IFMBE-CED
Brief situation analysis of the Division and initial proposal for the period 2003-2006
Prepared by Enrico Nunziata (n.enrico@botte.net)

BRIEF ANALYSIS

Since the election of the new IFMBE-CED (from now just called CED) board in Chicago in 2000, CED did not operate properly. Actually it did not operate at all. One of the many reasons could be the fact that there was not chairman.

With the objective to boost CED activities, IFMBE president, Dov Jaron, appointed, by office, two co-chairs in April 2003. One of the two co-chairs is the author of the present document, Enrico Nunziata from Italy; the other is Adriana Velasquez form Mexico.

Since April 2003, attempts were made to recreate a spirit within the Division but with little results, maybe, due to its long inactivity.

The author decided therefore to briefly analyze what happened in the last 10 years in the CED environment with the scope to detect the causes of this apparent disinterest in the Division by its own board members and by the Biomedical Community at large.

The Activities Reports from the two previous chairmen, namely, Nicolas Pallikarakis and Peter Heimann, have proved to be extremely interesting. These reports describe in details the work done during their chairmanship, the new trends in CE and the problems within the CE Division itself (electoral process, budget availability and "international" representation). Both reports illustrate the numerous activities sponsored by the CED in particular the numerous advocacy activities, the workshops around the world, the international directory of clinical engineers and the strategic document developed. They also provided important insight for the future of the CED.

Based on these two reports, on the author personal experience and what has been happening in the last decade in Europe and in the Unite States but also in Asia and in the "new" Africa", the work of the CED of the past two decades definitely led to the creation of a Clinical Engineering conscience around the world, including developing countries. Most western countries have, today, some form of CE Departments/Divisions at different level in the Health System Pyramid and Clinical Engineers have their national Associations either within the Biomedical one or on their own. In developing countries, donors tend to sponsor/finance more and more activities related to Clinical Engineering and/or Healthcare Technology Management. Even the beneficiaries of these aid in DCs started to understand the importance of this component within the Healthcare System. If this could be considered the best achievement of the CED past work, it has been, to the author opinion, its "death row".

Some if the reasons of the latter statement resides in the following:

- The surge of Regional Chapters (except for Europe[1]) and national Associations led to the "decentralization" of the system. The new societies needed to focus on internal problems and had to work to transform the

[1] To the author best knowledge.

message received by the CED into their own realities, starting their own advocacy work *vis a vis* to the medical community in their area;

- Clinical Engineering has changed over the year, leaving the strictly maintenance activities to expert, trained and certified technicians and moving into a more holistic Healthcare Technology Management but with the absence of a specific certification program (exception to this has been the CCE program in the US in the 80s and part of the 90s).

To these two factors (not new to CED and to IFMBE since they have been extensively mentioned in a comprehensive way in the reports cited before) it should be added a series of activities that happened in the last 4/5 years. These activities were, most of the time, sponsored by engineers or professionals who belongs or belonged to CED but they did not have a CED stamp on them. These activities did attract the attention of many CEs (but I would prefer to say HT Managers) around the world, especially for their *accessibility*. In particular (this is not an exclusive list, there are many more that the author knows of but has no details about):

- The INFRATECH Internet discussion group (sponsored by WHO, hosted by PAHO and coordinated by ACCE) (1999-2003);
- Several ACE Workshops (Advanced Clinical Engineering Workshop) around the world, managed by ACCE and sponsored by WHO, PAHO and other entities (1991-2003);
- The creation of an Internet site ICHTM financed by the KaR-DfiD program and developed at the University of Cape Town (2003).

Among them the INFRATECH Internet discussion has been extremely prolific and helped, in real term, Ces/HTMs around the world for documentation exchange, group discussion, view formulation and problem solving. INFRATECH management wanted to move into a web site. Funding and management was already set-up for the transition. With the creation of the ICHTM there have been discussion whether or not one site could be enough to serve the new objectives of the ICHTM Program and the INFRATECH purpose, one of them documentation sharing/exchanging.

Then, there are the reports of the different chapters and or associations with the activities carried out. Unfortunately, not all the existing CE associations reported since they are not member of the IFMBE due to the difficulties in some countries with the Biomedical and the Clinical Engineering associations. This is also one on the problem undermining CED and previously reported.

Before passing to the proposal for a minimum plan for the next three years, two final considerations should be made:

- CE is just a part of Healthcare Technology Life-Cycle or HT Management Cycle; therefore, as suggested by numerous publications, notes, previous chairmen reports, etc., CED should transform itself into a HTM Division (Healthcare Technology Management) including the HTA Division. This should not be a mere name change but a profound transformation, that, paralleled by other important actions, technical and financial, would lead to a new period of activities and new frontiers to be reached (as an example a certification for HTM Specialist);

- Financial availability appeared to be a problem as noted by previous reports. Advocacy, activities and meeting participation do require, for an international association like CED/HTMD, moving board members from several locations around the world and this requires funds.

PROPOSAL FOR 2003-2006

After this extremely brief and incomplete analysis (due to time constraints and short time in office by the author), following, there is a minimum plan of action to re-launch the future CED/HTMD. The proposal is based on activities in three major areas and it is open for discussions:

- Normative:
  - Join the CE and the HTA Division into the new HTM Division;
  - Prepare a new HTMD by-laws and its vision/mission and main objectives within the Medical and Biological Engineering Federation and societies at large;
- Strategic:
  - Review the position of the new HTMD with respect to the Regional Chapters in order to define the respective responsibilities;
  - Work closely with association like ACCE and ICC for the advocacy, formulation, preparation, and eventually co-hosting/co-sponsor of a HTM International Certificate;
- Operative:
  - Support and sponsor the International Certification on HTM;
  - Support on-going initiatives especially those that are web-site based in particular the new ICHTM with financing, expertise and ideas;
  - Sponsor an on-line newsletter and case-study publications on ICHTM
  - Prepare and implement a survey among the CE and Biomedical Associations around the world to perceive what they expect form an international association like the HTM;
  - Work with National Accounts evaluation Institutions to help to estimate sub-accounts that show national trends in Healthcare Technology Expenditures[2];

[2] This idea came from some discussion held on the INFRATECH.