

The Sensor

CASE STUDY:

Partial Nephrectomy for Renal Cell Carcinoma

Page 17

A surgical case study of how the anesthesia team addressed difficulties and potential risks.

IN THIS ISSUE:

Local Anesthetic Systemic Toxicity

A guideline to proper response.

Member Highlight

Meet Michael Craig, Cer.A.T.T., he is a Faculty Professor of Anesthesia Technology at Oklahoma City Community College and the current ASATT Secretary.

Education Director Article

An Innovative Anesthesia Technology Program at Stony Brook University.

Anesthesia Tech Week

Anesthesia Tech Week is March 29-April 4. Vote on your preferred event poster by February 26!



AMERICAN SOCIETY OF
ANESTHESIA TECHNOLOGISTS
AND TECHNICIANS

Looking for "Vintage" ASATT merchandise?

With the rebranding of ASATT, we find ourselves with an overstock of ASATT merchandise.

We have taken inventory and reduced prices on items such as Conference t-shirts, hooded sweatshirts, travel mugs, and more!

Check out the [Storefront on the ASATT website](#) for deals and be on the lookout for more sales announcements.



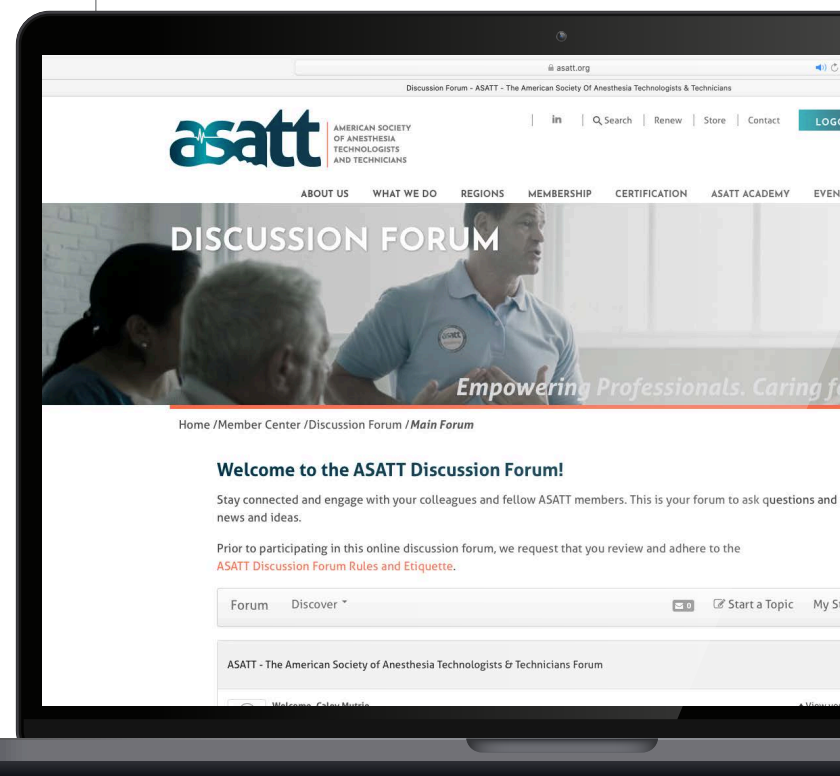
TID BITS

Share. Inquire. Learn.

ASATT's online Discussion Forum is available for members to connect and share!

You do not have to confront the COVID-19 crisis alone. ASATT has an online Discussion Forum that members can support each other through the sharing of vital resources, knowledge and experiences, and to seek answers to questions and concerns.

[Join the Conversation!](#)



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Editorial Board

- Michael Boytim
- Otoniel Castillo
- Matthew Chandler
- Michael Craig
- Greg Farmer
- Bryan Fulton

Sponsorships

- Kate Feuling
k.feuling@asatt.org

Perspective

PRESIDENT'S LETTER



Welcome Members To The New Year!

I hope all of you are staying safe, healthy, and happy. This past year has been quite the experience! Never has the expression, "hindsight is 20/20" been more appropriate than in these moments. Last year required all of us to change the way we do practically everything. We all had to stretch, strengthen, and push ourselves amidst an environment of continued uncertainty. Yet, we were not alone. Our friends, colleagues, and community provided the relationship support to weather this storm. As we move closer to the light at the end of the tunnel, let's not forget the connections we have.

Family is very important to me. As I am sure, it is very important to you all as well. But family is not defined by genetic bonds. All of us within ASATT and the anesthesia tech community are a family. As a family, we may have disagreements, and that is okay. This year for ASATT and the tech community, we are in a time where disagreements will be natural. However, I want to assure you ASATT, the volunteers that make up the board, and the management team, along with you, are committed to continued success.

I would like to take this opportunity to address some concerns from membership. There has been rampant

misinformation on social media by individuals who either misunderstand the provided information or are outright lying to members to further their own goals.

"Keep your words soft and sweet, you never know when you may have to eat them"

~ Jerry Lawler ~

1. PROCESSING FEES

The processing fees will only apply to third party vendor provider CEUs accrued beginning January 1, 2021. Any CEUs accrued from a source other than ASATT is a third-party vendor. ASATT regional meetings, national educational conferences, and ASATT virtual webinars/ regional seminars are automatically approved and stored on current members' ASATT database.

"The CEU processing fee for third party commercial providers is to not dissuade you from using these alternative sources but to streamline processes better. Approximately 90% of all CEUs submitted to ASATT are from third-party providers. This glut of submissions requires an inordinate amount of time to vet and verify. Unfortunately, in this process, a number of individuals have chosen to submit fraudulent CEUs that clearly do not meet outlined standards. This culminates in our management company imposing overage charges for processing these exogenous CEUs.

Additionally, it overly taxes the volunteers who spend hundreds of hours double-checking every CEU. So, practically speaking, it helps the organization by encouraging people to earn ASATT CEUs because they are already pre-vetted, so the processing is simplified. Additionally, the processing fee for third party CEUs covers the extra costs and time required to vet these CEUs for validity. Finally, the fee will disincentivize fraudulent attempts to submit fake CEUs. The benefit to the individual processing fees for people not wanting to use ASATT is it can actually open up more variety to accepting a broader array of CEUs if they meet ASATT's requirements. You can

find the new fee structure on the website in certification along with the form."- Bryan Fulton, ASATT Treasurer

2. NEW PATH FORWARD MEMBERSHIP MODEL

For years the question has been, "Why should I become a member?"

And we could not give a proper rationale, other than you should be a part of your professional organization.

That was simply, not acceptable.

In 2020, we worked on ways to make the membership equitable and provide a real tangible benefit to members. While working on this project, we discovered that our former business model was not sustainable for long term professional growth, which means that we as a board needed to develop a new strategy to provide more tangible benefits while allowing ASATT to pursue larger goals for the profession. This new plan was presented in the business meeting to the membership. The "New Path Forward" will ensure sustainability and professional growth for years to come.

"The current model proposes three tiers, a quarterly subscription with a one year contract that includes 12 CEUs (\$60 per quarter with a \$100 recertification fee), an annual fee that includes 12 CEUs (\$200 per year with a \$100 recertification fee), or a two-year fee that includes 24 CEUs (\$400 every two-years with no recertification fee). The CEUs included in the subscription rates would be 8 Sensor Quizzes per year and one workshop for 4 CEUs. These membership rates also includes discounts to other ASATT sponsored events (ie: national meetings, regional meetings, workshops, etc). A lot of discussions have been occurring on social media and this forum about how unfair this move is and that these fees are too high. To that end, the membership rates were explicitly chosen to lower the overall cost to the member and to provide tangible CEUs for being a member. After many hours of research into comparable organizations and the average cost to recertify for our current professional base, ASATT learned the average technician/technologist was paying between \$900-\$1200 to recertify. Our goal was to offer options to members that brought that overall cost down significantly. The new model does do that. That means the cost to maintain an ASATT certification over two-years

is \$400-\$580. Commercial CEUs are those that are earned outside of ASATT, except for AHA CEUs (ie: BLS and ACLS). The new membership method is to streamline your CEU earning process and include more tangible benefits."

Even with the full presentation, giving all the details, some people willingly spread false and misleading information. In addition to these rumors, disseminated primarily on social media, individuals also took actions that are simply not appropriate, including:

- Making threats to ASATT BOD members.
- Attacking ASATT BOD integrity with libelous accusations.
- Falsely spreading rumors about ASATT BOD members committing crimes
- Instigating threats of bodily harm to BOD members.

There are a few members who are very vocal with their unhappiness in their profession. And have been this way for years. I would like to ask,

If you hate the profession so much, why are you still doing it?

Over the years, some individuals have dedicated their time to share their hatred for the profession and have actively encouraged individuals interested in this profession to seek alternative career paths. I have one simple question if you hate this profession so much, why not follow your own advice and change careers?

There are rules of conduct in our society.

The first amendment does not give you the right to make threats, slanderous/libelous statements, and willingly spread lies. ASATT is taking these threats seriously.

3. ASATT BOD AS PAID EMPLOYEES

The lie that BOD members serve as paid employees or garner some type of financial interest in ASATT is an accusation that has been disproved repeatedly but is one that still seems to flourish. Unfortunately, the same individuals who spread falsehoods in an attempt to raise their own profile are the ones who are last to the forum to assist. These vocal members who decry the organization frequently and spread falsehoods are the same individuals

who never step up to assist ASATT when asked. For individuals who are so vocal about how far ASATT has gone astray, why do you never step up to actually help?

These people have no interest in volunteering to help ASATT or those of you who do see the benefit of ASATT. Why? Their agenda is not to further the profession or improve things; they seek to sow discord and serve themselves. I have had many conversations with some of these individuals when they had issues and needed help. Amongst the many hours of discussions, a few things rang true. When they needed help, we assisted, and they were thankful and gracious. Then at the drop of a hat, they would begin berating, threatening, and spreading falsehood about ASATT and those who took the time to assist them.

So for one final time: "Are ASATT BOD members paid employees?"

NO! WE ARE ALL VOLUNTEERS!!

We all have full-time employment, with some of us working multiple jobs in addition to volunteering for ASATT. The average BOD member spends a minimum of 25 hours a week volunteering. Personally, I work 60 plus hours a week at my job, then put in another 30 plus hours a week volunteering for ASATT. All of us on the BOD passionately dedicate our personal time, and we get tarred and feathered by a few who refuse to get involved in helping move the profession forward.

4. AEG MANAGEMENT

- ASATT has a contract with AEG, our management company.
- Alex Llanes is no longer with AEG. He left in June 2020.
- Our customer service/certification specialist is Nicole Cheever.
- Our account specialist is Samantha Repischak.
- Our account Executive Director is Amy Jurgens.

God Bless,
Greg Farmer, Cer.A.T.
 ASATT Interim President



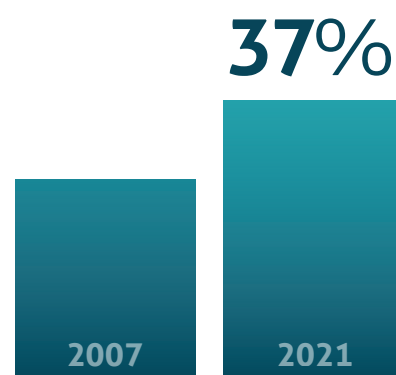
TID BITS

ASATT is YOU!

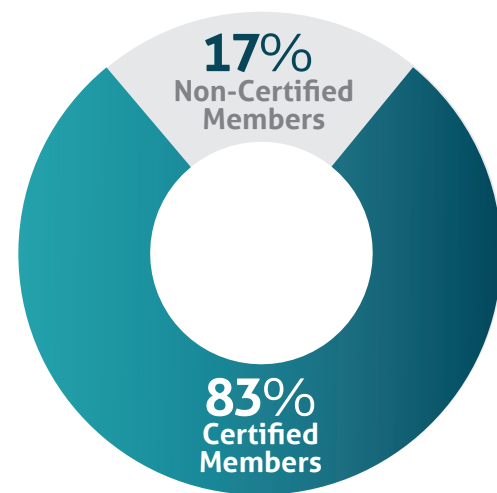
A breakdown of the current ASATT members, by the numbers.

1,393

Current ASATT Members



Member Growth Since 2007
 (Year that ASATT and AEG joined forces to manage the Society)



Highlights

SOCIETY NEWS

Write an article for the Sensor: ASATT forms new Editorial Board to support authors

Interested in writing an article for the Sensor? It's a wonderful opportunity for you to gain national recognition and earn CEUs! To support you, the ASATT Board is excited to announce a new Editorial Board! This committee will be available to answer questions and provide guidance: proofing grammar, reference documentation, etc. In addition to the article, authors provide 10 quiz questions. When answered correctly, it provides others the opportunity to earn one CEU. A wonderful opportunity for all!

[Click here](#) for details outlined on the ASATT website.

The ASATT Board of Directors extends their gratitude to the newly formed Editorial Board:

- Michael Boytim
- Otoniel Castillo
- Matthew Chandler
- Michael Craig
- Greg Farmer
- Bryan Fulton



Spotlight

MEMBER HIGHLIGHT



Michael Craig, B.S., Cer.A.T.T.

What is your current job title?
Faculty Professor of Anesthesia Technology at Oklahoma City Community College.

How many years have you been in the Anesthesia Technology profession?
Approximately 5 years.

What do you find most challenging about your job?
There are many challenges of being a new college professor. The main challenge is having the confidence in your own knowledge, skills, and abilities in the field to provide instruction to your students. I am always concerned about conveying the material in such a way that makes sense to students. I try to take the

aspects of classes that may be difficult to understand and try to engage the class in such a way that will help them absorb the material.

How many years have you been an ASATT member?
1 year

What is your fondest memory of ASATT?
My fondest memory of ASATT would probably be when I saw my name come up in the registry after I passed my NCE.

What has been your proudest accomplishment? (Personal life, professional life, or both.)
My proudest accomplishment to date is when I received my Bachelor of Science Degree in Exercise Science from High Point University, in North Carolina. It was a lot of work but I am glad I worked as hard as I did to obtain this accomplishment.

What is your favorite food?
It is a broad category but I am a big breakfast food type person. Avocado Toast with pickled onions and an over-easy Egg on a toasted bagel is the way to my heart. You have to supercharge your day with some strong black coffee and some mono-, and polyunsaturated fats.


People would be very surprised to know that...
When I was 12 years-old I had an ischemic stroke that caused me to lose the peripheral vision to the right

side. This is partly the reason that I have been interested in the field of healthcare, and living a healthy lifestyle. It was the main reason I wanted to study exercise in college. I always push myself to be the best I can be and to live as healthy as I can. It was a blessing in disguise because I firmly believe that when an incident like that happens in your life it makes you realize just how precious life truly is. My motto has always been "you only get one body... don't mess it up". Anesthesia Technologists in general see what poor life choices can yield in the OR. My goal is to not be the patient.

What do you enjoy doing in your spare time?
In my free time, I enjoy working out and doing anything physically active.

What is your favorite type of music?
I listen to music that goes with my mood. I generally like anything upbeat, but I like everything from Frank Sinatra type music to electronic dance type music. I'm open to mostly anything but country.


What is your favorite movie?
I am a big fan of documentaries. My current favorite to this point is "David Attenborough: Life On Our Planet" It is very well done, and really opens your eyes to a bigger picture. Plus, who doesn't like hearing that iconic voice!?

What would you like to get around to doing one of these days?
I am currently deciding to pursue a Master's in Public Health. I would eventually like to go to an Anesthesiologist Assistant Program to further my anesthesia education. 


Happenings

ASATT AND RELATED EVENTS

Region 1 Virtual Meeting: Earn 3 CEUs!


Region 1's first Virtual Meeting is February 27! Virtual Meetings offer great opportunities to earn CEUs. In addition, the virtual platform allows you to attend a meeting for a region other than the one in which you reside! Registration for this Virtual Meeting closed Tuesday, February 23, 2021 but no worries! The next regional meeting is currently being planned so ASATT will continue to provide future opportunities to earn valuable CEUs! 

Anesthesia Tech Week, March 29-April 4: Vote on your preferred poster!

ASATT members were invited to create a poster representing Anesthesia Tech Week! **Entries were due February 19.** Each entry has been posted on the ASATT website and voting continues through February 26. The winning entry will be announced on March 2 and the poster posted in hospitals nationwide in! [Click here](#) for all poster entries and voting details. 



2021 Annual Educational Conference

ASATT is currently planning an onsite 2021 Annual Educational Conference! Believing in the power of in-person networking and education, the ASATT Board will continue to monitor COVID-19 guidelines and adjust if necessary to ensure a safe and valuable experience. **SAVE THE DATE** and plan to join us Sept. 23-25, 2021 in Fort Worth, Texas! Details, including registration information, will be coming soon! 

Local Anesthetic Systemic Toxicity

Local Anesthetic Systemic Toxicity:

A Guideline to Proper Response



MICHAEL CRAIG, BS, AAS, CER.A.T.T.
OKLAHOMA CITY COMMUNITY COLLEGE

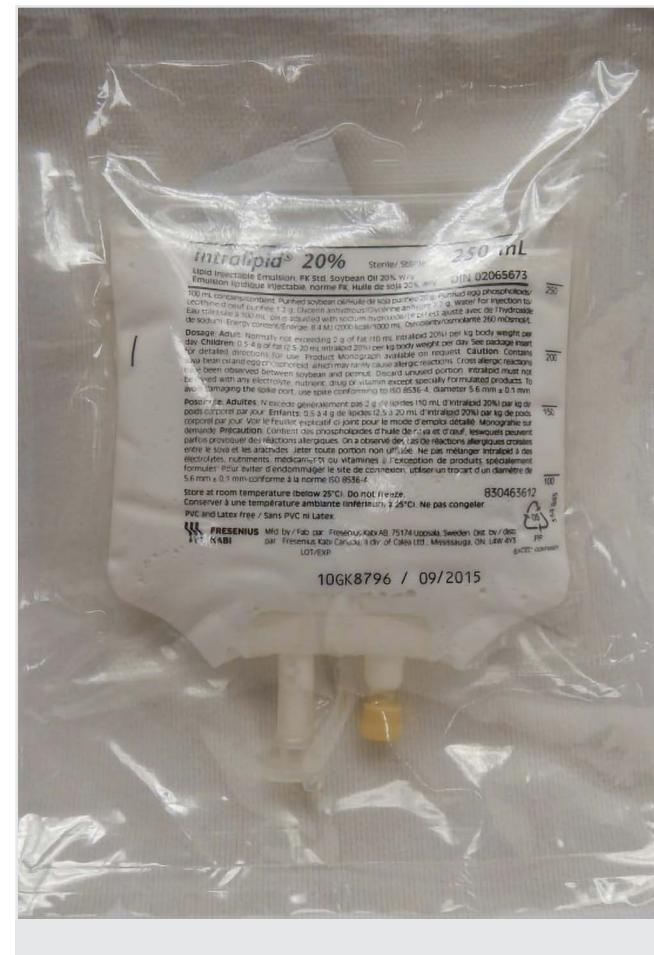
Proficiency in the identification of symptoms pertaining to local anesthetic systemic toxicity (LAST) is key in preventing patient mortality. Local anesthetic toxicity can happen to any patient in any setting utilizing regional anesthetic techniques. Procedure settings that establish protocol, properly prepare, and establish continuing education regarding LAST have a greater chance of preventing and resuscitating patients receiving local anesthetics for acute pain management. *The American Society of Regional Anesthesia & Pain Medicine (ASRA)* has developed a set of guidelines to educate clinicians on identifying and treating local anesthetic toxicity. As stated, a proper preparedness plan is key in preventing these types of events from occurring.

The ASRA strongly encourages facilities to develop a plan to manage these types of events when they occur. The organization advises facilities and anesthesia provider groups to make a "Local Anesthetic Toxicity Kit"— (ASRA, 2011) and encourages these instructions are clearly posted. The efficient and effective utilization of this treatment kit will help save lives when a toxicity event occurs.

Based on the ASRA's Checklist, the ideal Local Anesthetic Toxicity Kit (AKA Lipid rescue kit) should include everything necessary to treat such events. This Lipid rescue kit's contents will be touched on in further detail later in this response. In the ideal world, it is encouraged to prevent local anesthetic toxicity events from occurring. So what steps can be put in place to assist clinicians in preventing such events from happening?

The primary way a provider can prevent the LAST event from occurring on the front end would be to "Be Sensible"— (ASRA, 2011). ARSA's states that to avoid toxicity, the ACT should utilize the lowest dose of local anesthetic necessary to achieve the desired depth and duration of nerve blockade (ASRA, 2011). Second, it is important for the team to be knowledgeable on the patient populations that are more susceptible to local anesthetic toxicity. These populations include but are not limited to: Those of advanced age, patients with severe cardiac dysfunction (especially those with a low ejection fraction), mitochondrial disorders, patients on sodium channel blockers, and any other patients that may have liver or kidney abnormalities (APSF, 2020). The most susceptible patients are those with extraordinarily low ejection fractions (EF), and those of small stature and/or low muscle mass (ASRA, 2011).

Another way to prevent a LAST event is through pharmacological markers, such as using 1:200,000 (5mcg/



mL) (Neal et al, 2011) concentration of epinephrine mixed into the local anesthetic. The use of epinephrine can be used to disseminate whether or not the care team is injecting the anesthetic intravascularly, limiting the risk of a potential LAST event. Another way to prevent such injections would be to ensure that the provider/assistant (Cer.A.T.T.) is consistently aspirating (looking for blood return) before each incremental injection of local anesthetic. It is important to note incremental injection, patience during neuraxial and peripheral nerve blockade is essential to keeping the patient safe and promoting a successful block.

Finally, vigilance in monitoring the patient's hemodynamic state and clinical presentation during and after the procedure is essential in detecting and responding to LAST events. The utilization of the *American Society of Anesthesiologists (ASA)* standard monitors must be considered and most certainly utilized before the administration of any local anesthetics. Patient monitoring should begin prior to the block procedure and continued for at least 30-minutes post-injection (Neal et al, 2011). Signs and symptoms of Local Anesthetic Toxicity do not always readily present themselves after a patient has been

injected with a local anesthetic. The signs and symptoms will vary depending on the volume the patient was exposed to during the procedure. Central nervous system symptoms occur in three stages depending on the severity of exposure: *Excitation, Depression, and Non-specific*.



Stage three: Non-specific is the most advanced stage symptoms of exposure; this is presented as metallic taste, circumoral (surrounding the mouth) numbness, diplopia (double vision), tinnitus (ringing of the ears), and dizziness (Neal et al., 2011).

Severe exposure to Local Anesthetic Systemic Toxicity will eventually cause cardiovascular symptoms. Initially,

symptoms will present in a hyper-dynamic fashion in the form of hypertension, tachycardia, and ventricular arrhythmias, such as ventricular tachycardia, torsades de pointes, and ventricular fibrillation. After this initial excitation presentation, the patient will generally present with progressive

and worsening hypotension, the development of an Atrioventricular heart block, and, if left untreated, asystole (Neal et al., 2011). The rapid excitation and precipitous cardiovascular decline are why lipid rescue protocols are important to a facility in preventing and treating the LAST event.

Pharmacological treatment of LAST events should occur in a procedural fashion as provided by the *American Society of Regional Anesthesia & Pain Medicine*. The first

step of this process is to get help. A provider's initial focus should be airway management, in which the patient should be ventilated with 100% oxygen. The next step is seizure suppression, which is managed through the use of benzodiazepines. Next, a facility capable of cardiopulmonary bypass (CPB), or extracorporeal membrane oxygenation (ECMO) services should be notified in the event the LAST event progresses (Weinberg, 2010). The subsequent step in this process is to address the cardiac arrhythmias. This should be done by initiating BLS/ACLS procedures (Neal et al., 2011). Medications that should be avoided are vasopressin, calcium channel blockers, and beta-blockers (ASRA, 2020). It is also important to note that any further administration of local anesthetics should be avoided; in this case, the avoidance of 2% lidocaine is typically used in ACLS algorithms (note: medications and dosages may have to be modified). It is also recommended that epinephrine be limited to less than 1 mcg/kg for treating hypotension (Neal et al, 2020).

When there are signs of cardiovascular collapse, propofol should be avoided. Propofol is a cardiovascular depressant; its composition of lipids is known to be too low to provide any benefit to local anesthetic toxicity. The use of propofol is discouraged, especially when there is a risk of cardiovascular collapse (Neal et al., 2011).

Lipid emulsion therapy should initially be administered as a bolus. This dose should equate to 1.5 mL/kg over one minute.


Lipid emulsion therapy should initially be administered as a bolus. This dose should equate to 1.5 mL/kg over one minute. This infusion should be continued after the initial bolus over 10 minutes after cardiovascular stability has been obtained. The lipid infusion should be infused at a rate of 0.25 mL/kg/min. This rate should be increased to 0.5

mL/kg/min if symptoms of cardiovascular collapse persist (ie. hypotension). The recommended upper limit of a lipid emulsion infusion is approximately 10 mL/kg for 30-minutes.

After a local anesthetic toxicity event, it is advised to continue ASA monitors for more than 12 hours. This is mainly because symptoms of cardiovascular depression can persist or reoccur long after treatment (Weinberg, 2010). This event should be reported for statistical data purposes to the necessary websites provided in this paper's sources.

"Small patient size is a risk factor for LAST. The role of skeletal muscle as a large reservoir compartment for local anesthetic may explain this phenomenon, and was confirmed in rat models"

~ Weinberg, APSF, 2020 ~

With proper facility protocols in place, Local Anesthetic Systemic Toxicity events can be avoided, and patient lives can be saved. The prevention of a negative LAST event can be avoided, in most cases, if the Provider and technologists are prepared for the event beforehand, sensible in their blockade administration and vigilant in their monitoring (Neal et al., 2012). 

References

Neal, J. M. (2011). Checklist for Treatment of Local Anesthetic Systemic Toxicity. *Regional Anesthesia & Pain Medicine*, 00(00), 2–3. Retrieved from www.rapm.org

Weinberg, G. L. (2010). Treatment of Local Anesthetic Systemic Toxicity (LAST). *Regional Anesthesia and Pain Medicine*, 35(2), 188–193. doi: 10.1097/aap.0b013e3181d246c3

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Reporting Agencies

www.lipidrescue.org
www.lipidregistry.org

Take the QUIZ

[Click here](#) for a copy of the quiz.

Academy


ASATT ACADEMY

ASATT Offers Certification Refresher Program!

The Refresher Program’s objective is to promote attainment of the current knowledge and clinical skills necessary for safe anesthesia technology practice required for the technologist National Certification Exam (NCE).

It is offered to Certified Anesthesia Tech’s who have not been substantially engaged in the practice of anesthesia technology for more than two (2) years and must update their skills and knowledge of current clinical and theoretical practice in anesthesia technology in order to meet the established standards of practice and to apply for recertification through examination.

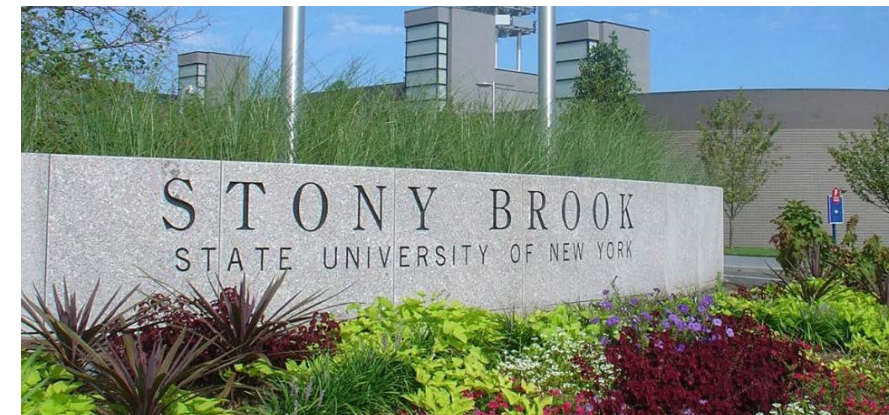
The Refresher Program also offers a technician or technologist who has an expired certification and is not eligible for the Provisional Recertification with the opportunity to be recertified. In order to qualify, certification would have had to expire within the last 2-5 years.

For all requirements and the specific [Refresher Program process](#), please visit the ASATT website or contact Nicole Cheever at certifications@asatt.org or 414-908-4942 x116. 

YEAR LAPSED:	TO QUALIFY, MUST APPLY BY:
2015	March 15, 2021
2016	December 31, 2021
2017	December 31, 2022
2018	December 31, 2023
2019	December 31, 2024

Outlook

PROGRAM DIRECTOR INSIGHTS



An Innovative Anesthesia Technology Program at Stony Brook University.

In 2002, the impetus to develop the Anesthesia Technology (AT) program was to address a work force need in our region. Prior to launching our AT program, at the technologist level, most hospitals were training anesthesia technicians on the job.

This innovative program was developed with two unique aspects. The AT program curriculum sequencing combines courses in the Health Science major with a clinical 9-month noncredit, non-degree certificate program. The other unique aspect is the AT program’s collaboration between School of Health Technology and Management’s, Health Science major; the Department of Anesthesiology, Renaissance School of Medicine; and Stony Brook University Hospital (SBUH).

This program could not be possible without the support and collaboration

of the Department of Anesthesiology. The former Chairman, Dr. Peter S.A. Glass introduced the Anesthesia Technologist concept to the department in 2000. Dr. Tong Joo Gan, Professor and Chairman continues to provide anesthesiologists in the department educational release time to lead and teach in the AT program. Our physician faculty includes: **Dr. Maria Lagade** as Founding AT Program Director. Dr. Lagade also has served as a member of the ASATT Education and CE committees and currently is a member of the ASATT National Certification Examination (NCE) committee and the Committee on Accreditation for Anesthesia Technology Education (Co-ATE) Twice she has been the recipient of ASATT Region 1 Educational Award. **Dr. Stephen Vitkun** as AT Co-Program Director and Medical Advisor. Dr. Vitkun has received the Asclepius Award for Teaching Excellence from the School of Medicine, two President's Awards and the SUNY Chancellor's Award for Excellence in Teaching. In

2010, he was appointed to the rank of SUNY Distinguished Teaching Professor, one of the highest academic ranks in the State University of New York. Recently, Dr. Vahe Tateosian has joined as AT Clinical Education Director. To enhance the quality of educational experience, he incorporated the AT students into the simulation education he conducts with the anesthesia residents. The program is proud to share that our clinical faculty includes, AT Intern Preceptors/Clinical Coordinators: **Melissa Day, CRNA, CCRN** and **Shoba Sanu, CRNA**. Both are skilled advanced practice nurses working at SBUH. Melissa Day is a Colonel, Nurse Corps and has been a critical care nurse for 16 years and a nurse anesthetist for over 14 years. Shoba Sanu, CRNA has been a registered nurse since 2000 and has over 16 years’ experience as a CRNA. Ms. Day and Ms. Sanu educate, evaluate student performance, and oversee the day-to-day operations of the clinical rotations. Additionally, since SBUH is designated as a teaching hospital, all of the hospital’s clinical/ medical staff working in the OR suites (Attending Anesthesiologists, Anesthesia Residents, Nurse Anesthetists, Anesthesia Technologists / Technicians, and other OR staff) participate in the AT student’s education. The AT program is grateful for the continued support of SBUH’s CEO, Carol Gomes MS, FACHE, CPHQ.

Continues on next page...

Health Science advancement requirements:		First year of the AT program (Credit-bearing/senior year of the Health Science major)		Second year of the AT program (Non-credit certificate program)
91 credits must include all general education courses, 16 credits of science, 21 related elective credits		Fall semester (15 credits)	Spring semester (14 credits)	Sept – June (9 months, fulltime 5 days a week)
16 credits of science must include: HAN 200: Human Anatomy and Physiology for Health Science I HAN 202: Human Anatomy and Physiology for Health Science II	21 credits of related electives must include: HAN 312: Human Anatomy, Health and Medical Language HAN 251: Research Methods in Health Science	HAN 300: Issues in Healthcare HAN 333: Communication Skills HAN 335: Professional Ethics in Healthcare HAN 364: Contemporary Issues in Health Informatics HAN 383: Scholarly Writing in Health Science	HAN 434: Corporate Compliance and Regulation HAN 481: Introduction to Anesthesia HAN 483: Cardiopulmonary Physiology for Anesthesia Technology HAN 485: Clinical Monitoring HAN 489: Pharmacology Anesthesia	Experiential learning through clinical rotations in surgical operating suites (OR): cardiac and thoracic surgery, neurology (Neuro) and cerebral vascular circulation (CVC) surgery; vascular surgery; ears, nose, throat (ENT) and airway surgery; pediatric (Peds), orthopedic (Ortho) surgery, Urology (URO) and Transplant surgery; General surgery (Gen); obstetric surgery (OB); gynecology (GYN) surgery. Students also rotate through ambulatory surgical center (ASC) and various non-operating room anesthesia (NORA) procedures such as magnetic resonance imaging (MRI) computed tomography (CT), transesophageal echocardiography (TEE) and endoscopy (Endo). Participation in other educational activities: <ul style="list-style-type: none"> • Attendance at Ground Rounds • Case presentations • Weekly journals • Simulation rotation


The Chair of the Health Science Department, **Deborah Zelizer, PhD**, working with physician leadership, developed a unique curriculum structure that addresses the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains required to be competent entry-level Anesthesia Technologists.

Curriculum sequencing for the AT program students, is illustrated in the table below. The blue columns are the major's pre-requisite courses which must be completed prior to advancement to the major's senior year. The column highlighted in green illustrates the core curriculum of the Health Science major. The Health

Science major's faculty teach the curriculum in the blue and green columns. The first purple column shows the credit-bearing anesthesia concentration courses taught by the previously mentioned physicians. Students in the AT program are required to complete all university and major requirements to be awarded a Bachelor of Science in Health Science degree prior to entering the AT certificate program. The second purple column illustrates the clinical rotations and other educational activities in the AT certificate program. While our program scaffolds learning outcomes, it is expected that by the end of December students are performing consistently

at the technologist level across all domains of learning. Successful completion of the curriculum in all columns is an eligibility requirement to qualify for the ASATT national certification examination.

In summary, we believe our innovative curriculum structure and interdisciplinary collaborations yield students prepared to provide the highest quality patient care while maintaining the ethical standards and professionalism required in the profession of Anesthesia Technologist

Deborah Zelizer, PhD
Health Science Department, Chair
Stony Brook University 

Learnings

STUDENT CORNER




ALEXIA CHRISTOPHIDES,
BSHS-EMT
STONY BROOK UNIVERSITY

As an undergraduate student looking to expand their knowledge of healthcare as a whole, I could not have asked for a better opportunity than the Anesthesia Technology Program offered at Stony Brook University. To be able to witness and assist providers with care of a patient under anesthesia has been such an incredible and empowering experience.

I had immersed myself in volunteer work and EMS prior to discovering the program and have found that the skills I acquired through the Anesthesia Technology program have been invaluable in assisting me to become a more proficient healthcare provider and leader. My professors granted me every tool that was needed to succeed prior to beginning clinical rotations. I had learned in depth about clinical monitoring, cardiopulmonary physiology, pharmacology, and the field of anesthesia as a whole. My first semester of learning was affected by the COVID-19 pandemic, however my instructors made the transition to online learning smoothly and effectively. Although it was initially intimidating to work alongside physicians and nurse anesthetists, it became clear the required curriculum for the program prepared us for the challenges we would face.

As my clinical year commenced, the opportunities that arose for me were incredible. I had the ability to assist the anesthesia clinical staff during procedures such as cesarean sections, parathyroidectomies, coronary artery bypass grafts, and countless more. As time went on, I developed the anticipation of what providers needed for specific procedures, which became valuable to the team and was rewarding for myself.

The program has proved itself to be extremely challenging at times, which in turn has provided me with countless

opportunities to grow and advance as a student, individual, and health care provider. It has been immensely gratifying to not only assist anesthesia faculty with difficult procedures, but to provide patients with comfort. 

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Case Study:

Partial Nephrectomy for Renal Cell Carcinoma



MAKAILA BRANCH, CER. A.T.T.
OKLAHOMA CITY COMMUNITY COLLEGE

Patient Presentation

A 60-year-old female patient presented to the operating room with renal cell carcinoma. The proposed surgery was a left open partial nephrectomy. The medical history noted allergies to penicillin and prochlorperazine. The anesthesia care team (ACT) quantified the patient as an ASA III. Her height was 67in. and she weighed 94.8kg. She was positioned in right lateral decubitus for the surgery. During the respiratory review, the ACT noted the patient was a smoker with COPD and concomitant allergic rhinitis. Her cardiovascular review noted a history of hypertension. Her central nervous system revealed anxiety and headaches. During the hepatic, renal, and gastrointestinal review, the ACT noted several pathological conditions, including urinary incontinence, liver metastases, and chronic nausea. The final pathophysiology analysis noted the patient was obese and did not have teeth. The patient's prior anesthetic history was extensive, an embolization of a basilar artery aneurysm, hysterectomy, cholecystectomy, and a D&C procedure. Basilar artery aneurysms The patient had not taken any medication the day of surgery.

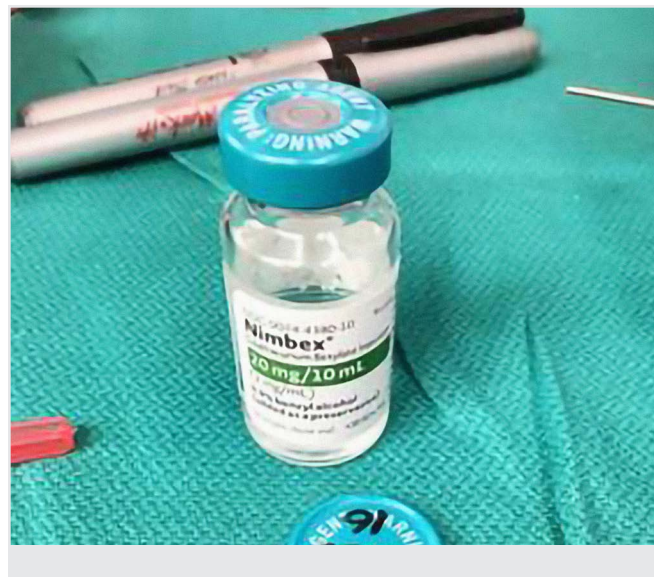
Surgical Background

Renal cell carcinoma is a common etiology for a patient requiring a partial nephrectomy. According to Jaffe's *The Anesiologists Manual of Surgical Procedures*, partial nephrectomies are ideal for small cell carcinomas.

"Partial nephrectomy is the surgical excision of the segment of the kidney harboring the pathology. It is performed for small renal cell carcinomas and benign tumors of the kidney, such as angiomyolipomas, and for duplicated collecting systems with a diseased moiety (Jaffe, 2014, p. 892-893)."

Given the patient's history, there were surgical implications the anesthesia technologist should be aware of in order to best assist the anesthesia provider in caring for the patient. One special consideration was needed to for the patient's COPD. Patients with COPD will have increased compliance due to the destruction of elastic recoil in the in alveoli. Pardo and Miller in the *Basics of Anesthesia* 7th edition recommend preoperative bronchodilator therapy to counteract the obstructive disorder.

"All patients with COPD should receive bronchodilator therapy as guided by their symptoms. If sympathomimetic and anticholinergic bronchodilators provide inadequate therapy, a trial of corticosteroid therapy should be instituted (Pardo and Miller, 2018, p. 466)."



Concerning the alveoli, the pre-surgical breathing treatment can help open the alveolar walls and decrease secretions. A drug that is typically used to reduce secretions from COPD is glycopyrrolate. In addition to the anticholinergic agents

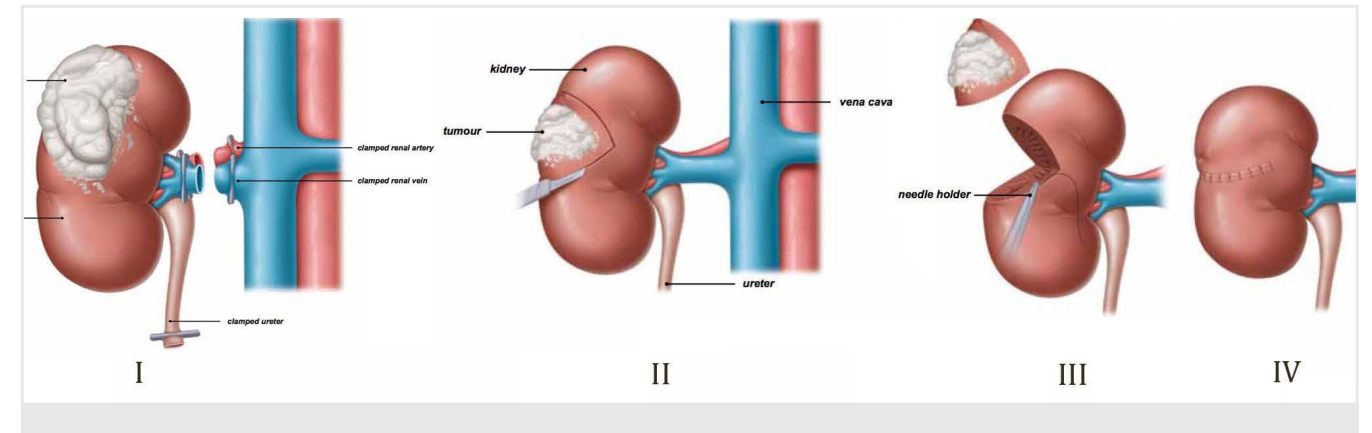


and bronchodilator breathing treatments, Pardo and Miller indicate that preoperative chest physiotherapy is noted to reduce pulmonary complications post-surgical intervention. (Prado and Miller, 2018, p. 466). Chest physiotherapy is a manual process of clearing mucous from the respiratory system. It relies on percussive measures being applied to different areas of the chest wall. The goal is to move the secretions to the patient's midline. The process also includes getting the patient to produce solid coughs to remove the repositioned secretions.

Before the start of the case, the anesthesia technologist should make sure suction is on the anesthesia machine, working effectively, and generating 40.6kPa (Dorsch, 2012). In addition to the standard yankaur used for oropharyngeal suctioning during induction, the technologist should ensure the anesthesia deck has appropriately sized tracheal suction catheters. A patient with COPD is likely to have more secretions upon emergence, and the anesthesia provider will need the suction ready to go to ease the emergence process.

Another anesthetic consideration specific to this patient dealt with her medication history. The patient was on chronic lisinopril, which could affect her drug metabolism due to her liver metastases. Lisinopril is a class of ACE inhibitor used as a vasodilator. In combination with the patients Liver metastases, the anesthesia care team should reduce hepatic and renal metabolized medications. For this reason, the patient was given Cisatracurium besilate for Neuromuscular blockade since this NMBA relies on Hoffmann elimination as opposed to hepatic and renal metabolism commonly associated with Rocuronium Bromide.

The technologist needs to have a fluid warmer setup and ready to use to compensate for evaporative heat loss due to the patient having open abdominal surgery. Due



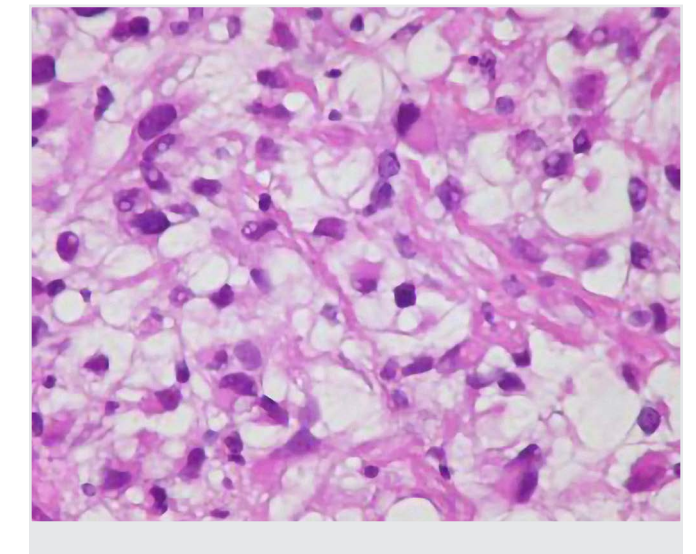
to the patients' comorbidities, the provider requested an ultrasound in the room to assist with the arterial line placement.

Patient Positioning

Proper positioning is imperative for patient safety. A partial nephrectomy is a 3-4-hour procedure, so appropriate positioning precautions were taken to prevent injury and nerve neuropathy. As stated earlier, the patient was in the lateral decubitus position for the surgery. A prone pillow was used to keep the spine in a neutral position. Another consideration taken during the positioning was making sure the patient's dependent ear was not compressed and the eyes were taped and free from pressure. It is important to note that the dependent ear and eye, or the eye and ear in closest contact to the OR table, should be routinely checked. The ear should be free from bending as this can potentiate localized ischemia. Additionally, the dependent eye is more prone to increased intraocular pressure (IOP). According to the American Academy of Ophthalmology, signs of increased IOP are forward displacement of the lens, corneal edema, irregular pupils, and mid-dilated pupils, among other clinical signs. Pharmacologically, the Seventh Edition of *Miller's Anesthesia* recommends avoiding ketamine and nitrous oxide when IOP increases are predicted. The text does recommend using volatile anesthetics and opioids as these are shown to reduce IOP (Miller, RD et al., 2009).

The positioning of the extremities is important when in the lateral decubitus position. Injuries to the Brachial Plexus and Common Peroneal nerve are the most common unless preventive measures are taken. According to Miller and Pardo's *Basics of Anesthesia*, injury to the brachial plexus is avoided when the arms are not abducted more than 90 degrees, and proper padding is used to prevent compression injuries to the Brachial Plexus induced by the humeral

head (Pardo and Miller, 2018, p. 325). During positioning, specific attention was given to the patient's extremities to prevent nerve damage. The dependent arm (in this case, the right arm) was placed in an arm board cushioned with foam padding. The non-dependent arm was folded over the dependent arm and placed in an attachable armrest with additional padding.



An axillary roll was placed just below the axilla to prevent damage to the Axillary nerve. The axillary roll was placed below the axilla rather than directly in the axilla to avoid compression against the axillary nerve, which would potentiate damage to the brachial plexus. Additionally, it should be noted that the axillary roll's placement below the axilla helps reduce suprascapular nerve damage (Pardo and Miller, 2018, p. 325). A pillow was placed underneath the patient's hips to protect the bony prominences and avoid damage to the sciatic nerve. According to Prado and Miller (2018), special considerations should be taken when positioning the lower extremities as well.

Continues on next page . . .

"The dependent leg should be somewhat flexed. A pillow or other padding is generally placed between the knees with the dependent leg flexed to minimize excessive pressure on bony prominences and stretch of lower extremity nerves (Prado and Miller, 2018, p. 325)."

To protect the patient's lower extremities, the dependent leg (right leg) was slightly flexed with padding underneath to protect the Common Peroneal nerve. A pillow was placed between the patient's knees to protect the popliteal nerve from injury. The non-dependent leg (left leg) was slightly extended and placed over the pillow on the dependent leg. Padding was placed under the dependent foot's heel and between the patient's ankles for further neuropathy prevention.

Induction Sequence

It is essential to be prepared and have the correct equipment for induction. If the anesthesia technologist is familiar with the anesthesia provider's preferred setup, the anesthesia technologist should have the induction equipment set up before starting the case. For this case, the resident used a MAC 3 laryngoscope blade, 7.0 endotracheal tube, and a 9cm Berman oropharyngeal airway. According to Jaffe (2014), this procedure can be associated with higher fluid requirements (8-10 mL/kg/h). Normal saline or lactated ringers should be given at 6-8 mL/kg/h, and all fluids should be warmed. Mild-to-moderate blood loss can be expected (Jaffe, 2014, p. 898). For this procedure, the patient had a 20-gauge macro drip IV in her left arm and an 18-gauge hotline with normal saline in her right arm.

An arterial line was placed in the patient's right radial artery for invasive blood pressure monitoring. The requirement of the arterial line was two-fold. The severity of the surgery and risk of acute hypotension and the intraoperative monitoring and management of the patient's hypertension. The arterial




line was free of kinks and zeroed at the phlebostatic axis. If the patient still had the basilar artery aneurysm, the arterial line would need to be zeroed at her ear to give a more accurate reading of the pressure in the head. However, since her basilar artery aneurysm was managed in a previous surgery, the arterial line was zeroed at the phlebostatic axis. Prior to the start of the case, the anesthesia technologist provided an ISTAT to have on hand for intraoperative blood testing. Blood administration was not necessary during this case. However, depending on the amount of blood loss, a partial nephrectomy could require blood administration. ASA monitors are required with every surgery. This patient was connected to a pulse oximeter, non-invasive blood pressure cuff, EKG leads, and a temperature probe, all of which had no artifacts or intraoperative anomalies. A foley catheter was placed to monitor urine output and assess fluid needs. According to Jaffe (2014), regional techniques such as a spinal or epidural may be combined with general anesthesia to minimize postoperative pain (Jaffe, 2014, p. 898). The patient, in this case, had an epidural placed preoperatively to aid in pain management. Upon successful extubation, the patient was taken to the PACU in a simple face mask with auxillary oxygen at 8L/min. Once the patient was moved to the floor, a PCA was administered to help with postoperative pain management.

Complications

Complications with this procedure include pneumothorax and decreased blood pressure due to the lateral position (Jaffe, 2014, p.898). Because the patient had COPD, she was at a higher risk for complications such as pneumothorax, atelectasis, and pneumonia. To prevent a pneumothorax or further complications with the patient's COPD, the endotracheal tube was taped securely and was monitored periodically to ensure negative tube migration and negative right bronchial mainstem lung isolation. At the start of the case, the resident had difficulty placing the arterial line. She first attempted to place the arterial line in the left radial artery before the patient was moved to the lateral decubitus position. However, she was unable to locate the artery, and the surgeon wanted to begin the procedure. After the patient was placed in the right lateral decubitus, the resident attempted to place the arterial line in the right radial artery under the sterile drapes. She could not locate the right radial artery as well, so the anesthesia technologist brought in an ultrasound. The ultrasound enabled the resident to get a better view of the artery, and she was able to place the arterial line.

Conclusion

In conclusion, a 60-year-old female with renal cell carcinoma was scheduled for a left open partial nephrectomy. The patient was placed in the right lateral decubitus position, which requires special attention to extremity placement and nerve padding. Several implications and considerations were to be taken with the patient's prior conditions, such as hypertension and COPD. Due to the preoperative concerns associated with this type of procedure, an anesthesia technologist must be familiar with the case and anticipate the anesthesia provider's needs by attaining a base understanding of renal physiology and pathophysiology. The anesthesia technologist played an important role in providing the best possible care for the patient. The technologist assisted with the patient's preoperative respiratory bronchodilation treatment, anesthesia room preparation according to best practice found in literature and provider preference, safe induction, and emergence from anesthesia, and safe transport to the PACU. The patient's surgery was successful with an ideal margin removal of cancer and was completed in 210 minutes. The patient was extubated after exiting Guedel Stage-Two of anesthesia to limit the possibility of laryngospasm. Upon extubation, the patient was given supplemental oxygen at 8L/min. via simple facemask and transported to PACU for continued monitoring and evaluation. 

References

Jaffe, R. A., Schmielesing, C. A., & Golianu, B. (2014). *Anesthesiologists manual of surgical procedures* (5th ed.). Philadelphia, PA: Wolters Kluwer.

Pardo, M. C., & Miller, R. D. (2018). *Basics of anesthesia* (7th ed.). Philadelphia, PA: Elsevier.

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QUIZ
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Vitals

INDUSTRY NEWS

Supply Chain Shortages

As the New Year begins, we continue to deal with the pandemic and in some areas, record numbers of hospital admissions of COVID-19 patients. Businesses continue to struggle to return to some semblance of normalcy and no area more so than the operating room, whether it be the hospital or the ambulatory surgery center setting. There were disruptions to the supply chain at the onset of COVID in March 2020 as everyone scrambled to secure PPE and airway supplies. Almost a year into the pandemic, the supply chain is struggling even more now than before. Federal allocations, shortage of raw materials, manufacturers not anticipating the demand for specific items and the workforce issues has posed significant challenges for perioperative leadership and the surgical teams. The workforce is getting creative in dealing with supply shortages. Obviously we can use a 5cc syringe in place of a 1 or 3cc syringe, but by doing so we reduce the availability of 5cc syringes which then leads to a manufacturer back order. Now, we put a strain in the 10cc syringes...thereby quickly reducing the availability of 10cc syringes. The underlying question then becomes at what point do we say, "This is a mission critical item and without it we will not proceed with performing surgeries"? Obviously we can use a 5cc syringe in place of a 1 or 3cc syringe, but by doing so, we reduce availability of 5cc syringes. Below is a brief list of items that are either on federal allocation or on manufacturer back order:

- Sterile surgical gowns & isolation gowns
- Endotracheal tubes (specifically 7.0 & 7.5)
- Syringes – specifically 1 and 3cc
- Gloves – regular exam and sterile
- Oral airways (90mm and 100mm)
- Disposable laryngoscope blades
- Needles/IV catheters – all sizes
- Suction tubing/yankeur tips
- Arterial blood gas syringes
- Surgical drapes
- Alcohol prep pads
- Foley catheters
- Tracheostomy tubes

Thank you,
Sue Christian, Cer.A.T.T. 


Partners

ASA

Fear the Virus Not the Vaccine

A few even in the medical profession are concerned about the mRNA (messenger RNA) technology, which is the backbone of our earliest available COVID-19 vaccines (Pfizer and Moderna). mRNA vaccines are the first of their kind for use in humans (at least for those that have been released on the market because we have tested mRNA vaccines in humans before). Most of our vaccines use altered or nonfunctional versions of the virus we are combating or pieces of the covering, whether it the envelope (lipid and protein) or capsid (protein). The mRNA vaccine contains a portion of the virus code or "blueprint" that produces just a part of the "coat", which was once identified as foreign within our bodies. This then generates an immune response; in this case, it is a portion of the crown or spike protein. mRNA is usually produced or transcribed from the DNA in the nucleus of a cell, which is then released into the cytoplasm where all the intra cellular building blocks exist to make proteins. The spike protein mRNA (does not in any way incorporate into our own genetic code) goes to the ribosomes and begins to be "read" or translated, proteins are then formed as per the nucleotide sequence within the mRNA. The pieces of the COVID-19 protein coat are then transported to the surface of the cell and expressed on MHC I or II receptors. The proteins are identified as foreign by T helper cells. The T helper cells bind to the receptors and then generate an immune response by producing a myriad of cytokines that will create an army of plasma cells from B cells. These B cells form specific antibodies as well as cytotoxic T cells that will bind to and remove the "antigen" and/or infected host cells. Any future spike proteins, especially those attached to the coronavirus (SARS-CoV-2), will then be identified as foreign and be removed due to the "memory" within the B cells and T cells. It is a simple but magnificent design. Do not fear the vaccine. Fear the virus.

Joseph F. Answine, MD, FASA


Liaison to ASATT 

AANA

National Certified Registered Nurse Anesthetist Week occurred January 24-30, 2021 which is an annual celebration of the nation's nearly 57,000 nurse anesthetists. Currently, as we traverse and successfully work through the COVID-19 pandemic, the AANA recognizes the dedicated commitment of all members of the anesthesia care team including all of the anesthesia technicians and technologist that contribute so much to patient care and assist in anesthesia care delivery. This in part due to the standardization of the curriculum in the anesthesia technologist educational programs in the US. The objectives of the anesthesia technician educational program are to prepare program graduates to become an integral member of the anesthesia patient care team and assist in many aspects of anesthesia delivery. The curriculum is based on the standards published by the Committee on Accreditation of Anesthesia Technology Education (COA-ATE) and the Commission on Accreditation of Allied Health Education Programs (CAAHEP). ASATT is the recognized organization responsible for raising the standards for patient care and level of competence for anesthesia technicians/technologists in all areas of practice. The AANA along with other anesthesia and nursing organizations acknowledge the power of our diverse anesthesia care team community as we continue a future of providing safe and effective collaborative anesthesia care to a multitude of patient populations.

Take care and stay safe!

Michael Boytim CRNA, Ed.D.

Liaison to ASATT 

Notes

REGIONAL UPDATE

REGION 1



Happy New Year everyone!!

Well I have some great news! Region 1 has scheduled its first virtual meeting for February 27th. Unfortunately, registration has closed for this meeting. Please keep an eye out on the ASATT events page for future meeting information.

I know there are quite a few of you that have had some concerns regarding the new Membership fees and what it all entails. Please be patient with everyone and do not panic, I know easier said than done. ASATT membership for years has asked for more benefits of the organization. The last time the membership fees were increased was several years ago. In order to provide ASATT membership with more benefits, the membership fee will need to increase. Below is the following regarding Membership Model Benefits.

2 YEAR MEMBERSHIP INCLUDES:

16 Sensor Quizzes, 2 Webinars for 4 CEUs each, 25% Discount on the National Meeting and other ASATT sponsored events, as well as a discount on the recertification fee. That is an amazing deal. I love to save money in this day and age. I will definitely jump on to this opportunity!!!!

STAY SAFE AND HEALTHY,

Jonnalee Geddis, Cer.A.T. 

REGION 2



Hello to our members,

I hope everyone has had a great start of this New Year!! I hope that 2021 will be a healthier and brighter year! I know our facility is pleased to announce that they have the Covid-19 vaccine (Pfizer) available to our employees. I am very pleased

that I now have had both doses. Remember to get your flu shots and your Covid-19 vaccines.

As most of you have seen or heard there will be new changes moving forward to move our profession in the right direction. I know our members have or will have concerns regarding the new membership fees. I have heard for years that members wanted more benefits to being a member and now we will have that available to us. For questions regarding the new membership model, please email ASATT Headquarters at customercare@asatt.org.

Do not forget to visit our ASATT website; it has a plethora of useful information. Including articles on Healthcare news. Moreover, do not forget the discussion boards where you can ask questions and share ideas. **Remember if you would like to discuss the new membership with other members and the ASATT board, please visit the Discussion Forum.**

It is not too early to be thinking about our Annual Educational conference; held on September 23 - 25, 2021 in Fort Worth, TX. Be watching for updates regarding our Annual Conference.

As a reminder: Please everyone stay safe, and wash your hands and practice social distancing.

Take care and stay safe everyone!!

Karen Patrick, Cer.A.T. 

REGION 3



Greetings Region 3,

It has been a long, strange trip navigating through the pandemic. As we continue to navigate our way and vaccines become available, my wish for this New Year is that everyone will get vaccinated so that we

can be one-step closer to moving to a more normal way of life. I contemplated long and hard about whether or not to get vaccinated. I will tell you that the first shot was minor with no symptoms other than a sore arm. The second shot was slightly different. After about 6 hours of having received the shot, I developed fatigue, a headache and chills. By the next day, all symptoms had subsided and I felt fine. Realizing that not everyone will react the same way, I would encourage you to discuss the pros and cons with your family physician as well as your immediate family.

As we continue on in our virtual world, I am seeking speakers for a virtual Region 3 meeting. If you know someone that is interested in speaking, have those individuals email me.

Our annual meeting is slated from being held in-person in Fort Worth, Texas; however, that is subject to change based on the pandemic. The dates are September 23-25th, 2021, so stay tuned to the website for further information.

As we enter the New Year, we can anticipate new changes to move the profession forward. Changes to membership will be occurring, as will changes to the recertification process. Speaking of recertification, please do not procrastinate and wait until the last minute to earn your CEUs. Every one of us has two years to earn the respective CEUs. Failure to comply with the requirements will ultimately come with an additional penalty. Individuals who need to maintain their certification should be aware that while ASATT grants a 30-day extension, we have no power to override your employer's requirement of meeting the 12/31 deadline. It should be noted that there are major holidays within that period. Please be mindful that submitting a hard copy by mail, results in a SIGNIFICANT delay in the review process of your submission. Finally, please note that the recertification process fees are non-refundable.

Stay safe,
Sue Christian, Cer.A.T.T.

REGION 4



Happy 2021 Region 4!

I hope y'all had a great holiday season with family and friends...socially distanced of course!!

I'd like to thank everyone that attended our 2 regional

webinars in October and December, they were a huge success. We had some great feedback and I am looking forward to having another 3 webinars over the course of this year; so if you have any ideas for topics or speakers, please let me know so I can make it happen.

Don't forget to start planning towards this year's National conference down in Fort Worth, it'll be nice to see some familiar faces again!!

As always, be safe and see y'all soon,
Matthew Chandler, Cer.A.T.T.

REGION 7



Howzit Region 7!!!

I hope all of you in our ASATT Ohana had a great holiday season. For my family and I, it was really different this year. My sons didn't want to come home for the holidays with all of Hawaii's Covid-19 precautions.

Plus, they were following our leaders call to not travel during the holidays. I hope many of you did the same.

With the pandemic raging and we continue to set new records, please continue to stay vigilant. We don't need any more of our peers contracting Covid-19. Have some situational awareness. Don't let your guard down and stay alert.

"Safety isn't expensive, it's priceless."
 ~ Unknown ~

2020 was a year to put into our rearview mirror. Let's all look for a better year in 2021. We're not going to get over this pandemic quickly but, as vaccines are distributed and administered, we should see less extremely sick Covid-19 patients. Don't get me wrong, I LOVE my family and our ASATT family, but do you want to be the person responsible for spreading this disease to an elderly family member or them giving it to you?

"If safety is a joke, then death is the punchline."

~ Paul Leforest ~

As we reflect on what 2020 taught us or brought us, it was virtual reality. ASATT had to adapt and has been full of surprises for everyone. ASATT has had to endure the changes like the rest of the world because of the pandemic. I would like to thank Interim-president Greg Farmer who has helped provide leadership to get us through up until this point. He helped guide us from face to face meetings to virtual synchronous meetings. Although there were many obstacles to navigate, we also had a successful virtual Annual Meeting.

Region 7 was the only region that was able to hold a face-to-face educational meeting in February at Chemeketa Community College. Our first virtual meeting was held in August. All of the regions are moving forward and having their virtual meetings.

How many meetings are we going to have in Region 7? Will we be able to have face-to-face meetings? How many virtual meetings are we going to coordinate? This is the year a larger population of our certified members will need to recertify. Even with coordinating virtual meetings, we need assistance in acquiring speakers. I asked these questions in my last two website updates but have not received any response from anyone. Please send me an email at your earliest convenience if you are interested in speaking/ presenting a lecture.

"Plan your work for today and every day. Then work your plan."

~ Margaret Thatcher ~

I'll say it again and again, ASATT is the society that will help our profession move forward into the future. I know ASATT's plan WILL NOT make everyone happy, but you must look at the overall direction that our profession is headed. Give our leaders the benefit of the doubt they are not out to short change you. There are and will be some hard decisions to be made and they are making these decisions with great amount of concern and determination to improve our profession. I have been around for a LONG time and we have grown and improved more than many of you know. There's only a small percentage of our peers that have been in this profession >30 years as myself. I was around when this profession was just beginning to flourish and look at how far we've come!

Last, let's resolve to continue to uphold Region 7's status as the leading region in ASATT, helping educate our peers and help us move our profession forward. As I have said before... We are laying the foundation for future generations of Anesthesia Technicians & Technologists and we MUST build this together.

"Leadership is based on inspiration, not domination, on cooperation, not intimidation."

~ William Arthur Wood ~

Please be careful with Covid-19, it's nothing to take lightly. Take precautions and follow all of the CDC bulletins and guidelines, but don't let it overwhelm your life.

PLEASE BE SAFE AND PROTECT YOURSELVES...

Aloha,
Delbert Macanas, Cer.A.T.T.

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