Volume 3, Number 3

July 1993

THE ASATT SENSOR

THE QUARTERLY NEWSLETTER OF THE

AMERICAN SOCIETY OF ANESTHESIA TECHNOLOGISTS AND TECHNICIANS

PRESIDENT'S MESSAGE ...

by George Mann

It is with deepest regret that I have accepted the resignation of Dean Rux, Director of Region 4. Dean has taken a supervisory position at Chandler Hospital, located in Chandler, Arizona. The Board of Directors and I wish Dean all the best in the world in his new job. A letter has been sent to all Region 4 members, in search of an Interim Director of Region 4. This position must be filled by the 15th of July, so that the new director can become familiar with the region and his/her duties. This appointment will be held until October, 1994.

Every organization seems to have the same problems. It seems that you have the strength in numbers, but you never have enough people that want to involve themselves with the everyday management of the organization. Elections are coming up and the number of candidates running for President-Elect or Regional Director is very limited. This is **your** organization, <u>you must become involved!</u>

October is fast approaching and the ASATT Annual Meeting is set to go. The exhibit is near completion and the hotel is ready. Now all we need are your registrations. Last year, in New Orleans, we reached our highest attendance (185). This year, let's set a goal of 240! To all East Coast technicians...this is the first time that the meeting has been held in our territory. Let's give the Society all the support we can and attend this meeting.

My year as President is almost over. The programs that we have started are doing great, but it will take the President-Elect, Lee Amorin, to see them through to their completion. Thanks for all the support. We are out of the baby stage and learning to walk on our own. Next stage: running!

Inside your Sensor:

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800-352-3575

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All submissions pertinent to the objectives of the ASATT will be considered for publication. Photographs, preferably black-&-white, are also welcome and will be returned.

Deadline for the next issue is September 1, 1993.

THE VIEW FROM...

THE UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER
DENVER, COLORADO

by Judith Drakiotes

The University of Colorado Health Sciences Center is a 393 bed multi-care facility. UCHSC has served the public since 1876, offering a wide span of care from specialty clinics such as AIDS treatment, high risk obstetrics, and vision services, to our very successful transplant services. Our transplant patients (heart, liver, and lung) are among the nation's highest survival group - a fact we are quite proud of.

The Department of Anesthesiology provides anesthetizing care for 10 main OR's, 2 short stay OR's, and Labor and Delivery. We currently have 7 Labor & Delivery Rooms and 2 fully equipped OR's in our obstetrics wing. During the next fiscal year, we will expand this wing, adding a total of 5 more Labor & Delivery Rooms.

Anesthesia Support Services at UCHSC are available five days a week, from 0530 to 2300. The level of performance of the techs in our department is quite high. Our day shift personnel start the IV's and if needed, the arterial lines for all patients awaiting surgery in the pre-anesthesia area. The technicians are assigned specific anesthesiologists, and coordinate their services accordingly. Other job duties range from room turnovers to assisting with Swans-Ganz placement. The staff is comprised of 3 clinically active technicians, and a workroom staff member, whose job is to stock supplies, assist in equipment/monitoring line set-ups, and generally to keep the room turnovers up to date.

Our department conducts regular inservices and training on new equipment, anesthetic complications, and techniques for improving the quality of our services. We recently sent a survey to all staff M.D.'s to gauge our effectiveness and level of expertise. In general, the responses were very favorable, and we obtained enough information to keep our inservice schedule full for quite a few months.

The entire Department of Anesthesiology is committed to supporting the role of the anesthesia technician, as is evidenced by our very successful Anesthesia Technician Course held in conjunction with the yearly "CRASH" seminars. We are always seeking ways to update this course. Another pet project will be the development of an anesthesia technician training course, following many of the guidelines of the ASATT.

As the president of our local society, I hope to foster a greater interest in the ASATT, and to encourage all technicians to become members at the local as well as national level. Our profession is rapidly expanding, causing us to constantly strive to put forth an ever higher level of care and support for our physicians and patients. It is this constant challenge that will enable us to grow, and to continue to be vital members of the Anesthesia Care Team.

TECHNOLOGY...

HANGING YOUR EQUIPMENT BY A THREAD

by Doug Draper
University of California, Davis Medical Center

If you do not make decisions about equipment purchases in your department, you most certainly should become involved in the decision-making process. In a myriad of medical equipment suppliers, there are numerous options available for each piece of equipment. This is particularly true when it comes to physiological monitors. At one time, state-of-the-art physiological monitors consisted of an ECG and one or more pressure channels. Today's physiological monitor can be configured with an infinite number of features. In fact, many companies can provide virtually all monitored parameters in one chassis. At UCDMC, every anesthesia site is configured to monitor:

-2 channels of ECG (usually lead II and lead V)
-3 invasive pressure channels (ART, CVP, and PA or ICP)
-NIBP (non-invasive blood pressure)
-pulse oximetry
-respiratory gases (O_2, CO_2, N_2O, N_2, and anesthetic agents)

It is now possible to purchase a single device capable of monitoring all the above parameters. Consolidation of features provides a number of advantages and one very **important disadvantage**. These new age monitors can capture data, display trends, and even create a complete electronic anesthesia record. This provides the anesthesia provider with the ability to view retrospectively any point in time. This feature is often misused, allowing some providers to be careless with their documentation. In major cases, traumas for instance, real time record keeping is not possible and retrospective review is useful for putting all the pieces together.

Unfortunately, virtually all manufacturers have elected not to design monitors for the OR environment. Sales representatives may indicate otherwise, but monitors available to us today were designed with the ICU in mind. Additional features have been added for OR applications, but they are still ICU monitors. If these monitors were truly designed for the OR, they would not be such massive structures. Anesthesia providers stand or sit directly in front of their monitors; they do not need to see them from across the room.

(Continued on page 11)

TECHNICALLY SPEAKING

by Wes Simpson II
San Diego, CA

This edition of *Technically Speaking* focuses primarily on innovative uses of new and existing technology. Several of the innovations are simple, inexpensive modifications of equipment that you likely already have on hand. Other citations focus on case reports regarding patient safety issues.

Holzman RJ: **Latex Allergy: an emerging operating room problem.** Anesth Analg 76:635-641, 1993.
This review article provides a good foundation for understanding potential problems associated with latex allergies. Although written from a pediatric practice perspective, the information can be applied broadly to all anesthetic settings. The comprehensive bibliography, with 58 citations, provides ample opportunity for further research into the problem.

Gaughen SD, Benumof JL, Ozaki CT: **Can an anesthesia machine flush valve provide for effective jet ventilation?** Anesth Analg 76:800-8, 1993.
This study compares design differences between the Ohmeda Modulus II and Modulus II Plus, and the North American Drager Narkomed 2, 2A, 2B, and 3 anesthesia machines. Differences in design and construction are compared and contrasted, as well as the effects of various jet ventilator catheter sizes. The authors conclude that the Narkomed models and the Modulus II machines are capable of providing effective jet ventilation by using the oxygen flush valve, while the Modulus II Plus is not. They also caution that changes in I:E ratio may be necessary when using the Narkomed 2 or Modulus II machines.

Chaney MA: **Delivery of excessive airway pressure to a patient by the anesthesia machine.** (Letter) Anesth Analg 76:1166-7, 1993.
Describes a scenario where circuit pressures of 60cm H2O were produced within 4 -5 breaths after the beginning of mechanical support using the ventilator on a Drager Narkomed 2B. Manual ventilation was accomplished without difficulty. The problem discovered was a kinked pilot line between the base of the ventilator bellows assembly and the adjustable pressure relief valve. This enabled the ventilator to deliver the set volume, while restricting the ability to exhale, resulting in cumulative airway pressures.
(While this letter specifically mentions a Narkomed 2B, the same type of malfunction is possible with any model of ventilator utilizing an external pilot line between the bellows assembly and the pressure relief valve.)

Lowson SM, *et al*: **Yet another place for the pulse oximeter probe.** (Letter) Anesth Analg 76:1167, 1993.
Describes a unique placement of the pulse probe on an 8 year old, 12 kg patient who was being supported on continuous arteriovenous hemofiltration (CAVH). The patient was undergoing emergency orthoptic liver transplantation. After multiple attempts at placing a pulse oximetry probe on all extremities as well as the nose and ears, a disposable pediatric probe was placed on the arterial line of the CAVH circuit. A high quality signal was obtained, and the displayed heart rate and saturation values correlated well with the cardiac monitor and multiple blood gas readings.

Szafranski J: **A modified portable system for oxygen supply using anesthetic rebreathing bags.** (Letter) Anesth Analg 76:1168-9, 1993.
A simple method for delivering oxygen to spontaneously breathing patients during short distance transport is described. The breathing bag is hyperinflated and used as the reservoir. Utilizing a 3 liter bag with a stopcock as the flow controller/restricter, the system is capable of delivering oxygen at 6 L/min for 5 minutes, or 4 L/min for 10 minutes. It is described by the author as a "reliable, expedient alternative to an oxygen cylinder".

Andrews JJ, Johnston RV, Jr: **The new Tec 6 desflurane vaporizer.** Anesth Analg 76:1338-41, 1993.
This technical article provides an overview of the Tec 6 desflurane (Suprane) vaporizer. The operating principles are delineated and the Tec 6 is compared and contrasted with the other calibrated vaporizers. The effects on output caused by altitude changes and carrier gas composition are explained. An appendix provides the formulas used for determining flow calculations.

Brull SJ, *et al*: **Liquid crystal skin thermometry; an accurate reflection of core temperature?** Can J Anaesth 10(4):375-81, 1993.
The ability of a liquid crystal (CR) skin temperature monitor to accurately reflect core temperature was studied. Comparisons were made against esophageal, bladder, and PA catheter sites. In general, there was good agreement between the CR and esophageal monitors. Temperature trends were linear over time. Comparable results were achieved compared to bladder probes. There was poor correlation compared to the PA site when going on coronary bypass, fur to direct application of slush ice to the open chest. Good correlation was obtained while on bypass and during rewarming. The ability of C skin monitors during a malignant hyperthermia episode is uncertain and has not been studied. This paper was presented in part during the 1990 ASA Annual Meeting and the 1991 IARS Congress.

Baroczky GI, *et al*: **Continuous spirometry for detection of double-lumen endobronchial tube placement.** Br J Anaesth 70:499-502, 1993.
This study evaluated the ability of continuous spirometry to detect malplacement or migration of a double lumen

(Continued on page 11)

HAZARD...

POWER OUTAGES: AN EVER-PRESENT DANGER

by Doug Draper
University of California, Davis Medical Center

In many operating rooms there are serious and dangerous conditions developing. I'm sure each of you has been present at one time or another when all AC power to the anesthesia equipment has been lost. When AC power is interrupted, the ventilator and all patient monitoring equipment becomes inoperative. (Excluding battery operated equipment.) Sadly, this seems to occur at the most critical of times.

The problem is multi-focal. First, older operating rooms were designed and built long before the age of lasers, blanket warmers, humidifiers, blood warmers, and an endless list of other electronic devices. The electrical demand from some of these devices is very high. In the newer operating rooms, the problem is not as severe, but herein lies the second part of the problem.

It has become standard practice to plug all the power and extension cords into the outlets at the anesthesia end of the room in an effort to make it easier to move beds and other equipment in and out of the room. Additionally, there seems to be concern for using the outlets at the side of the room because of close proximity to the sterile instrument tables. The problem is further complicated by the use of too many extension cords and minimal knowledge of equipment power requirements. Some equipment such as blanket warmers, blood warmers, and lasers should never be plugged into extension cords because of their high current requirements. Also, the electrical outlets built into some anesthesia machines are meant to provide power to monitors; equipment with higher current requirements can easily overwhelm the capacity of these outlets. Another poor practice is plugging extension cords into extension cords, which can cause fires and other problems.

Possible efforts to correct this dangerous situation might include the following:

-Make every effort to train staff on the importance of trying to evenly distribute the power requirements around the room.

-Mark power cords to high demand equipment so that they will not be plugged into extension cords or ganged up with other equipment.

-After room cleanup, lay out extension cords in a orderly manner along the wall such that they can be reached without compromising the sterile tables.

Other suggestions may be appropriate.

In my presentation at the Annual ASATT Meeting this October, you will learn why the circuit breaker blows and how to calculate just how much equipment can be supported on a single circuit. Understanding power requirements for your equipment will help you to prevent disaster.

CERTIFICATION...

The ROAD TO CERTIFICATION

by Dennis McMahon, Immediate Past President
Seattle, WA

From its beginning, the ASATT has had three objectives: the establishment of a generic definition of the anesthesia technician/technologist, the promotion of education for AT's, and the development of a certifying process for them. The first of these goals was achieved through the cooperative efforts of our liaisons with the AANA and the ASA within our first two years. The second objective, formal training at the entry level as well as continuing education, is an on-going process. There are several in-house programs in place for AT's at several locations, and plans for others. Regional meetings, the annual ASATT meeting, and seminars offered by manufacturers and AAMI have increased in number and scope. The third objective, certification, has been the topic of countless discussions and inquiries, and is now finally coming into focus.

What exactly is certification? It is any process by which an individual's competence in his/her profession is assured by meeting a specific standards, established by an agency or committee qualified to set those standards. Usually, this means passing a written examination made up of carefully composed questions that cover the basic knowledge required for the job. In some cases, the certifying agency may require that the candidate provide evidence of work experience in the field before taking the examination. Certification is not a license. In the context of health care, a license is an authorization to assume clinical responsibilities granted by a government (*eg* federal or state). Anesthesia technical personnel normally do not make independent clinical judgements on patient care, so licensure is not appropriate. Nor is certification just "registration"; registration is the recording on an official list of individuals qualified for a profession. If one is certified, he/she is by default registered as such by the certifying agency.

Why certify? Who benefits? *Everyone benefits:* The patient benefits by virtue of assured competence in his or her care, the clinicians (MD's and CRNA's) benefit by virtue of more effective assistance, prospective employers (anesthesia departments, OR directors, personnel departments) benefit by having an impartial reference for hiring and promoting, and we - the community of technicians - benefit by having a means with which we can document our competence for a position or a promotion anywhere in the country. This kind of standardized reference simply does not yet exist, and is badly needed. Certification is in place for many other allied

(Continued on page 11)

A Capital Idea !

The Fourth Annual

ASATT Meeting & Educational Program

Saturday - Monday, October 9 - 11, 1993

Sheraton Crystal City Hotel
Arlington, Virginia

20 Minutes from Downtown Washington D.C.

Presentations on:

- Anesthesia for Burn Cases
- Universal Precautions
- Laryngeal Masks
- Anatomy for Anesthesia Techs
- Cardiac Output
- Latex Allergies
- Electricity for Techs

Mini-Lecture Series:

- Swan-Ganz Catheters
- Rapid Infusion
- TEE Setup & Monitoring
- Arterial Lines
- The CLIA Amendments

The Jami Blue Lecture: *Dr. Clayton Petty on Anesthesia Machines*

The Anaquest Lunch/Lecture

REGISTRATION:

ASATT Member: $150
Non-Member: $185

Registration includes tuition, course, materials, breakfasts, coffee breaks, Saturday reception, Sunday lunch/lecture, and Certificate of Attendance.

No registrations accepted after 1 October, 1993.
Refund requests must be in writing. Service charge of $25 for refunds requested after 1 October.

Call ASATT for program and registration forms: 800-352-3575.

AIRFARE:

Uniglobe Paragon Travel Co. is the official travel agency for arrangements to the conference this year. Air transportation and automobile rentals can be made quickly and conveniently. Special meeting fares have been arranged with United Airlines and Delta Airlines.

Phone: 800-888-5410 (8am - 5pm PDT)

MEETING SITE:

Sheraton Crystal City Hotel
1800 Jefferson Davis Highway
Arlington, VA 22202
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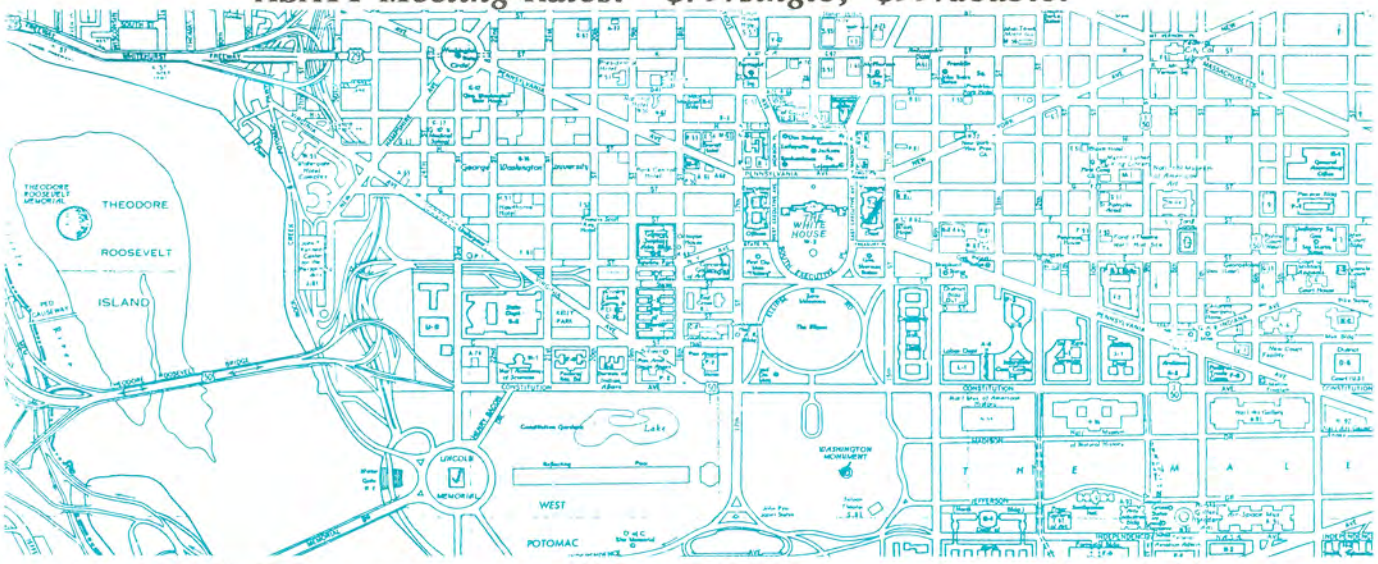
ASATT Meeting Rates: $79/single, $99/double.



Optional Technician Registration at the
American Society of Anesthesiologists
Annual Meeting & Exhibit
at the D.C. Convention Center .

Access to lectures and the exhibit hall:
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- Hands-on experience performing preoperative checkout procedures to FDA recommendations.
- Skills to perform routine user maintenance on the equipment.
- Familiarity with and understanding of technical terms for anesthesia equipment, troubleshooting, and applications.
- First level troubleshooting knowledge and skills through theory and hands on experience.
- Knowledge of manufacturer recommendations for anesthesia equipment cleaning and sterilizing.

1992-93 Class Schedule

Nov. - Chicago, IL
Jan. - Orlando, FL
Feb. - Fresno, CA
Mar. - Atlanta, GA
Apr. - St Louis, MO
May - Denver, CO
- Washington, DC
Jun. - Knoxville, TN
- Lexington, KY
- San Francisco, CA
Jul. - Boston, MA
- Charleston, WV
Aug. - Dallas, TX
- Seattle, WA
Sept. - Detroit, MI
- Salt Lake City, UT

For further information or brochures call Tessa Gillham: 1 800 345 2700.

REGIONAL SOCIETY ACTIVITIES...

Let us announce what's happening in your area. Send a brief report of recent or future activities for the next issue by August 31 to Dianne Holley. Send newsletters, if available, or give your info on my answering machine if I'm not home. Photos (captioned) are also welcome.

California -

Monterey was the location of the *9th Annual Meeting and Seminar* of the **California Association of Anesthesia Technologists and Technicians**, May 21-23. Those attending enjoyed a full schedule of educational, business, and social activities as well as access to the Monterey Bay area.
For further information:
Ron Turner at (510) 674-2241.

Colorado -

A one-day seminar is tentatively being scheduled for late July or early August by the **Colorado Society of Anesthesia Technologists and Technicians**. This meeting will be sponsored by the University of Colorado Health Science Center and will feature local speakers. Also, **CSATT** is trying to arrange for reduced housing rates for attenders at their *"Crash 94"* annual meeting next late February/early March.
For further information:
Judy Drakiotes at (303) 270-8399.

Florida -

The **Florida Society of Anesthesia Technicians** will hold their annual seminar and business meeting at the Holiday Inn-Busch Gardens on September 25-26. This meeting will be co-sponsored by the University of South Florida Department of Anesthesia. **FSAT** will also soon be mailing out ballots for state offices.
For further information:
Jerry Guttery at (904) 374-6051 [wk] or (905) 472-3925 [hm].

Illinois -

The **Illinois Society of Anesthesia Technology** held an educational meeting May 22 and also were invited to attend the *Midwest Anesthesia Conference*, May 6-8, both in Chicago. The *ILSAT State Meeting* is scheduled to take place November 6-7 at the Oak Brook Hotel and Resort.
For further information:
Jim Underwood at (309) 968-6998.

Maryland/DC -

A tentative meeting is being planned for August, further information will be available soon. A May 22 meeting featured the topic of airway management. Elections are also upcoming.
For further information:
Richard Harrison at (410) 225-8176.

Michigan -

For further information:
Louise Martin at (313) 593-7696 or Jim McEvoy at (313) 343-4766.

New York -

Monthly meetings of the **New York State Anesthesia Technology Association** have been suspended through the summer, but will recommence in September.
For further information:
John Armstrong at (716) 336-3377.

Ohio -

July is vacation month for the **Ohio Society of Anesthesia Technologists and Technicians**, but the monthly meetings resume in August with the educational topic: "Generic *vs* Brand Name Pharmaceuticals". The September topic is "PCA Pumps". Look for these meetings on the fourth Saturdays of the month. **OSATT**'s one-day seminar last April featured 9 speakers, 13 vendors and had 40 anesthesia techs in attendance.
For further information:
Wilma Frisco at (216) 541-5710.

Pennsylvania -

The **Pennsylvania Society of Anesthesia Technicians** held a one-day seminar May 22. Educational topics included the Laryngeal Mask and the lightwand, laser surgery and endotracheal tubes, and the FDA anesthesia apparatus safety check. A business meeting followed in the afternoon and T-shirts were available for purchase.
For further information:
Norm Holst at (215) 590-2798 [wk] or (215) 927-4958 [hm].

Tennessee -

Vanderbilt Plaza in Nashville will be the location of an organizational meeting for the recently chartered **Association of Tennessee Anesthesia Technicians and Technologists**. July 31 will be the date, and 9:00am-1:00pm will be the time. All interested persons are encouraged to attend.
For further information:
Sharon Baskette at (615) 322-4000 [wk] or (615) 646-1599 [hm].

Texas -

Austin is the site of the *Fall 1993 Meeting and Seminar* of the **Texas Society of Anesthesia Technology**, this September 11. **TSAT** is also meeting on a regular basis in different cities: San Antonio [Raul Sanchez at (210) 675-1564] and Dallas [Kyle Logsdon at (214) 820-2165] both host monthly meetings. Austin, Houston [Drucilla Overton at (817) 729-5606], and El Paso [Estella Ramirez at (915) 544-0606] also meet regularly.
For further information:
Dianne Holley at (512) 451-7457.

Virginia -

For further information:
Linda Ferris at (703) 985-8351.

Washington -

For further information:
Dwight Shields at (206) 548-6538 or -6510.

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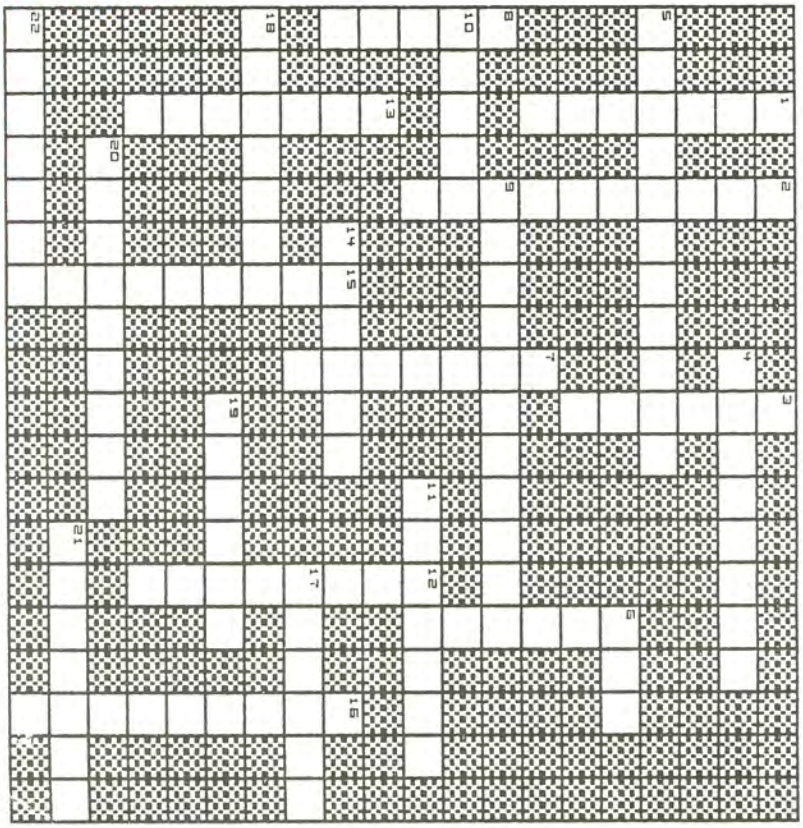
TECHNICIAN CROSSWORD



Reference: F.H. Netter, MD: *Atlas of Human Anatomy*, Ciba-Geigy Corporation, 1989

Answers to previous puzzle:

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T
R     CIRCLEOFWILLIS
A M   O     U        A
CLAVICLE    S        T
H S   H   S TRIGEMINAL
E S   L   T A        A
A E   E   E CAROTID  S
  T   A   R H
O E    MANDIBLE   P  Z
CORNEA  U A  S  A  Y
C       M N  O  L  G
INFERIOR     P  A  O
P       L    PHILTRUM
I       A  S A  E  A
T R    ORBIT G T
A E     Y  A U W
LATERAL N  POSTERIOR
  I     X  E  L
  N        S  V
 LACRIMAL   ANTERIOR
```

HOW'S YOUR ANATOMY? 2: The Thorax

ACROSS:

4 Collarbone
5 Membrane surrounding the heart
6 Number of floating rib pairs
9 Muscles between the ribs
10 Vessel that delivers blood to the entire body
11 Sacs where air interfaces with blood vessels
14 Either of two chambers that take blood into the heart
17 Blood is taken to the lungs by the pulmonary _____
18 Tubes from the trachea to the lungs
19 Valve between chambers of the left heart
20 Muscular membrane between thorax and abdomen
21 Vessel that return blood from head and neck
22 Projection of cartilage below the breastbone

DOWN:

1 Breastbone
2 Artery that passes below the collarbone
3 Membrane surrounding the lungs
6 Total number of rib pairs
7 Ring-like cartilage at the upper trachea
8 Major nerve that serves the thorax and abdomen
12 Vessels that bring blood to the right heart
13 Vessel that sends blood to the head and neck
15 Valve between chambers of the right heart
16 Either of two chambers that send blood out of the heart

OFFICIAL NOTICE

The ASATT Board of Directors will hold its next meeting on Friday, October 8th, 1993 at the Sheraton Crystal City Hotel in Arlington, VA. All individuals wishing to address the Board or present items for the agenda, shall notify the Board in writing no later than September 3rd, 1993. All individuals proposing amendments to the ASATT Bylaws shall notify the Board in writing no later than August 6th, 1993.

Please address all correspondence to the Society address.

Technically Speaking *(Continued from page 4)*

endobronchial tube. This study of 49 patients found that 19 tubes were malpositioned after intubation, as confirmed by fiberoptic bronchoscopy, and the 34.7% of all tubes migrated during patient positioning and subsequent surgery. The study concluded that utilization of continuous flow volume loops were helpful in early detection of tube migration, and this should be confirmed by fiberoptic bronchoscopy.

McLeod GA, Carson D, and Bannister J: **"Concorde Nose" in Whitacre spinal needles.** (Letter) Br J Anaesth 70:593, 1993.
Two instances of tip bending of a 25g Vygon Whitacre needle during insertion are reported. In both cases, in the section of needle between the tip and the side orifice bent upon meeting firm resistance or touching bone. The authors caution that any needle which meets with bone or firm resistance should be withdrawn and discarded. Similar precautions have been published in the United States for the use of the Sprotte needle.

APSF NEWSLETTER: Volume 8, #1, 1-12; Spring 1993.
This edition of the quarterly APSF newsletter introduces a dialogue on the potential dangers posed by contaminated medical gases. Recent changes in the NFPA standards for construction and certification of medical gas pipelines are discussed. The controversy over FiO2 monitoring vs pulse oximetry is explored, and innovative ways of providing supplemental oxygen and excess O2-CO2 clearance under the drapes during MAC for cataract surgeries are suggested.

By a Thread *(Continued from page 3)*

The anesthesia machine is moved often to accommodate surgical necessity. True anesthesia monitors would have been designed to fit on the anesthesia machine and to accommodate the ergonomics of the practice. To this end, both Ohmeda and Drager have created very impressive anesthesia machines with built-in monitors.

So what is the disadvantage, you ask? When all monitoring is consolidated in one chassis, then there is only one power supply; there is only one display; and there is only one AC power source. A failure of any one of these system components leaves you without any monitoring capability. Thus it follows that in our facility, we have elected to buy separate monitors. The most important of these is the pulse oximeter. Individual pulse oximeters have battery backup. It is extremely comforting to see that pulse oximeter glaring back at you in the dark when you have lost AC power to all other equipment.

In short, it has never been a good idea to put all your eggs in one basket; one-for-all does not necessarily translate into all-for-one. Good luck with your monitoring decisions.

Certification *(Continued from page 5)*

healthcare professions, and anesthesia techs in several other countries have had a certifying process for many years.

Who certifies? A number of organizations or agencies have been explored in our discussions about a certifying body. The ideal would be a certifying commission that is already in place, and that already certifies technical personnel parallel with our specialty. The most promising candidate is the International Certification Commission for Clinical Engineering and Biomedical Technology, the agency that tests and certifies clinical engineers and three types of biomedical equipment techs. The Commission is based within the offices of the Association for the Advancement of Medical Instrumentation (AAMI) near Washington, D.C. At its meeting in Boston last May, the Commission established a task force to review the prospects of a certifying process for our specialty. At the same time, our liaisons with the ASA and with the AANA have both offered to provide assistance with the formulation of a certifying examination. This assistance would be part of the Commission's exam-writing process, and would assure that the exam questions cover material at an appropriate scope and depth for the entry level technician. Eventually, a second exam would be formulated for the technologist level, which will encourage a sense of career development and improve our usefulness to anesthesiology.

Will certification be required for me? Not necessarily; in fact, certification is not *required* for employment in many allied healthcare specialties. But it is a useful reference for an employer to be assured of a minimum level of competence. It's the option of the employer to use it in selecting or promoting people. Those of us who have been tech's for some time would be "grandfathered" to certification by providing documentation from our employers that we have a minimum number of years of experience as tech's, and/or a certain amount of education pertinent to the role. After a specific date, the certification exam would be offered.

What's next? Over the next three months, your president and the regional directors will be discussing these issues and options, and they expect to be able to report progress in October at the annual meeting in Washington, D.C. *Your input is invited and encouraged.* Contact your regional director with your ideas or concerns. Certification is an important part of professionalizing any specialty, and we will all benefit from it. The current climate of healthcare reform and its focus on quality assurance, productivity, and "down-sizing" need not be a threat to us, if we demonstrate our value to the healthcare team.

Regional Activities *(Continued from page 9)*

Wisconsin -
On September 10-11, in Lake Geneva, the **Wisconsin Great Lakes Society of Anesthesia Technicians** will host a business and educational meeting. **WGLSAT** will miss the experience and leadership that Dean Rux, ASATT Region 4 Director, has provided through the years, when he moves to Chandler, Arizona. Good luck, Dean.
For further information:
Noreen Soeller at (715) 387-7179 [work] or (715) 387-4792 [home].

Advertizing Rates for The Sensor

Effective 1 August 1993

Display Ads: Announcements of products, services, or educational programs relevent to the theory, maintenance, or application of anesthesia technology.

Rates: Display Advertizing (camera-ready mechanicals, one-color process):

Half-Page Horizontal	7½"wide X 4¾"deep:	$200 per insertion.
Half-Page Vertical	3½"wide X 9½"deep:	$200
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Corporate Member Discount: 25%

Classified Ads: Individuals seeking employment, or employers seeking candidates, in anesthesia technical support.

Width: 3½", CG Times type, 12-point. Typeset by editors.

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