Infusion pumps followed a March 2009 Baxter press release and MedWatch alert. The format of the program is primarily relatively brief "talking heads" with some more-or-less static graphics. Occasionally there is additional video such as a July 2007 item on MRI safety and a November 2006 story on the Alaris SE infusion pump button bounce issue. The latter included a video demonstration of the then newly recommended user procedures to control for and note button bounce effects.

For this article I have focused on samples from the last 12 months (August, 2008 through July, 2009) with respect to medical device stories. The sample list is:

August, 2008: Potential Problems with Insulin Pens in Hospitals

September, 2008: More Patient Deaths from Luer Misconnections

October, 2008: CT Scanning May Cause Malfunction of Electronic Medical Devices,

February, 2009: Recall of ReliOn Insulin Syringes

May, 2009: Burns from Medicated Patches during MRI Exams,

Safety Problems with Baxter Colleague Volumetric Infusion Pumps,

Welch Allyn Automated External Defibrillators (AED) Recalled

June, 2009: Zoll AED Plus Defibrillator Recalled

July 2009: Avoiding Infant Burns from Heel Warmers

It is noteworthy that most of the device issues listed above do not pertain to "traditional" clinical engineering concerns, defined here as a focus on hospital owned or used permanent, multi-patient devices. For example some address procedural issues, disposables, or implants. However many clinical engineers have moved beyond traditional interests as I have defined them. For example, tubing misconnections have received attention from clinical engineers as has a more generalized device safety focus. On the other hand, there are, of course, matters that are directly within basic clinical engineering concerns such as defibrillator and infusion pump recalls. The June and July reports illustrate this dichotomy. The Medtronic shunts are part of an implanted hydrocephalus shunt system, while the heel warmers are a single use disposable. How many clinical engineers are playing an active role in selecting implants and disposables, and/or processing their alerts and recalls? The insulin pump is a patient used device and therefore reflects, in part, the as yet unresolved challenge of supporting home use devices.

More within the clinical engineering mainstream is the Zoll defibrillator recall which covers battery and software issues with devices manufactured between May 2004 and February 2009, with serial numbers below 200000. Such devices require a software "upgrade" to version 5.32. This is perhaps a classic of the modern era in that it involves otherwise identical appearing devices that can be running different software, and therefore performing differently. In addition, do software version numbers to three significant figures suggest anything about software quality control? And finally, the software industry has to be acknowledged for calling fixing something that is broken an "upgrade".

Although the Patient Safety News has limitations with respect to the timeliness of the information, and it's repetition of what has already been disseminated by other means, it is worth your attention for illustrations of issues, and as a double (triple? quadruple?) check on recalls. In some cases the material, which is without copyright, can be adopted for internal training and other presentations. In addition the scope of the devices that is addressed may suggest the increased involvement by clinical engineers in a broader array of device issues. This may be part of next-generation clinical engineering, especially if routine maintenance/safety checks continue to be (successfully?) attacked as not justified or fruitful—which is a subject for another day.

1. FDA Patient Safety News Home Page, http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/index.cfm

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International Report: Robert Malkin Recognized by AIMBME for Improving Healthcare in the Developing World

ACCE member Robert Malkin, PhD was recognized recently for his contributions to improving health care in the developing world. Dr. Malkin was named a fellow of the American Institute of Medical and Biological Engineering and this recognition came with a citation noting his work in founding Engineering World Health (EWH). Dr. Malkin is the director of the Duke University Engineering World Health. This unique study abroad program allows undergraduates to study and work in developing world hospitals. Dr. Malkin is also the faculty advisor for CUREs, a non-profit business promotion program.

"I am honored that AIMBE selected me as a fellow. However, Engineering World Health has succeeded due to the efforts of hundreds of volunteers, students and professionals, engineers and technicians," Dr. Malkin says modestly of his award. "Thanks to their efforts, EWH has placed back into service in desperately poor hospitals many millions of dollars worth of medical equipment saving thousands and thousands of lives. The honor really belongs to our volunteers."

EWH began in 2001 with the vision of Dr. Robert Malkin and Dr. Mohammad Kiani, then professors in Memphis, Tennessee. Appalled by hospital conditions he encountered during his travels to Nicaragua, Malkin set out to create a charitable organization that could harness the resources of collegiate engineering programs for the improvement of conditions in hospitals of developing nations.

Robert A. Malkin, PhD, Professor of the Practice of Biomedical Engineering at Duke University and Director of Engineering World Health (EWH)

Today, Engineering World Health has bloomed into a national organization with chapters at schools around the country. Since the announced partnership with Duke University in 2004, EWH has continued to expand and create new initiatives, including the CUREs program and the Design for the Developing World class being taught currently at Duke.

For more information on EWH please visit www.ewh.org

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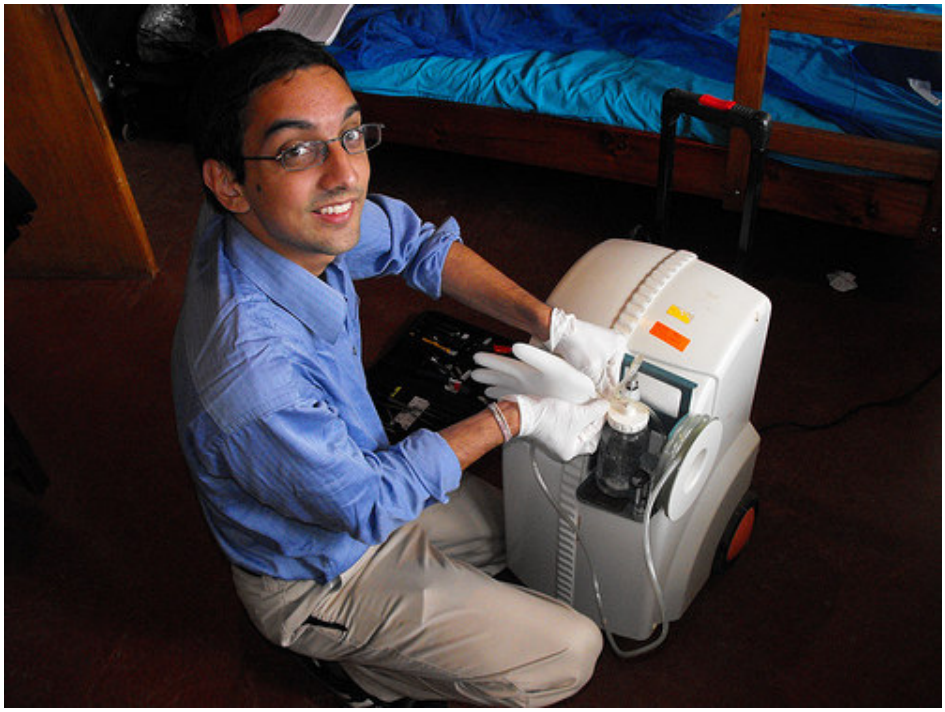

EWH student Chris Withers repairing an oxygen concentrator in Machame hospital in northern Tanzania, on the slopes of Mt. Kilimanjaro.

Perspectives from ECRI Institute:

Jim and Daniel Keller's Travels to Hong Kong

I recently had the pleasure to travel to Hong Kong to provide a full-day seminar on medical technology and patient safety for the Hong Kong Hospital Authority. The Hospital Authority is the statutory body responsible for managing all of the public hospitals and clinics in Hong Kong. ECRI Institute provides the Hospital Authority and its 41 hospitals with membership in our SELECTplus healthcare technology advisory service, a custom version of our SELECTplus membership Web site, and occasional on-site training on a variety of medical technology issues.

This was my second trip to Hong Kong. My previous visit was during 2006 when I provided a similar seminar for the Hospital Authority. It was nice to have an opportunity to visit Hong Kong again, but this year's trip was extra special because I was able to bring my 16 year-old son Daniel along. My seminar covered ECRI Institute's list of top ten health technology hazards, new and emerging safety technologies like infusion pump dose error reduction systems, hazard and recall management, and the impact that the convergence of medical devices and information technology will have on patient safety. The seminar attendees included a mix of about 200 nurses, physicians, administrators, and clinical engineers from many of the Hospital Authority's 41 hospitals.

I was honored to have Joel Nobel, M.D., ECRI Institute's founder and President Emeritus and Jin Lor, Regional Director of ECRI Institute's Southeast Asia office join me for the seminar. Dr. Nobel was instrumental in setting up the ECRI Institute membership program for the Hospital Authority, which was driven by its strong commitment to quality and patient safety. Check out the link below to the Hospital Authority's excellent Web site if you'd like to learn more about Hong Kong's public healthcare system. http://www.ha.org.hk/visitor/

Jin Lor and I also had a meeting with senior staff from the Hong Kong Department of Health's Medical Device Control Office. The Medical Device Control Office is the regulatory arm for medical devices in Hong Kong. The Medical Device Control Office recently established the Asian Medical Device Nomenclature System (AMDNS) which will be used in the Department of Health's Medical Device Administrative Control System for product descriptions and identifications. AMDNS is derived from ECRI Institute's Universal Medical Device Nomenclature System (UMDNS).

The Medical Device Control Office is located in the 64-story Hopewell Centre in Wan Chai on Hong Kong Island. The Hopewell Centre was Hong Kong's tallest building until the 1980's and has an impressive revolving restaurant on its 62nd floor. My son Daniel, Jin Lor, and I were treated by the Medical Device Control Office staff to "high tea" in the revolving restaurant which offered some amazing 360 degree views of Hong Kong.

Hong Kong is a wonderful place to visit. Daniel and I had several days to tour around the city after my presentations and business meetings. We were driven to the border between Hong Kong and Mainland China by Roger Lai, a friend and colleague who recently retired as Director of the Hong Kong Electrical and Mechanical Services Department. We took the 3.4 mile Ngong Ping cable car to see the ten-story high Tian Tan Buddha statue (also known as Big Buddha) and the Po Lin Monastery. The cable car ride offered spectacular views of Tung Chung Bay and the surrounding islands and skyline of Hong Kong. We also swam at a wonderful beach on the South China Sea at Repulse Bay on Hong Kong Island.

Daniel and I finished up our trip with a 45 minute ferry ride to a fishing village on Cheung Chau Island, which has reportedly been inhabited since the mid-1300s. The island is home to about 30,000 people but amazingly has no cars. Bicycling is the main mode of transportation. Daniel and I had a great time on rented bikes checking out lots of beaches and taking in some amazing views of the island from a lookout point called Beitiao Pavilion about 300 feet above the main part of Cheung Chau's fishing village. We strongly recommend a trip to Cheung Chau Island if you get a chance to visit Hong Kong.

Jim Keller

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Jim Keller, shown checking out the views on Cheung Chau Island in Hong Kong, is ECRI Institute's Vice President for Health Technology Evaluation and Safety and a past Member at Large for ACCE's Board.

The View from the Penalty Box: Speakout!

As I enjoy the only two months of the year when professional hockey is not being played, I have come to the conclusion that the season is too long. When I played, the season was 72 games with a maximum of 14 in the playoffs and we were done by the end of March. Now it is 84 games with up to 28 in the playoffs and they are lucky to be done by the middle of June. I do have to say that it is difficult to enjoy a hockey game when the temperature outside is in the 90's.

Like so-o-o-o many things people think that more is better. With the "more is better" mind set, the Centers for Medicare and Medicaid Services (CMS) is proposing that high-end device utilization must be 90% or above to get reimbursed. Just think of all the questions this raises that we have pushed over the years to the OEM's on the "guaranteed up-time" wording in service contracts with little or no satisfaction. To my simple brain the 90% is 21.6 hours per days for 365 days. To others, it may be 7 hours a day for 5 days a week. I hope that CMS provides a good definition of the 90% rule and that we apply that definition to all our equipment. We truly need the one set of rules and regulations, not the hundreds that seem to be floating around, and they should be published and provided to us at no charge.

Hopefully all of you have been following the debates over healthcare reforms. One very common theme seems to be in everyone's package, "what is best for me and my group". The theme should be what is best for the patient. If we truly care about the patient first then we will have a common electronic medical record system, we will have a common billing system where only one form is used, we will have the correct information on what drug or treatment works and most of all we will have affordable insurance rates. Also, have you noticed that so many of the published position papers are written by "experts" in academia, legal, political and financial fields with little or no hands-on experience in healthcare. Many of these are the same "experts" that brought us the financial problems, high unemployment and a slumping economy. But generally we cannot complain since we, clinical engineers, seem to have chosen, again, not to raise our voices and give our opinions on what we feel should be done. We need to get involved. Please, at least write a letter to the editor of your local newspaper giving your views on the healthcare reforms. Also, when a politician shows up in your town or hospital talk with them about healthcare, bringing them your thoughts and concerns which are probably very different from what they've heard in the past.

Some of you might have seen information coming out of Texas that they were, or are, (it is not quite clear to me where it stands), trying to license people that work on medical devices. It was interesting that much of the opposition was coming from people currently doing the work. If you need a license to groom a dog shouldn't you have one if you are working on life support equipment? What is the position of the ACCE on this? At some point we will need to face some sort of licensing or certification to practice our profession so shouldn't we have a say in what happens and when? We tried it here in Massachusetts some 30 years ago but it never got out of committee in the legislature as we as a profession did not have a great enough number of people to support a registration system It was about money, not patient care, then as it is now.

This is a request to our officers. Please consider nominating members of ACCE to serve on FDA Advisory panels. If we take a "consumer" spot on the panel our costs would be covered and there would be a stipend for each day of service, generally about 4 per year. This is a simple process and we actually might get our voices heard if we get the appointments, our collective expertise is needed now more than ever.

Lastly I would like to congratulate Tobey Clark on receiving the Morris Award at the AAMI meeting;. This is a well deserved honor for Tobey and all the support he has given to the international efforts of the ACCE.

I hope your summer is great.

Dave Harrington

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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

Baltimore CCE Review Course Completed

On June 4th and 5th, immediately preceding the recent AAMI conference in Baltimore, ACCE conducted a CCE examination review course that was attended by eleven clinical engineers.

The course was designed and presented by the following faculty of experienced certified clinical engineers: Robyn Frick, CCE, (Manager, Clinical Engineering, Eastern Maine Medical Center, Frank R. Painter, MS, CCE (Director, Clinical Engineering Program, University of Connecticut), Arif Subhan, MS, CCE (Senior Clinical Engineer Masterplan (Course Director), James Welch, CCE (Vice President, Systems Engineering , Masimo Corporation), David Wilder, MSEE, MSM, CCE (Director, Clinical Engineering & Technology Southcoast Hospitals Group), and adjunct faculty Ismael Cordero, (Senior Clinical Engineer, ORBIS).

The course provided an overview of the 2009 CCE examination topics which are based on the Clinical Engineering Body of Knowledge (BOK) survey conducted recently. The course helped the students identify areas in which they need further review and help in preparing for the CCE examination while providing an opportunity to meet other candidates to form study groups. The course materials included PowerPoint presentations, a mock written exam questions, sample questions for the oral exam, and suggested references for further study.

The participants had very positive things to say about the course. The words of Miguel Narvaez, Biomedical Engineering Manager at The Scarborough Hospital in Scarborough, Canada, characterizes the feedback provided:

"Thank you very much for the great CCE Review Course which ACCE put together with a team of very professional instructors. I truly believe that attending this course enriched my professionalism and expanded my horizon.. It encouraged me to always excel in the field of clinical engineering and to deliver the best service, safety and efficiency for the benefit of the patient. Once again thank you to the team of instructors, your efforts are truly valued and appreciated."

ACCE thanks the Baltimore Veterans Affairs Medical Center for kindly providing the room for the course.

Ismael Cordero

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CCE Preparation Course students, with course director Arif Subhan (front center), take a break from their studies

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

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www.accenet.org

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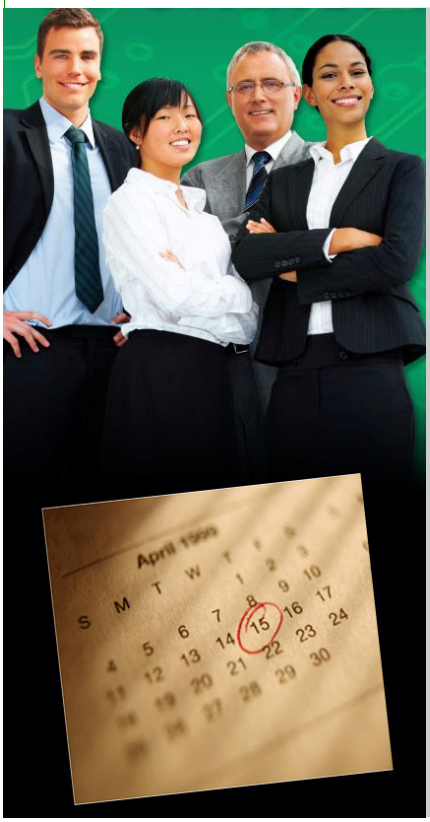

Calendar of Events

August 20, 2009
How to Prepare for the Certified Biomedical Equipment Technician (CBET) Exam

September 4, 2009
Medical Devices 101, An Educational Forum
FDA Medical Device Industry Coalition
Houston Texas

September 10-11 2009
Inaugural Medical Device Connectivity Conference & Exhibition
Harvard Medical School, Boston, MA.

September 7-12, 2009
Medical Physics & Biomedical Engineering
World Congress 2009
Munich, Germany

September 17, 2009
NFPA 99 changes Affecting Clinical Engineering

October 15, 2009
IEC 80001 Application of risk management for IT networks incorporating medical devices

November 7, 2009
CCE Exam
28 cities in US

November 19, 2009
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