

# THE ASA M SENSOR

Volume 2, Number 2

April 1992

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THE QUARTERLY NEWSLETTER OF THE  
AMERICAN SOCIETY OF ANESTHESIA TECHNOLOGISTS AND TECHNICIANS

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## *President's Message ...*

*by Dennis McMahon*

Organizations, like individuals, grow and develop with the help of people whose influence we often never fully appreciate. I have the sad duty to report to you the loss of one such person. Jami Blue, Chief Anesthesia Technician at the University of Colorado Health Sciences Center in Denver and Director of our Region 5, passed away March 10th. Jami was one of the founding members of this Society. Before coming to U of C in 1988, she was Senior Technician at Children's Hospital in Denver. She participated in the first discussions on a national society for anesthesia technicians, and she was there in New Orleans when the ASATT was formed and when regions were established. She accepted the role of director for her region, and also organized the Colorado Society. (She and her sister Jill designed the present Society logo.) She also directed the seminars in anesthesia technology at Breckenridge and Vail in '90, '91, and '92.

Jami will be missed, and we intend that she not be forgotten. At the ASATT Directors meeting in May, we will discuss a means by which Jami's contributions to the Society will be commemorated.

This issue of the *Sensor* includes the results of the annual membership survey. Our roster has almost doubled

over the past twelve months, and our increased membership is accompanied by a shift in some categories, most notably in the scope of duties. Perhaps most encouraging is the increased proportion of members reporting training in formal inservices or at manufacturer schools. The Society continues to encourage formal training in our specialty, and we hope to see further increases in these categories each year. The Education Committee and I thank everyone who responded to the survey.

Thanks also to the members who took the time to vote on the Bylaws amendments. The results are published on page three of this issue. This "fine-tuning" of our structure will ultimately enable us to meet our objectives more efficiently. Almost all the amendments were approved, and a copy of the revised Bylaws will be sent to each member early this summer, when ballots will be mailed for election of Directors.

Nominations are being solicited for six of the seven Regional Director positions. As discussed and agreed upon at the last business meeting, three of the seven positions open in 1992 will be for a one-year, rather than a two-year term, in order to stagger the

Director terms thereafter. Staggered terms for the directors will provide a smoother transition of the leadership in the coming years. Please consider nominating a qualified candidate for Director of your region - yourself or a member you know.

The Society's Training Guidelines are being revised, and will also be sent out within the next three months. An important addition will be a suggested reading list, to support informal as well as formal continuing education in our specialty.

We have had an excellent response to our video tape loan program - so good that we have not been able to meet all requests. We hope to have a second complete set of the tapes through the generosity of the Burroughs-Wellcome Company, and should soon be able to meet demand. Bear with.

Finally, begin making plans now for the annual ASATT Educational Program and Meeting in New Orleans, in October. This year's conference will feature both lectures and workshops, and should be the best yet. We plan a program that sends everyone home a bit more proficient in our specialty. Jami would appreciate that.

## 1991-1992 ASATT OFFICERS:

### President

Dennis McMahon  
Virginia Mason Medical Center  
Seattle, WA  
206 223-6980

### Vice President

George Mann  
SUNY - Health Science Center  
Syracuse, NY  
315 464-4640

### Secretary

Chris Patterson  
San Jose Medical Center  
San Jose, CA  
408 977-4500

### Treasurer

Lee Amorin  
Harborview Medical Center  
Seattle, WA  
206 223-3055

## 1991-1992 REGIONAL DIRECTORS:

### Region 1: ME,NH,VT,MA,RI,CT,NY,NJ

Alberto Gonzalez  
St. Luke's Roosevelt Hospital  
New York, NY  
212 523-6139

### Region 2: PA,MD,OH,IN,MI,VA,WV,DE

Ricki Kallish  
Children's Hospital of Philadelphia  
Philadelphia, PA  
215 590-2798

### Region 3: KY,TN,NC,SC,AL,GA,FL

Geoffrey Bright  
Shands Teaching Hosp,  
Univ of Florida  
Gainesville, FL  
904 395-0077

### Region 4: WI,IL,MO,MN,ND,SD,IA

Dean Rux  
Marshfield Clinic  
Marshfield, WI  
715 387-7179

### Region 5: CO,NE,KS,OK,LA,AR,MS

Lee Amorin (*interim*)  
Harborview Medical Center  
Seattle, WA  
206 223-3055

### Region 6: CA,NV,UT,AZ,NM,TX

Chris Patterson  
San Jose Medical Center  
San Jose, CA  
408 977-4500

### Region 7: WA,OR,ID,MT,WY,AK,HI

Lee Amorin  
Harborview Medical Center  
Seattle, WA  
206 223-3055

## NEWSLETTER EDITOR:

Paul Faupel, Jr  
Childrens Nat'l Medical Center  
Washington, D.C.  
202 745-2015 (work)  
202 939-5999 (fax)  
301 598-2949 (home)

## The View From...

### VALLEY MEDICAL CENTER, Renton, Washington

by Don Millbauer,  
Anesthesia Coordinator



Valley Medical Center is a 303-bed hospital located in Renton, Washington. We serve and are operated by Public Hospital District #1, which includes the cities of Renton, Kent, and other suburban areas south of Seattle.

The Anesthesia Department, along with the O.R., PACU, Out-Patient Surgicenter, and Endoscopy make up Surgical Services at Valley. Surgical Services is a division of the Nursing Department and our director is an RN. We operate eleven of twelve available O.R.s, and have three more in our Birthcenter. We average 1100 cases per month, of which 60% are outpatients. An additional 60 cases per month are done in the Birthcenter O.R.s. Types of surgeries performed at Valley include everything except open heart and transplant procedures. In 1992 we will open a new three-O.R. Day Surgery to be located across the street from the hospital. Its focus will be surgery for eyes, ENT, and GYN.

Our Anesthesia Department is staffed by sixteen anesthesiologists, fourteen of whom make up Valley Anesthesia Associates, or VAA. VAA employs ten CRNAs, and a positive working relationship exists between them. Typically, CRNAs at Valley are able to practice within the full scope of their training, with each one being supervised by an anesthesiologist. There is a staff of nine anesthesia support personnel split between the day and evening shifts. The staff includes the coordinator, two technicians, four assistants, and two secretaries. We staff the department between from 6:30 am until 11:00 pm. One tech or assistant is scheduled to work on Saturdays, when we run a limited schedule, and that person takes call on Sunday when no cases are

scheduled. Weekend duty is rotated between all techs and assistants.

As coordinator, I'm responsible for overseeing the department's operations, including materials management. Although I'm a hospital employee, I report to both the Chief of Anesthesia and the Director of Surgical Services.

Although we promote teamwork among the anesthesia support staff and our duties overlap, each job has its own specialty. Anesthesia technicians are new to Valley this past year. Besides the usual turnover, supply, and equipment duties, our techs provide hands-on assistance to the anesthesiologists. They're experienced with invasive monitoring, difficult intubations including the fiberoptic laryngoscope, and setting up for complicated anesthetics. They also have expertise in operating and troubleshooting our monitors, anesthesia machines, and other equipment. In 1992, they will be certified to give IV medications under the supervision of an anesthesiologist. The anesthesia assistants are the experts in turnover, supply, and equipment cleaning. Our secretaries do all the data entry for patient billing as well as schedule our Outpatient Pain Clinic procedures. They are also the hub of communications for the department. All the anesthesia support employees are represented by Service Employees International Union, Local 6, although membership is not required.

Our anesthetizing stations are equipped with Drager anesthesia machines in a combination of NAD 2's, 2A's, and 2B's. The older 2's and 2A's were retrofitted this past year with ascending ventilator bellows. New this year are Hewlett-Packard "Merlin" monitors mounted on

*continued on page 5*

## RESULTS OF PROPOSED BYLAWS AMENDMENTS

Total ballots received:	131
Disqualified ballots:	
postmarked after 3\1\92:	10
received without signature:	5
Qualifying ballots:	116.

A 2/3 majority (or 78) affirmative vote necessary to pass each amendment.

	YES	NO	ABSTAIN
<b>Article III: Membership:</b>			
Sec B-2: deleted paragraph	74	8	34
Sec C-1: changes application for membership	102	11	3
Sec D-1: changes determination of eligibility	100	14	2
<b>Article V: Voting:</b>			
Sec D-1: defines majority as "simple majority"	101	13	2
<b>Article VII: Board of Directors:</b>			
Sec A-1: changes office of Vice-President to Vice/President-Elect	106	7	3
Sec F-1: no salary for services to Directors, officers, committee members	93	21	2
Sec F-2: allows reimbursement to Directors, officers	113	2	1
Sec F-3: allows reimbursement to Directors for meeting travel	102	13	1
<b>Article VIII: Officers:</b>			
Sec A-G: changes office of Vice President to Vice/President-Elect	107	5	4
<b>Article IX: Elections:</b>			
Sec B-2: changes voting time	105	6	5
Sec B-3: changes majority vote	106	6	4
Sec C-1: provides for office of Vice/President-Elect	105	7	4
Sec C-2: changes election of Secretary and Treasurer to Board Meeting	100	11	5
Sec D-1: changes Vice President to Vice/President-Elect	100	11	5
<b>Article X: Meetings:</b>			
Sec D-1: defines majority as "simple"	101	10	5
<b>Article XI: Committees:</b>			
Sec B-1: changes Vice President to Vice/President-Elect	105	6	5
<b>Article XVI: Amendments &amp; Review:</b>			
Sec A-1: amendment submission from 120 to 60 days	94	12	10
Sec A-2: changes format of proposals to members	106	5	5
Sec A-3: defines majority as "simple"	103	7	6
Sec A-4: provides reporting of ballot results	112	0	4
Sec A-5: stipulates amendments effective Jan. 1 each year	111	0	5

All accepted changes become effective 1 April 1992.

Questions: please contact Lee Amorin, Chairman, Bylaws Committee at 206 223-3055.

## TECHNICALLY SPEAKING ...

by Wes Simpson II, San Diego, CA

*Quite often when sifting through the literature, you come across articles that seem a little too cerebral in style and content to be readily comprehensible. It seems that certain journals, by the nature of their primary readership, encourage this style. Other journals seem to encourage articles which better reflect the world we all work in. For this reason, some journals are cited more frequently in this column than others.*

Banner TE & Gravenstein JS: Comparative effects of cuff size and tightness of fit on accuracy of blood pressure measurements. *Journal of Clinical Monitoring*, 7:4, 281-284, October 1991.

*This study of six subjects concludes that selection of an appropriate size blood pressure cuff is of greater importance to accurate measurements than is applying the cuff too loosely or snugly. Optimal snugness of cuff fit is difficult to determine. Differences in algorithms used by the various manufacturers may cause variable results.*

Palve H: Reflection and transmission pulse oximetry during compromised peripheral perfusion. *Journal of Clinical Monitoring*, 8:1, 12-15, January 1992.

*This study compared the accuracy and reliability of reflection vs transmission pulse oximetry probes in situations where cardiac index, peripheral temperature, pulse pressure, and systolic pressure are low and SVR is high. Measurements were obtained prior to, during, and after extracorporeal circulation for cardiac bypass surgery. The author concludes that a reflection sensor on the forehead is a suitable site for monitoring SpO<sub>2</sub> in patients with poor peripheral pulsatile perfusion.*

Wright JG, McGeer AJ, Chyatte D, Ransohoff DF: Mechanisms of glove tear among surgical personnel. *Journal Amer Med Assoc*, 226:1668-1671, 1991.

*Data was collected from operating room personnel over a three month period, involving a variety of surgical procedures. The results showed that most glove tears (failures) are unrecognized or caused by an unknown mechanism. Double gloving is encouraged.*

Gonzalez AA: Building a collaborative work culture. *Survey of Anesthesiology*, 36:1, February 1992.

*Explores stress factors in the operative setting, different personality styles and coping mechanisms, and how these can be integrated into a collaborative work environment.*

Waring PH & Vinik HR: A potential complication of the Patil-Syracuse endoscopy mask. *Anesth Analg*, 73:5, 668-676, 1991.

*Describes the potential for the formation of a foreign body caused by a ruptured diaphragm. Cautions that both fiberoptic and diaphragm should be generously lubricated before use, and the integrity of the diaphragm should be verified before advancing the endotracheal tube.*

Campbell C, Viswanathan S, Riopelle JM, Naraghi M: Manufacturing defect in a double lumen tube. *Anesth Analg*, 73:6, 825-826, 1991.

*Describes blockage of one side of a double-lumen endobronchial tube. Urges that patency of both lumens should be assured to intubation.*

Ley SJ & Jones BR: Strength of continuous spinal catheters. *Anesth Analg*, 73:4, 394-396, 1991.

*Compares the breaking strength of currently marketed continuous spinal catheters. Discusses differences between spinal and epidural catheters. Concludes that spinal catheters have only one-third to one-half the break resistance of commonly available epidural catheters, and that most manufacturer claims are overstated.*

Zacher AN, Zornow MH, Evans G: Drug contamination from opening glass ampules. *Anesthesiology*, 75:6, 893-895, 1991.

*Recommends that rubber-stoppered vials replace glass ampules whenever possible. Concludes that when glass ampules are a necessity, the neck should be wiped with alcohol before opening to reduce potential bacterial contamination.*

Gross JB: Book Review: "Studying a study and testing a test: How to read the medical literature." *Anesthesiology*, 75:6, 1128, 1991.

*According to the reviewer, provides clear, concise answers to questions of study design, analysis, and interpretation. Enables the reader to look at medical literature with discernment. Particularly useful since many manufacturers' claims are based on what the studies "prove".*

Reynolds KJ, DeKouk JP, Tarassenko L, Moyle JTB: Temperature dependence of the LED and its theoretical effect on pulse oximetry. *British Journal of Anaesthesia*, 67:638-643, 1991.

*This study investigates the effects of ambient temperature changes on the light-emitting diode (LED) within the spectrum used for pulse oximetry. Demonstrates temperature shifts within the 0 to 50 degree C range produced negligible differences in the accuracy of SpO<sub>2</sub> readings. Concludes that inaccurate readings are far more likely to be caused by changes in peripheral perfusion, rather than temperature sensitivity of pulse oximeter probes.*

Beydon L, Isabey D, Boussignac G, Bonnet F, Duvaldestin P, Harf A: Pressure support ventilation using a new tracheal gas injection tube. *British Journal of Anaesthesia*, 67: 795-820, 1991.

*Describes a new modification of an endotracheal tube (Porges) that may offer significant safety advantages over current jet ventilation tubes.*

## The View From...

continued from page 2

all our Drager machines. We use the Merlins to monitor EKG, NIBP, invasive BP, temperature, and cardiac output. It also has software for ST segment analysis, hemodynamic calculations, and tabular and graphic trends on all monitored parameters. We use Nellcor N-100's for pulse oximetry and capnometry monitoring. We're budgeted for Nellcor N-1500 agent analyzers for every station early in 1992. Currently, our cell-saver needs are met by an outside contractor. We hope to have our own by 1993. With the exception of our

equipment still under warranty, all repairs and preventative maintenance, including the Drager machines, are done by our responsive Biomed Department. We're a busy and growing department, as is the hospital. Because we don't have open heart cases, and have a higher percentage of out-patients, we don't do much heavy monitoring. Thus, we need only one anesthesia technician on each shift. Although the technicians and I are relatively new to Valley, we have a seasoned group of assistants. Our CRNA's are well respected too. The

medical staff has grown in recent years with anesthesiologists fresh from local residency programs.

We are not a large teaching hospital or trauma center, but we are not an ordinary community hospital either. We have all the latest technology, and handle those exciting cases when they come. The staff is dedicated and our attrition rate is negligible. The hospital values its employees, and we're treated well. The administration has a "big family" philosophy, and we're not too big to make it work.

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### ANESTHESIA TECHNICIAN SUPERVISOR in SUNNY WEST FLORIDA

...needed for Anesthesiology Department  
in a 1000-bed hospital.

Challenging clinical environment;  
active program in hearts,  
and in liver- and kidney-transplants.  
State-of-the-art equipment.

*Responsibilities include  
development of a training program for  
anesthesia technicians, supervision of  
technicians, and inventory management.*

Qualifications:

5 - 7 years anesthesia technician  
experience.  
3 - 5 years supervisory experience.  
1 - 2 years college or technical  
training in a related health care  
related field preferred.

*Salary commensurate with experience and  
training; excellent benefit package.*

Contact: Susan Audrain,  
Administrative Director  
(813) 251-7206  
Department of Anesthesiology  
Tampa General Hospital  
P.O. Box 1289  
Tampa, FL 33601

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### ANESTHESIA TECHNICIAN SUPERVISOR

The Department of Anesthesia at San Francisco General Hospital seeks a hospital Lab Tech II Supervisor for our Anesthesia workroom.

*Duties include supervision and ongoing  
evaluation of three anesthesia assistants,  
recruitment when vacancies occur, review of  
supply inventory, review of equipment and  
supply budget, drug ordering and outdating,*

*equipment preventative maintenance and  
repair, calibration of instruments, setting up  
IV's and fluid warmers, and assisting  
anesthesia staff in difficult cases as time  
permits. Job also involves interfacing with  
various departments such as biomedical  
engineering, respiratory therapy, and  
purchasing, and outside manufacturers and  
sales representatives.*

Send resume to:

Bryan Andrews, M.D.  
Dept of Anesthesiology, Room 3S-50  
San Francisco General Hospital  
1001 Potrero Avenue  
San Francisco, CA 94110

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### POSITION DESIRED

Technical specialist in Anesthesia desires  
challenging position in a medical center  
setting.  
Former Chief Technician of large Upstate  
New York medical center, with seven years  
experience in anesthesia, solid background

in purchasing, inventory, and materials  
management. Factory trained service  
technician for gas delivery systems.  
Eighteen years experience in the medical  
field. Salary commensurate with experience.

Send inquiries to:

N.Y.S.A.T.A.  
Technical Applicant  
P.O. Box 18215  
Rochester, NY 14618-0215

# RESULTS OF THE 1992 ASATT MEMBERSHIP SURVEY

## VALIDATION:

Participation: Mailing = 459 Returns = 137 Proportion = 30%

Participation by Region:	Membership:	Returns:
Region 1:	15%	16%
Region 2:	25%	22%
Region 3:	15%	16%
Region 4:	18%	13%
Region 5:	5%	8%
Region 6:	14%	16%
Region 7:	7%	8%

## INDIVIDUAL DATA:

Age:	Average: 38.9	Max: 60	Min: 20
Sex: Male: 50.7%      Female: 49.3%			
Years worked as an anesthesia tech:	Average: 7.4	Max: 25.5	Min: 0.5
Current Salary (annualized):	Average: \$26,254	Max: \$54,000	Min: \$12,528

## WORK SETTING:

Number of anesthetizing locations:	Average: 13.6	Max: 42	Min: 2
Number of anesthetics annually:	Average: 9700	Max: 30000	Min: 1000
Number of anesthesia technical personnel:	Average: 4.5	Max: 18	Min: 1
Averaged anesthetics annually per tech: 2111.8			
Averaged anesthesia locations per tech: 3.1			
Levels of anesthesia technical personnel:	Average: 1.8	Max: 5	Min: 1

Employee of a hospital: 90.4%	Employee of a group: 5.9%	Both: 3%
Membership in a work-related union?	Yes: 11%	No: 89%

Who is in direct charge of the techs?	MD anesthesiologist:	48.5%
	CRNA:	16.9%
	O.R. Nursing Supervisor:	19.1%
	Other:	15.4%

## TRAINING & CERTIFICATION:

Highest degree earned:	Certification or Licensure:
H S diploma:            59.9%	RN:                            4.4%
AA/AS:                    21.2%	LPN/LVN:                    12.4%
BA/BS:                    15.3%	CBET/BMET:                3.6%
MA/MS:                    3.6%	ORT:                         5.1%
	RRT:                         2.2%
	CCVT:                        1.5%
	Other:                        13.5%

Where have you received training as an anesthesia tech? (composite)

On the job, informally: . . . . .	82.5%
On the job, formal inservices: . . . . .	51.8%
Technician seminars: . . . . .	42.3%
Manufacturer classes: . . . . .	31.4%
Active military: . . . . .	9.5%

Does your employer provide funding for educational meetings?

Yes: 73.1%      No: 26.9%

Outside of work, did you attend any anesthesia technical seminar in 1991?

Yes: 64.2%      No: 35.8%

## DUTIES: (composite)

Supervise others: . . . . .	51.1%
Clean anesthesia machines & equipment: . . . . .	90.1%
Maintain supply levels . . . . .	97.7%
Prepare IV set-ups: . . . . .	84.7%
Perform IV placements: . . . . .	23.7%
Prepare pressure transducer set-ups: . . . . .	90.1%
Calibrate pressure transducer set-ups: . . . . .	83.2%
Prepare arterial line set-ups: . . . . .	85.5%
Perform arterial line placements: . . . . .	15.3%
Prepare CVP set-ups: . . . . .	77.9%
Assist with CVP placements: . . . . .	68.7%
Assist with Swan-Ganz catheter placements: . . . . .	71.8%
Operate cell-saver: . . . . .	22.1%
Operate ECMO: . . . . .	6.1%
Assist with intubations: . . . . .	76.3%
Prepare regional anesthesia set-ups: . . . . .	72.5%
Assist with regional anesthesia procedures: . . . . .	66.4%
Support pain clinic functions: . . . . .	38.2%
Mix pharmaceuticals (eg thiopental, nitroprusside): . . . . .	52.7%
Administer pharmaceuticals under supervision: . . . . .	35.9%
Perform blood gas analysis: . . . . .	32.8%
Perform hematocrits: . . . . .	40.5%
Perform blood clotting-time determinations: . . . . .	23.7%
Draw arterial blood samples: . . . . .	50.4%
Order in-house supplies: . . . . .	95.4%
Order outside supplies: . . . . .	80.2%
Meet with sales representatives: . . . . .	87.0%
Order capital equipment (>\$500): . . . . .	59.5%
Provide input for capital budgets: . . . . .	67.2%
Order pharmaceuticals: . . . . .	80.2%
Sign-out scheduled pharmaceuticals: . . . . .	38.2%
Perform preventative maintenance on anesthesia machines: . . . . .	64.1%
Repair anesthesia machines: . . . . .	34.4%
Trouble-shoot monitoring equipment: . . . . .	93.1%
Repair monitoring equipment: . . . . .	38.2%
Clean/maintain fiberoptic bronchoscopes: . . . . .	87.0%
Assist with fiberoptic intubations: . . . . .	69.5%
Assist/operate intra-aortic balloon pump: . . . . .	7.6%
Maintain a mass spectrometer: . . . . .	23.7%
Other duties involving >10% of time: . . . . .	29.8%

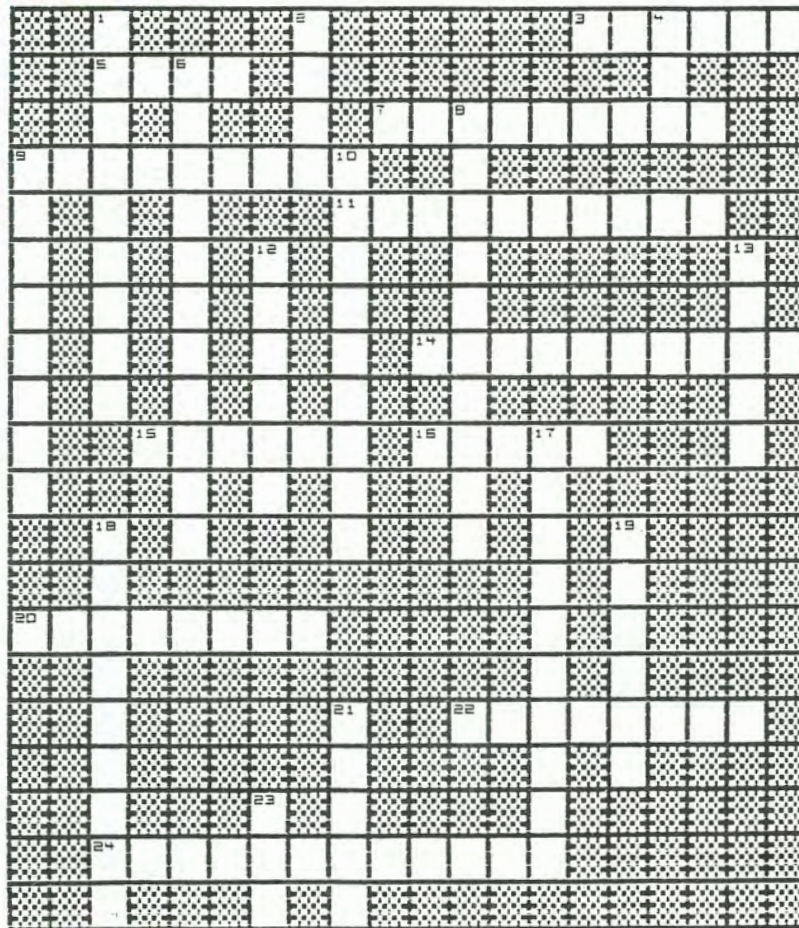
### Notes:

- > *Salaries* The broad range here reflects the diversity in duties, formal education, and experience, in that order of effect.
- > *The ratios of anesthetics per year to technicians, and of anesthetizing location to technicians,* are consistent with previous surveys of this type. But they do not allow for technician duties; eg an employer whose techs support open hearts, transplants, or trauma generally involve more technician support.
- > *Reporting relationships* show a change from last year, probably due to a shift in the work setting of the typical member, as well as increased membership. "Others" listed were O.R. directors, biomedical engineers, and administrators.
- > *Certification and licensure* numbers are generally consistent with previous surveys, and with duties reported on individual returns. "Other" included certifications as nursing assistants, emergency medical techs, and a variety of laboratory and pharmacy credentials
- > *Training* reports show a decided increase in the membership benefitting from formal (vs informal) inservices, as well as training at manufacturer schools.
- > *Duties* reported are generally compatible with last year's survey in most areas, but show an increase in responsibilities with specialty technology (eg cell-savers, ECMO, blood-gas analysis). "Others" here included entry of patient charges and related bookkeeping, documentation for QA and QC, providing in-services, and participation in hospital committees.

The Society's leadership and committees all appreciate your response to this survey; these results are useful to every member to gain a perspective on our specialty, as well as to help focus the ASATT's efforts for everyone's benefit.

# TECHNICIAN

ANSWERS



## Answers to previous puzzle:

G  
 FDA  
 SLOWLY  
 A  
 S  
 WHITE  
 E  
 REGULATOR  
 P  
 X  
 TRANSPORTATION  
 E  
 L  
 F S TON GREY  
 I S S R E  
 F U DIAMETER L P  
 T R O C E L I  
 OXYGEN N U N OPEN  
 A R W  
 LIQUID BLUE  
 G D  
 LITERS

## MACHINE MAZE

### Across:

3. The Adjustable Pressure Limiting valve is often called the \_\_\_\_\_ valve.
5. Standards-setting organization that sets design standards for anesthesia machines (abbr).
7. SodaSorb and Baralyme are both a type of CO<sub>2</sub> \_\_\_\_\_.
9. Machine component that indicates delivery of each gas.
11. Respired gases flow from the patient to the absorber at the \_\_\_\_\_ valve.
14. Respired gases flow from the absorber to the patient at the \_\_\_\_\_ valve.
15. The point at which the machine delivers fresh gas to the absorber is the common gas \_\_\_\_\_.
16. The \_\_\_\_\_ in the check-valves on the absorber must always open and close freely.
20. There should always be a \_\_\_\_\_ for each gas on an anesthesia machine.
22. In the \_\_\_\_\_ Index Safety System, gas supply connectors are specific to one gas.
24. Besides oxygen, \_\_\_\_\_ is supplied on virtually all anesthesia machines.

### Down:

1. Machine component that provides anesthetic agent to the carrier gas mixture.
2. Machine component that secures the gas cylinders on an anesthesia machine.
4. In the \_\_\_\_\_-Index Safety System, a cylinder of only one specific gas can be attached.
6. In contrast to earlier models, modern vaporizers maintain their accuracy despite variations of flow and of \_\_\_\_\_.
8. System that manages the removal of waste gases from the anesthesia machine.
9. Misleading name referring to the Oxygen Supply Failure Valve and Alarm.
10. Machine component that reduces and controls gas supply pressures.
12. Type of valve used to control gas flow to the patient circuit.
13. Machine component that indicates each gas flow to the patient circuit.
17. Machine component that prevents back-flow from the patient circuit to the machine.
18. Oldest anesthetic agent currently in common use.
19. The "Link System" or "ORMC" are systems that assure that a minimally safe percentage of \_\_\_\_\_ is delivered at all flow levels.
21. The \_\_\_\_\_ valve is used to provide a brief, high delivery of oxygen to the patient circuit.
23. Gas that is not delivered by the machine, but is a component of the waste gases.

References: Petty C: *The Anesthesia Machine*. Churchill-Livingstone. 1987  
 Bowie E & Huffman L: *The Anesthesia Machine: Essentials for Understanding*. Ohmeda Corp. 1985



# 1992-1994 ELECTION GUIDELINES

for

## VICE-PRESIDENT and REGIONAL DIRECTORS

This letter contains the election nomination form for the 1992-1994 offices of Vice-President and all Regional Directors. Also included is the sequence by which the elections will be held until it's conclusion on September 18, 1992. The membership will be informed of the results of the elections in the October 1992 issue this newsletter, the SENSOR. The newly elected Vice-President and Regional Directors will take office at the annual meeting that is being held in New Orleans on October 17-19, 1992.

A member shall be eligible to hold office provided he or she has been an *active member in good standing* of the Society for at least *six, (6), months* immediately prior to the annual meeting or election to office. Any *active member* may nominate another *active member* who is eligible to hold office or they may declare themselves a candidate as long as they are eligible. Nominations for Regional Director must come from an active member who resides within that

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region. The candidates for Regional Directors must also reside within that region. All nominations must be made on the form at the bottom of this page and the *nomination must be received* by the elections committee no later than *May 12, 1992*. Any nominations received after this date will not be accepted.

As the nominations arrive at the elections committee, a notice will be sent to each nominee with instructions to notify the committee if they accept their nomination and if so, they will be instructed to supply the committee with a brief professional autobiography. The letter of acceptance, or rejection, of their nomination *must be received* by the election committee no later than *June 12, 1992*. Any letter received after this date will not be accepted for consideration.

The *voting ballots will be sent* in the July 1992 issue of this newsletter, the SENSOR, to all active members for their vote. The *ballots must be post-marked by September 4, 1992*. Any ballots post-marked after this date will not be counted.

Again, all ASATT members will be informed of the elections results in their October 1992 issue of this newsletter, the SENSOR.

Please complete the form below with your nomination, fold this form where indicated using the back as your return envelop.

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### ASATT OFFICIAL NOMINATION FORM

Print your name in ink . \_\_\_\_\_

Your category of membership . \_\_\_\_\_



Sign your name in ink to be valid . \_\_\_\_\_

Your membership number . \_\_\_\_\_

What region? \_\_\_\_\_

I nominate \_\_\_\_\_ for Vice-President.

I nominate \_\_\_\_\_ for Regional Director, Region # \_\_\_\_\_.

\* I am declaring myself a candidate for the position of: \_\_\_\_\_.

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stamp  
here

**ASATT Election Committee**  
**9805 N.E. 116th Street - Suite A183**  
**Kirkland, Washington 98034**

**REGIONAL SOCIETY ACTIVITIES ...** by Dianne Holley Let us announce what's happening in your area! Send a brief report of recent and future activities for the next issue by May 31st, 1992 to Dianne Holley, 3810 Tonkawa Trail, Austin, TX 78756; (512) 451-7457. Sends newsletters, if available, or even give your news on my answering machine. Photos are also welcome.

### California

The California Society of Anesthesia Technologists and Technicians is making final preparations for the 8th Annual Meeting and Educational Program to be held May 29-31 at the Monterey Convention Center. Neuromuscular blockade, airway gas monitoring, neuroanesthesia, and a half day autotransfusion workshop are among the topics to be covered. Attendees will also have access to the CSA exhibit hall with no additional registration or charge.

Association members are also considering bylaws to increase Regional Directors from 5 to 7, and will be holding elections for those positions in the near future.

For further information:  
Wes Simpson at (619) 749-7375.

### Colorado

The Colorado Society of Anesthesia Technicians held their annual seminar and ski-fest in Vail, Feb 29-Mar 2. The 2-1/2 day seminar emphasized anesthesia machine safety, troubleshooting, and checkout. The course was part of the University of Colorado's "Crash '92: Review of Anesthesia and Ski Holiday".

For further information:  
Ann Martin at (303) 270-8275.

### Florida

The third statewide meeting of the Florida Society of Anesthesia Technicians is being planned for late July or early August in Gainesville. Geoff Bright of Shands Teaching Hospital is coordinating this educational and business meeting, and may be reached at (904) 395-0077 for more details. Elections will also be held at the meeting.

For further information:  
Ed Vasquez at (407) 897-1529 [work],  
or (407) 823-7687 [home].

### Illinois

After a series of preliminary meetings over the past three months, the Illinois Society of Anesthesia Technology has been formed, with the enthusiastic support of the Illinois Society of Anesthesiologists. Growth in

membership has been brisk, and the first newsletter will be out soon. Their first statewide seminar is slated for November of this year.

For further information:  
Greg Alexander at (708) 355-6525 [home].

### New York

Plan now for the Anesthesia Technician Seminar and Workshop at the SUNY Health Science Center in Syracuse, April 25-26. The New York State Anesthesia Technology Association is branching-out with technicians found by a survey conducted by the state's anesthesiologist association. Plans are underway solicit memberships with major corporations. This is being accomplished by having obtained federal tax exemption upon organizing in 1990. Write or call for more information regarding obtaining this exemption for your society: NYSATA; P.O. Box 18215; Rochester, New York 14618-0215.

For further information:  
John Armstrong at (716) 275-5545 or  
George Mann at (315) 464-4640.

### Ohio

Recent meetings conducted by the Ohio Society of Anesthesia Technologists and Technicians included CPR training and certification in February and blood gas analysis and interpretation in March. Meetings are held on the fourth Saturday of each month. Regional meetings are being considered for Dayton/Columbus and Zanesville; details will be announced later.

For further information:  
Wilma Frisco at (216) 541-5710.

### Texas

The Texas Society of Anesthesia Technology met as a Board of Directors and as a regional mini-seminar in Dallas, March 28. This was in conjunction with the Texas Association of Nurse Anesthetists' annual meeting. Future regional meetings include one in San Antonio, tentatively in May, and West Texas (El Paso and possibly Lubbock). The second annual statewide meeting and seminar is scheduled for September in

El Paso. For further information:  
Dianne Holley at (512) 451-7457.

### Virginia

Historic Williamsburg, Virginia is the site of the Tri-State Anesthesia Tech Meeting, May 16-17, sponsored by the Virginia, Pennsylvania, and Maryland Tech Societies. The meeting is concurrent with the Central Atlantic Society of Anesthesiologists Annual Meeting. In addition, the Virginia Society of Anesthesia Technologists and Technicians will conduct their society's business during this weekend. Educational topics will include "Principles of Pulse Oximetry and Capnography", "Data Acquisition in the OR", "Update on Infection Control in Anesthesia", "Trouble-shooting Equipment", and "Monitoring of Coagulation by Thromblastography".

For further information:  
Linda Ferris (703) 985-8351 or  
Paul Faupel (202) 745-2015.

### Washington

The quarterly meetings of the Northwest Society of Anesthesia Technology have been changed to bi-monthly. The March 28 meeting was held in Bremerton, and details on the May meeting will be announced this month. The annual Seafair Meeting in Seattle is being planned for Saturday, August 1, in conjunction with the Washington State Society of Anesthesiologists.

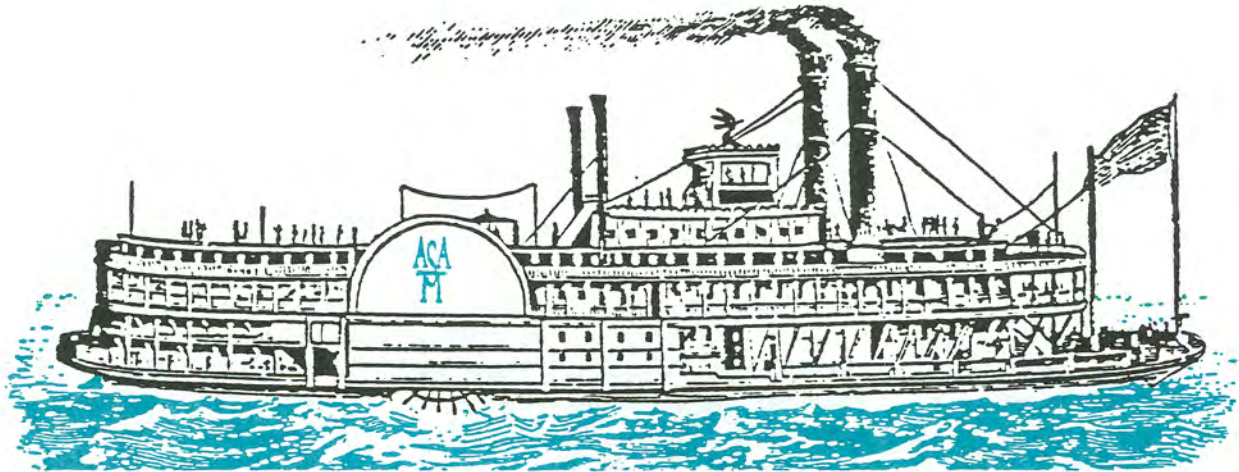
For further information:  
Dwight Shields at (206) 548-6510.

### Wisconsin

The officers of the Great Lakes Society of Anesthesia Technicians will meet this spring to work on bylaws and other society business. The first statewide meeting is scheduled for September 12-13 in Oshkosh, in conjunction with the statewide anesthesiologists annual meeting. The focus of the GLSAT meeting will be anesthesia machines, pulse oximetry and Critikon non-invasive blood-pressure monitors, and will include both lectures and "hands-on" workshops.

For further information:  
Dean Rux at (715) 387-7179.

LECTURES,  
WORKSHOPS,  
EXHIBITS,



AND ALL THAT JAZZ.

The **ASATT** Educational Program & Meeting  
New Orleans      October 17-19, 1992

**ASA** American Society of Anesthesia Technologists & Technicians  
**TM**

9805 N.E. 116th St. #A183, Kirkland, WA 98034