BOARD OF HEALTH PROFESISONS
REGULATORY RESEARCH COMMITTEE
PUBLIC HEARING ON EMERGING PROFESSIONS
JULY 10, 2009

TIME AND PLACE:	The public hearing was called to order at 9:12 a.m. at the Department of Health Professions. The purpose for the hearing was to receive public comment pursuant to its study into the need to regulate the emerging professions: Surgical Assistants and Surgical Technologists.
PRESIDING CHAIR:	Elizabeth A. Carter, Ph.D., Executive Director, Board of Health Professions
MEMBERS PRESENT:	Damien Howell, P.T.
STAFF PRESENT:	Sandra Ryals, Director, Department of Health Professions Justin Crow, Research Assistant Carol Stamey, Operations Manager
OTHERS PRESENT:	Ira Gantt, ST Mark Polson, CSA Henry Jacobs, CSA Tracee Gamon Susan M. Andrews Mary Armstrong, CFA, CSA, CST Theresa Cooper, CFA, CSA, CST Rebecca Music, AD, CST Catherine Sparkman Bonnie P. Vencill, RN, CNOR Kevin Browne, CST, SAAAS Boris Feldman Catherine Churche, St. Marys Susan Ward, VHHCA
COURT REPORTER:	Lynn Aligood, Capitol Reporting, Inc.
PUBLIC COMMENT:	Ira Gantt, ST, Reston Surgical Center, spoke of two types of accreditation. He inquired of the Board which type of accreditation the Board was considering regulating and requested clarification on recertification and grandfathering.

serving in the Army Reserves, presented comment in favor of regulation. Further, he requested that if the Board recommends regulation, then it should consider military training equivalency or grandfathering for military trained personnel.

Henry Jacobs, CSA, representing himself, presented comment in favor of regulation. He stated that the surgical assistants serve as the right hands of the surgeons.

Mary Armstrong, CSA, CST, presented comment in favor of regulation to insure baseline knowledge. She further requested that the Board consider grandfathering. Ms. Armstrong informed the Board that there were various programs, including those at Sentara, that offered educational courses to assist in obtaining certification. Ms. Armstrong provided a handout of Sentara's Surgical Technology Program, and it is incorporated into the minutes as Attachment 1.

Theresa Cooper, CSA, apprised the Board of an article in the newsletter, *The Edge*, entitled "What You Don't Know Could Hurt (Kill) You." The newsletter is sponsored by the National Board of Surgical Technology and Surgical Assisting and is incorporated into the minutes as Attachment 2. Ms. Cooper further reported on the various invasive surgeries that surgical assistants may perform and stated that the profession must be policed. Further, she stated that it was her belief that the profession should be regulated through the Board of Medicine.

Rebecca Music, AD, CST, representing the Association of Surgical Technologists, stated that the goal of the surgical assistants was to provide good patient care and good outcomes. Ms. Music reported that she would research the issue of patient outcome and provide the data to Mr. Crow. She further expressed her support of regulation.

Catherine Sparkman, Esquire, Director of Public Affairs for the Association of Surgical Technologists provided data on the number of graduating students and an update on other states' regulation at various levels. She further advised that data was being gathered on patient harm issues relating to medical errors, adverse events, infection reporting and cost analysis. Ms. Sparkman reported that there is little outcome data on non-certified versus

certified surgical assistants and surgical technologists. Further, that the Association is seeking outcome data from the hospitals for review. With regard to higher education and mortality, Ms. Sparkman described a study by Linda Aiken from Johns Hopkins. Ms. Sparkman stated that the Association of Surgical Technologists supports regulation across all states.

Susan Bonbotch, R.N., informed the Board that surgical assistants perform delegated medical tasks, and she supports regulation of the profession.

Bonnie Vencill, R.N., representing herself, advised that she supported certification and would be willing to assist the Board in its study.

Kevin Browne, CST, stated that he supports certification of surgical technologists as well as continued competency assurance. Further, he stated that the associations, hospitals and the annual national conference offered continuing education at minimal cost.

Boris Feldman, CSA, M.D., representing surgical assistants from INOVA Fairfax Hospital and Capital Surgical Services, a private company providing surgical assistant services, informed the Board of his support of regulation. With regard to non-certified surgical technologists, he expressed concern over a variety of issues, such as as scope of practice restrictions, personnel relations, education, and malpractice insurance. He also offered to provide a list of other surgical assistant private contractors.

David Jennette, CSA, Sentara Hospital, President of National Surgical Assistant Association, stated that he was in support of regulating surgical assistants and surgical technologists. Further, he stated that he supports grandfathering and accepting military credentials if the required military forms are provided. Additionally, Mr. Jennette noted that he did not favor long distance or on-line education. Specifically, that these educational courses may not include the clinical skills component. Mr. Jennette provided a certification pamphlet provided by the National Surgical Assistant Association. The pamphlet is incorporated into the minutes as Attachment 3.

Dr. Carter informed the public that an additional public hearing is scheduled for August 11, 2009 at 9:00 a.m. with a deadline of August 15, 2009 to receive written comment. She further stated that that the Regulatory Review Committee will review the draft report at the August meeting and may make its recommendations to the full Board at that time.

The public hearing transcript will be incorporated into the minutes as Attachment 4 upon receipt from Capital Reporting, Inc.

ADJOURNMENT: The Hearing adjourned at 11:00 a.m.

____

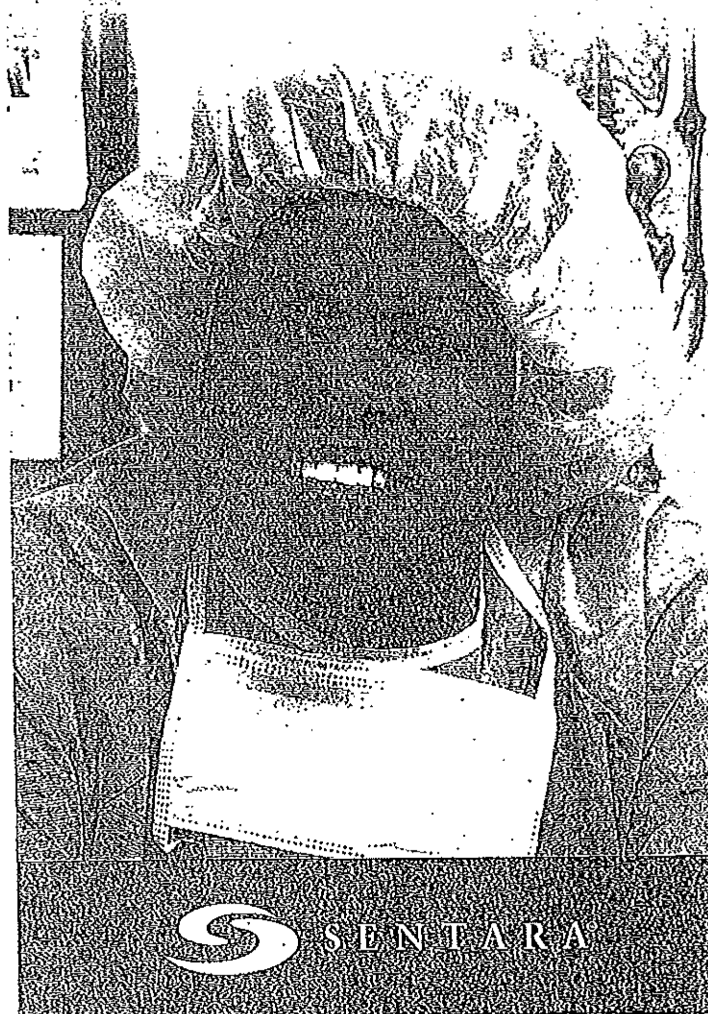
Elizabeth A. Carter, Ph.D. Executive Director
Board of Health Professions

Attachment 1

Sentara School of Health Professions

Advanced Placement Option for the

Surgical Technology Program



SENTARA SCHOOL OF HEALTH PROFESSIONS

Advanced Placement Option – *A Pathway to Certification*

You've worked long and hard. Your skills and technique are among the best in the business. You are respected by your peers, manager, and surgeons. You want to advance but you must sit for the National Board of Surgical Technologist and Surgical Assistant (NBSTSA) exam.

For the first time all experienced Surgical Technologists have an avenue to attain certification status. Improve yourself, your department, your patient care skills, and how you are viewed by peers and management by becoming a Certified Surgical Technologist through the Advanced Placement Option at the Sentara School of Health Professions.

Who Should Advance Place?

Any Surgical Technologist who has:

- Been unable to sit for the certification exam because of education constraints.
- Been trained on the job.
- Attended a non-accredited military training program.
- Attended a non-accredited health programs school.
- Current enrollment in another program and wishes to transfer.

If you meet any of the criteria, you qualify to be eligible to advance place. Through Advanced Placement you will challenge out of each semester with an exam.

Where Do I Begin?

- Apply to the Sentara School of Health Professions as a student.
- Meet the prerequisites of the ST Program. (High School Diploma or GED & 3-8 credit Non-lab Anatomy and Physiology or Human Biology)
- Take the admissions exam (HOBET).
- Become an accepted student.
- For additional admissions information, contact Student Services at 757.388.2666 or link to www.sentara.com/healthprofessions.

What's Next?

- Submit a letter of reference from your direct supervisor as to the number of cases on average you have done in the last three years.
- Submit a letter of reference from a currently practicing surgeon validating your skills and technique.
- Recommended purchase of the current textbook in use - Surgical Technology Principles and Practice, 4th Ed. Fuller.
- Schedule an appointment with the Program Director to receive the first semester syllabus and plan a completion map.
- Upon successful completion of each exam you will automatically be eligible to take the next. Using your syllabus and text you must prepare for these exams. Exams are offered twice a semester. You can progress at your own pace, however the Program must be completed within twelve months.
- With each passing grade of 77% you can move on to the next module. There are three exam modules. Prior to completion, every student must take a Program Assessment Exam (PAE) as required by our accrediting body, Accrediting Bureau of Health Education Schools (ABHES).

Will I Be Considered A Graduate?

Yes. You will receive a diploma stating you are a graduate of the Sentara School of Health Professions Surgical Technology Program.

What About Certification?

- You will be eligible to sit for the certification exam.
- You may be given the opportunity to test with a graduating class at the School in May or November of each year, OR
- You may test at a NBSTSA approved testing center.
- Refer to: www.NBSTSA.org
  www.AST.org

Total Cost of Tuition and Fees
$1,200.00

SENTARA®

School of Health Professions

Your community, not-for-profit health partner.

Surgical Technology Program
Advanced Placement:
Tel: 757.388.4240
Fax: 757.388.2905
www.sentara.com/healthprofessions

Crossways I ◦ Suite 105
1441 Crossways Boulevard ◦ Chesapeake, Virginia 23320

Sentara School of Health Professions is owned and operated by Sentara Norfolk General Hospital

December 2007

Attachment 2

What You Don't Know Could Hurt (Kill) You

The operating room is a cloistered, mysterious place where gory, scary, invasive, and yes- even life and death events occur. If you've watched *House, Gray's Anatomy, Nip Tuck,* or any number of "reality" programs on Discovery Health or TLC, you are already aware of the growing fascination with this often misunderstood realm of health care. Nearly always, the storyline involves the doctors/surgeons. Lately, the focus is on the nurses. How often do the writers explain to you who all of the other people decked out in green or blue garb are? Isn't everyone in the operating room a surgeon, a nurse, or a patient? Doesn't everyone who works in the operating theatre hold an advanced degree and a form of professional licensure, certification, or registration? Of course one would think so. One would be wrong.

When you go to the beauty salon, you expect to see the state issued license of the person who is cutting and styling your hair proudly displayed at his or her station. Much is made about whether the person teaching your child is a certified teacher. When you look for a plumber or an electrician, do you check their credentials? What about your real estate agent? Have you ever been swayed by the fine print in commercials for attorneys saying that they are "Board Certified" or not in their area of legal practice? Do we not pride ourselves on checking out the qualifications and track records of people who work on our various forms of "stuff"? Likely, most of the answers to these questions would be YES. The old adage, "Buyer Beware!" is an example of "informed consent".

What does this have to do with your surgical procedure? There is a little known allied health field called Surgical Technology. Why is this designated as an allied health field? Because it is not Nursing. It is not Medicine. It is made up of people specially trained to: prepare and protect the integrity of the sterile field, handle sterile instrumentation, identify the needs of the surgeon, perform the necessary checks and balances (counting sponges, sharps, and instruments), check and label all medications used intraoperatively, assist the registered nurse in proper positioning or transfer techniques, and be an informed, aware, and integral part of the surgical team. As much as anyone else in the operating room, the surgical technologist is responsible for being the patient's advocate. The fundamental concept taught first, foremost, and continuously reinforced is *"AEGER PRIMO"*. Translation: "the patient first."

With all of this responsibility, surely this is a highly regulated, compensated, and valued profession. Think again. The public-at-large has no idea that there is little or NO regulation at this time for the oversight of those practitioners of this mysterious and misunderstood vocation. In some areas of the country, hospital employees working in non-patient care areas such as central supply, housekeeping, or medical records can be reassigned to be on-the-job trained or "OJT'd" at a lower salary with quicker access than hiring educated and Certified Surgical Technologists (CSTs). The people put in charge of making sure that your loved one's surgical procedure is performed with sterile instruments; that nothing is left behind to cause injury or potential death; or the medications used during the operation are not mixed up, do not currently need to be held to a professional standard. Some corporate "wisdom" has tried to rationalize the practice by stating that it is safe because there is a professional registered nurse (RN) overseeing any and all unlicensed assistive personnel (UAPs) in the room.

The shortage of qualified nurses to work in all areas of healthcare facilities is what has spawned the explosion of allied health professions. Nurses used to be expected to be proficient in nearly every aspect of patient care. However, nowadays, there are respiratory therapists, radiological technologists, pharmacy technicians, medical laboratory technicians, phlebotomists, ultrasonography technologists, perfusionists, sterile processing technicians, and patient care technicians to name a few. These are highly specialized, non-nursing, allied health professionals. There are training programs for all of these offered at community colleges, universities, or technical schools throughout the country. Most of them have some form of mandatory state regulatory practice requirements and oversight. Laboratory and on-site clinical practice curricula are structured, monitored, and irreplaceable educational criteria for the "real world" recipients of these various caregivers: the patients.

Just because surgery goes on behind closed doors by people in scrubs, masks, gowns, and gloves, it does not mean that what you don't know about them might not impact on you or your loved one. Do you think you have cause for concern that the person doing your manicure might be risking your health with poorly cleaned instruments? You could get an infection. Transfer that concern to the person in charge of the instruments that are going to be used to replace your hip or your knee. What about those used for coronary bypass, for excision of your diseased gallbladder or uterus? If your baby is born via Cesarean section, should that person be skilled in that procedure? Many facelifts, tummy tucks, or liposuction procedures are now being done in doctors' offices. Who cleans and sterilizes those instruments and passes them during the procedure? The surgeon performs the actual procedure. Everyone knows that. The paperwork—consents, history, assessment, and O.R. records—are filled out by the registered circulating nurse (RN). The anesthesia provider is either an anesthesiologist (MD) or a certified registered nurse anesthetist (CRNA). Doesn't it then make sense that your surgical technologist should be a certified surgical technologist (CST), not just a convenient "body"? Patients can suffer prolonged treatment and even die from hospital acquired illnesses (HAIs) and surgical site infections (SSIs). That's a bit more concerning than a scalp rash or fingernail fungus.

Why has the public not known about this glaring hole in the fabric of surgical care before? The reasons are complex and yet very basic. Money is often a reason. It is more cost effective for hospitals to hire >>

What You Don't Know... *Continued*

non-certified surgical technologists to fill positions in the operating room than to try to hire all RNs or well-trained CSTs. Another reason is title protection. The nurse in the O.R. has traditionally been known as the patient's advocate. This means that they are still duty-bound to follow the surgeon's or anesthesiologist's orders, but they have the ability and responsibility to question those orders in order to protect the patient from mistakes or malpractice. This role and duty of the RN in the operating room is not in question. However, some have maintained that the RN is the only qualified person to advocate for the proper care of the patient simply because of the title and license they hold.

Nurses can receive an Associate's Degree in Nursing (ADN) from a community college or a Bachelor's of Science in Nursing (BSN) from a university. In very few cases does the curriculum of either the four-year or two-year nursing program allow for any real time in surgery. The student nurse may have one or two visits to the O.R., when the focus is on a particular patient's continuum of care, following the patient from admission to discharge. There are some elective courses in perioperative nursing taught at some schools. But, the vast majority of graduate nurses who come to work behind the closed doors, past the red line, have little or no experience in the highly structured techniques and subtle nuances of the surgical suite. They gain skills by being mentored by experienced RNs. The quality of their on-the-job training hinges on the quality of the O.R. nurse educator.

Surgical technologists, on the other hand, have intensely focused surgical training. They are taught many of the same skills that the registered nurse performs. This is not to try to eliminate the need for the nurse, but to understand the inherent interconnections of the various duties and responsibilities. Once the surgical technologist has performed the surgical scrub and donned the proper sterile attire, he or she can only interact with and touch other sterile items. The circulating nurse is the unsterile person who "circulates" around the sterile field and interacts with only the nonsterile items/areas. Both team members share dual responsibility for protecting the patient by keeping focused on all aspects of the surgical procedure.

The CST is guided by a *"Surgical Conscience"* which basically states that he or she is responsible for recognizing, admitting, and correcting any breaks in aseptic (without infection) or sterile (absence of all living microorganisms) technique, regardless of whether anyone else witnessed it. In more colloquial terms, it means: "When in doubt, throw it out." and "If you mess up, you 'fess up." This sense of duty and accountability is the cornerstone and foundation of the practice of Surgical Technology. These professionals: stand for long periods, carry heavy sterile instrument trays, come in on call at any hour of the day/night or on holidays, witness the heartbreaks of child or elder abuse, traumatic injuries, and results of bad life-choices. They witness and participate in the human miracles of birth, death, organ donation, curative measures, and re-establishment of bodily functions. And lastly, they are, for all intents and purposes, completely unnoticed or unrecognized, but certainly worthy of a professional status and title.

Surgical technologists are underpaid for the intensity of the work they do on a daily basis. Dedication and a pure love of the job are what keep people in this field, despite the disproportionately low wages as compared to the other surgical team members. Nearly any surgeon you ask will tell you that a good surgical technologist can contribute greatly to the success of the procedure. They may use the term "scrub nurse" or "scrub tech", ORT or CST, but the person to whom they are referring is, in all likelihood, a surgical technologist.

What you don't know can hurt you. Do you want to chance it that the person behind the mask and gown is an educated professional or someone trained in a few easy lessons on how to simply respond to a command? You must give informed consent, for all kinds of possible untoward events related to your surgery, before you go under the knife. Shouldn't you have the right to insist that you have a Certified Surgical Technologist (CST) assisting your surgeon and RN during your procedure? The hospital associations are not going to tell you they train from within or hire non-certified surgical techs in order to save money. Surgeons do not usually want to get involved with the hospital's personnel issues. They just want to know that they have someone to give them what they need—before they ask for it. Nurses will assure you that they oversee and monitor everything that goes on in the O.R., even the unlicensed folks. That can be tricky when they are not part of the sterile field and may have to be in and out of the room during the procedure.

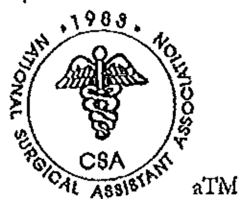
Surgical technologists are trying to raise the bar and their own standards of practice. This will create a higher level of professional status to work in concert with the already highly regulated and educated professional nurses and physicians who practice in surgery. Competition with the other team members is not the intent. Collegiality and shared patient advocacy by all parties are the ultimate goals.

The professional membership organization, the Association of Surgical Technologists (www.AST.org) has been in existence for forty years. It currently has over 27,000 members. AST has helped to form individual state assemblies, which offer continuing education seminars and provide guidance in pursuing legislation in all states for standardized educational levels, certification, and/or registration of practitioners as a condition of employment. The national certification exam and credential are offered by the National Board of Surgical Technology and Surgical Assisting (www.NBSTSA.org). The Accreditation Review Committee on Education handles the accreditation process for surgical technology and first assisting programs for Surgical Technology and Surgical Assisting (www.ARCSTSA.org). The ARCSTSA comes under the umbrella of the Commission on Accreditation of Allied Health Education Programs (www.CAAHEP.org). CAAHEP is, in turn, recognized by the Council for Higher Education Accreditation (www.CHEA.org).

A successful surgical procedure is a wonder to behold. The teamwork and cooperation that goes into the performance of these highly technical interventions is paramount to good surgical patient outcomes. It just makes logical sense that EVERY member of the team be recognized for the unique individual strengths and talents they bring to the O.R. table and expected to carry a professional credential in order to function in that capacity. Consider yourself informed.

Margaret Rodriguez, CST, CFA, FAST, BS
Vice President, Association of Surgical Technologists
Associate Professor, Surgical Technology Program, El Paso Community College
Council on Surgical and Perioperative Safety (CSPS), Board of Directors
Texas State Assembly of AST, Board of Directors

Attachment 3



aTM

National Surgical Assistant Association

Providing the Gold Standard in certification of the Non Physician Surgical Assistant since 1983.

CSA—Certified Surgical Assistant

National Surgical Assistant Association and the Certified Surgical Assistant

National Surgical Assistant Association (NSAA) was established in 1983 for the purpose of setting standards of professionalism, assuring competency testing and certifying competency through their CSA (Certified Surgical Assistant) designation. NSAA was the first organization in the nation to test the competency of the non-physician surgical assistant and provide a professional certification. NSAA mandates continuing education for Certified Surgical Assistants throughout the country and re-certification of the CSA credential, by the establishment of continuing medical education standards and verification.

The Certified Surgical Assistant:

- The Certified Surgical Assistant possesses a working knowledge of all operating room procedures with respect to attire, infection control, and is familiar with individual requirements and recommended practices of compliance.
- The Certified Surgical Assistant accepts responsibility for his/her integrity with respect to maintenance and compliance, to and of these policies.
- The Certified Surgical Assistant must have the ability to anticipate the needs of the surgeon, and other team members, with respect to the requirements of a particular surgical procedure.
- The Certified Surgical Assistant must be able to demonstrate and maintain dexterity sufficient to successful completion of his/her assistant duties on each particular procedure.
- The Certified Surgical Assistant must maintain a professional attitude with respect to the dignity, privacy, and safety of the patient.
- The Certified Surgical Assistant must possess the ability to only function with the limits of his/her ability, and within the scope of practice set forth by the medical facility.

Education and Training

The Non-Physician Surgical Assistant comes from a variety of disciplines, including military training with an emphasis on surgical assisting, formal surgical assistant programs at universities and colleges, nursing surgical assisting specialty programs, physician assistant surgical assisting specialty programs, foreign trained medical doctors with surgical training, as well as US trained medical doctors with surgical training who choose to work in the surgical assisting profession.

Although standards for surgical assisting programs have been developed by CAAHEP (Council for Accreditation of Allied Health Education Programs) and NSAA was instrumental in the development of the entry level standards, NSAA chooses to approve all accepted programs through our own approval process, to insure they meet the high standards and quality of education that is required to meet the stringent standards of the Certified Surgical Assistant.

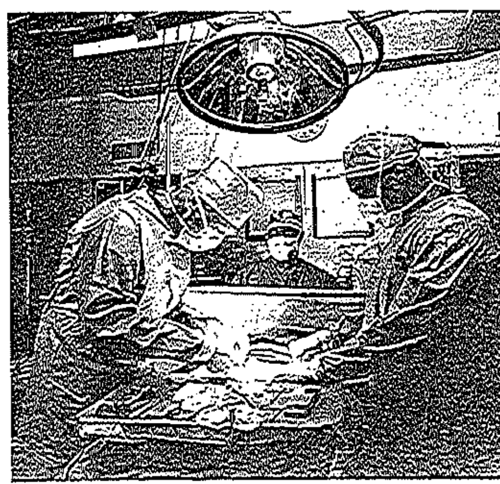
Surgical Assisting is a specialty profession that requires specific training over and above a degree in science, nursing, allied health, physician assistant and more. The National Surgical Assistant Association requires RNs, PAs, NPs, etc. to have clinical training—"at the table" to reach the advanced skill level requirements to be eligible to sit for the CSA examination.

NSAA Members are a vital part of the OR Team

Working under the direction of the surgeon in the capacity of the non-physician surgical assistant, NSAA CSAs offer the gold standard in patient safety, technical skills, professionalism and efficiency. Surgeons across the country request CSAs to assist them in the OR!

About NSAA

The National Surgical Assistant Association (NSAA) began its roots in Norfolk, Virginia at the Norfolk General Hospital. A group of Surgeons and Surgical Assistants felt strongly that certification was needed to distinguish the Surgical Assistant form other positions within the OR. In order for this credential to have the full impact—it need to include an extension, comprehensive examination. This type of credential would assure patients, Surgeons and hospitals that the individual carrying the CSA credential had the training, knowledge and skills needed to perform in the Surgical Assistant role. These Surgeons and Surgical Assistants worked together to develop the first certification examination for Non-physician Surgical Assistants in the country. They formed the Virginia Surgical Assistant Association in the early 1970s and in 1983 became the National Surgical Assistant Association—offering the examination nationwide. NSAA was the first to establish standards and continues to this day to hold the "gold standard" for certification for the Non-Physician Surgical Assistant.



The Second Pair of Hands

Certified Surgical Assistants (CSA) provide that second pair of hands needed in surgery to assure patient safety and efficiency. The CSA credential assures the patient, surgeon, and hospital that a professional with highly honed skills at the advanced level will be assisting in the surgery!

National Surgical Assistant Association
2615 Amesbury Road
Winston-Salem, NC 27103-6502

Toll Free Phone: 888-633-0479
Phoe: 336-768-4443
Toll Free: 888-633-0479
Fax: 336-464-2974
Email: nsaa@namgmt.com
Website: www.nsaa.net

Attachment 4

(10U

1

2

3 DEPARTMENT OF HEALTH PROFESSIONS

4

5 PUBLIC HEARING IN RE:

6

7 THE NEED TO LICENSE SURGICAL ASSISTANTS
AND
8 SURGICAL TECHNOLOGISTS

9

10

11

12

13

14

15

16

17 9960 Mayland Drive
Board Room 1
Richmond, Virginia

18

19

20 July 10, 2009
9:00 a.m.

21

22

23

24 CAPITOL REPORTING, INC.
P.O. Box 959
25 Mechanicsville, Virginia 23111
Tel. No. (804) 788-4917

1 APPEARANCES:
2 Elizabeth A. Carter, PhD. - Chairman
3 Justin Crow - Research Assistant
4 Sandra Ryals - Department of Health Professions
5 Damien Howell, P.T.
6 Carol Stamey - Operations Manager
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1

2 S P E A K E R S:

3 Ira Gantt 5

4 Mark Polson 8

5 Henry Jacobs 14

6 Mary Armstrong 17

7 Theresa Cooper 25

8 Rebecca Music 34

9 Catherine Sparkman 36

10 Bonnie Vencill 50

11 Kevin Brown 52

12 Boris Feldman 55

13 David Jennette 59

14

15

16

17

18

19

20

21

22

23

24

25

1

2 DR. CARTER: Good morning. I'm Elizabeth
3 Carter. This is a public hearing to receive public
4 comment on the board's study of emerging professions
5 specific to surgical assistants and surgical
6 technologists.
7 At the Board of Health Professions last
8 meeting in February, they asked that we hold an
9 additional public hearing between now and the next
10 meeting. We will also hold one more. We had one more,
11 we are going to have one on August 11th prior to the
12 regulatory research committee meeting beginning at 9:00
13 o'clock, and the reason we are holding an additional
14 one -- thank you all for coming today -- but we had an
15 electronic glitch. I don't know if you all heard how
16 much trouble we had with our computers. It did not
17 notice on the Commonwealth Calendar or Town Hall this
18 meeting, so if you heard about it, you either heard it
19 through our public participation guidelines mailings,
20 the notice on board meetings, associations also sending
21 out the word, which we very much appreciate, but
22 anyway, just to make sure that everybody gets a chance
23 before we go further with the study, we'll have that
24 hearing as well.
25 And let me do one little technical thing

1 here this morning as well.

2 NOTE: Instructions given for evacuation

3 in event of emergency.

4 DR. CARTER: The Code of Virginia

5 authorizes the Board of Health Professions to advise

6 the Governor, General Assembly, and department director

7 on matters related to the regulation of health care,

8 occupations and professions. Accordingly the board is

9 conducting this study to provide recommendations on

10 whether there is a need for regulation of the surgical

11 assistants and/or surgical technologists.

12 At this time I will call on persons who

13 have signed up to comment. As I call your name, please

14 come forward and sit over here so you'll be more

15 comfortable, and tell us your name, your profession

16 that you wish to speak about, and where you are from.

17 If you are representing an organization or if you are

18 just simply representing yourself. Is this Judy Gantt?

19 MR. GANTT: It's Ira Gantt.

20 DR. CARTER: I'm sorry, Ira Gantt.

21 Please come forward.

22 MR. GANTT: My name is Ira Gantt. I'm a

23 surgical technologist from Reston Surgery Center in

24 Northern Virginia. This is the first time I have been

25 to one of these, but I got the e-mail and my

1 institution elected me to come down and find out what's
2 going on.
3 I have heard this has been going on for a
4 while down the pike, and the questions that were posed
5 to me from my fellow techs were the fact that we have 2
6 different certification criteria. We have the AST,
7 which is national, and the, I believe it's called the
8 ACT which is also accreditation, and now we are going
9 to be, if we have to be accredited by Virginia, will
10 this be unified or standardized and how will it be
11 accredited?
12 DR. CARTER: I think that's certainly
13 part of the review. We need to determine what is the
14 least invasive regulatory scheme that can be created,
15 and you don't want to put people out of work, we never
16 try to do that. We certainly go for parsimony, but the
17 first thing that must be met, if you are familiar with
18 our criteria, there must be a clear harm to the public
19 from unregulated practice. That's the first criterion
20 that must be met, and there's a whole host of others
21 relate to economic impact and autonomy and all those
22 sorts of things, so as part of the review we will look
23 into that, but we have to make sure that there is at
24 least minimal competency insured, and neither one of
25 these, you know about these, he's actually doing work

1 on it. This is Justin Crow.

2 MR. CROW: I have identified 3 groups

3 that certify surgical technologists right now and the

4 board will basically review what their standards are,

5 if they decide to regulate what their standards are and

6 whether or not they'll accept those certifications or

7 come up with their own, and that's the process. Right

8 now we are just looking through and gathering as much

9 information as we can.

10 MR. GANTT: Also what about people like

11 myself? I'm just recently recertified, so if my

12 certification currently will not be accepted, will I

13 have to be recertified or will I be grandfathered in?

14 DR. CARTER: I would not like to jump to

15 conclusion about your particular certification at this

16 time. We have to determine whether or not we need to

17 regulate the 2 groups in the first place. Also

18 whatever recommendations are provided by the Board of

19 Health Professions, it would be a matter of the General

20 Assembly and the Governor working through the process,

21 but we would give a recommendation at this point.

22 That's all we do.

23 MR. GANTT: That's all I have.

24 DR. CARTER: Thank you, Mr. Gantt.

25 MR. GANTT: Thank you. That's all I

1 have.

2 DR. CARTER: Mark Polson.

3 MR. POLSON: I hope that I will not be

4 too long and take up too much time.

5 Greetings, ladies and gentlemen. First

6 let me say that I'm grateful to be able to come here

7 and speak to you today and offer my opinion and only my

8 opinion regarding this matter.

9 My name is Mark Polson. I'm a certified

10 surgical assistant, and I pretty much represent myself.

11 I also work on occasion as a surgical technologist. I

12 am a former special operations medical NCO, a special

13 forces soldier, known worldwide as the Green Beret. I

14 enlisted in the Army in 1981, served as a special

15 operations weapons NCO for 4 years. During that time I

16 received many accommodations and medals for my service.

17 In 1987 after leaving active duty, I

18 enlisted in the Army Reserves as a special operations

19 medical NCO. I completed my training and was awarded

20 the MOS 18 Delta 30 which was a staff sergeant. The

21 training course was over 57 weeks in length and it

22 covered the following: Basic life support/automatic

23 external defibrillation, pharmaceutical calculations,

24 anatomy and physiology, patho-physiology, medical

25 terminology, basic physical exam techniques, medical

1 documentation, pharmacology, basic airway management,
2 medical patient assessment, advanced airway management,
3 pre hospital trauma emergencies, patient
4 management/tasks and skills, advanced trauma skills,
5 operating room procedures, minor surgical skills,
6 obstetric and pediatric emergencies, cardiac
7 pharmacology, advanced cardiac life support, clinical
8 and ambulatory rotation, extended care to the trauma
9 patient in a field environment, mass casualty, military
10 triage system, medical mission planning, medical
11 threat, preventive medicine, physical examination,
12 veterinary medicine, dental medicine, medical diseases
13 and case studies and nursing, initial and long term
14 wound care. We were also instructed in the echelons of
15 care including training in combat trauma management, on
16 conventional warfare hospital, surgical procedures,
17 pre-anesthesia, anesthesia, post anesthesia care,
18 nursing care, records and reports, radiology, central
19 materials supply. During this 57 week course we
20 attended a 30 day stay at CONUS which is within the
21 continental United States working in a hospital,
22 usually the military, rotating through clinical
23 specialties.
24 Once we completed our training we were
25 pretty much considered, I don't want to say finished,

1 because in the medical field, as you know, you never
2 finish training, but we were considered by medical or
3 military standards highly skilled individuals.
4 Over the course of the next 16 years I
5 would serve in a medical capacity in 4 different
6 conflicts: Operation Desert Storm, Operation Restore
7 Hope and Gothic Serpent, they were one and the same,
8 Operation Enduring Freedom, Operation Iraqi Freedom,
9 serving as both a junior and senior medical NCO and an
10 operational detachment alpha, and a surgical first
11 assist on a FAST or which is known as a Forward
12 Airborne Surgical Team. I would also serve as a medic
13 on numerous continents. I served with distinction,
14 again receiving numerous accommodations and medals.
15 Now as a reservist I wasn't always in the
16 military, so I was home, and while I was home I was
17 attending college. In 1999 it got to the point I was a
18 little more in debt than my income could handle and I
19 decided to go ahead and take a full time job. At that
20 time I took a job as a surgical technologist. I worked
21 in a major teaching hospital in Washington, D.C.,
22 George Washington University Hospital which is also a
23 Level 1 trauma center. There I achieved the respect of
24 not only my peers and supervisors but also the surgeons
25 that I worked with.

1 Now prior to taking this position I had
2 served over 10 years as a special operations medical
3 NCO, and however, because of the training that I
4 received and the time that I received it, as you have
5 stated, there are numerous boards that are currently
6 certifying surgical technologists. None of them would
7 recognize the training I had gone through, so I was not
8 eligible to sit for certification.
9 In September 2001, on the day of the
10 attack of the World Trade Center and the Pentagon, 2
11 months after I submitted my retirement letter, I had my
12 20 years in, I was recalled to active duty. Because of
13 my experience as a surgical technician I was trained
14 along with several others to work as a surgical
15 assistant. I would deploy to Afghanistan as a surgical
16 assistant on a FAST, a Forward Airborne Surgical Team.
17 We would be responsible for going into the field,
18 picking up the more critically wounded, treating them
19 there in the field, stabilizing them, and bringing them
20 back to a hospital setting. When there was no wounded
21 in the field to pick up, we worked in the hospital.
22 I worked over 6 months in Afghanistan 7
23 days a week sometimes 18 plus hours a day. I would
24 return home to serve as an instructor to those who were
25 about to deploy, and when we went to Iraq, I was there

1 as well.

2 In 2007 while working as a surgical

3 technician, I was even informed that I was eligible to

4 sit for the certification exam given by the National

5 Surgical Assistants Association. I successfully

6 completed the exam and was awarded my certification.

7 Now the reason I bring this up is so you

8 have an idea what I have gone through to achieve what I

9 have today. I have had people question my level of

10 experience because of my training; however, I have

11 always met or exceeded anyone's expectations when it

12 comes to my performance in an operating room.

13 As you consider the options before you,

14 I'd ask you to remember there are people like me who

15 don't have a degree, who are not eligible for

16 certification, who are very competent, and who can

17 possibly lose their livelihood if you go ahead and pass

18 certain legislation. There are states and agencies who

19 if I was to apply to them today would tell me I'm not

20 qualified to work in the field I have worked in most of

21 my adult life. Because of their legislation, I am

22 prevented from seeking employment in certain parts of

23 this country. There are states who have, who currently

24 have legislation on the board that is going to make it

25 pretty much impossible for anybody who doesn't have a

1 master's degree to do the job that I do today.
2 In closing, I agree that these 2 fields
3 need to be regulated, but I urge caution when making
4 your decision. Make sure you don't take away
5 somebody's ability to make a living. Also don't make
6 it impossible for someone to obtain their career goals.
7 The last time I spoke here I said I know
8 people who have lost their jobs, who would have lost
9 their jobs, I'm sorry, if certification was mandatory
10 because they freeze or panic when taking exams. A good
11 example, I have a friend who served over 20 years, he
12 was one of my instructors in the Army, served over 20
13 years as a surgical technologist in the Army. He just
14 cannot pass that certification exam, but he's probably
15 forgotten more than most people remember when it comes
16 to instrumentation and surgical techniques.
17 As far as surgical technologists, I have
18 seen both sides of the coin. Whereas some states
19 require it, JCAHO currently doesn't require for anybody
20 to be certified, well, JCAHO doesn't require for
21 surgical assistants to be certified but certain states
22 do. In order to work in a certain hospital you must be
23 certified. I worked out in Wisconsin over the winter
24 and they do not require certification. They have a
25 tendency to take someone who they feel is skilled and

1 qualified and do what's called on the job training, but
2 I have also seen those people who, for lack of a better
3 term, they lack the certain something that makes them a
4 good surgical assistant. Again that's just my opinion.
5 So I hope with your legislation, however
6 you decide to choose or road you decide to choose, that
7 you will do first and foremost protect the patient.
8 Thank you.
9 MR. CROW: Mr. Polson, can I ask you what
10 was that military position?
11 MR. POLSON: I was an 18 Delta or special
12 operations medical NCO.
13 MR. CROW: Okay. What was the MOS
14 number?
15 MR. POLSON: 18 Delta.
16 MR. CROW: 18 Delta. Thank you, and I'd
17 like to thank you for your service.
18 MR. POLSON: Thank you, sir.
19 DR. CARTER: Henry Jacobs.
20 MR. JACOBS: I won't be quite as long as
21 Mark.
22 My name is Henry Jacobs. I'm a certified
23 surgical assistant. I work for myself and part-time
24 for the Bon Secours System here in Richmond.
25 I just want to say that surgical

1 assistants are very highly skilled, very competent
2 people that go out of their way to insure that patients
3 get the best care. I feel that they should be
4 regulated in some form, and we should be recognized.
5 As they stand right now, when -- a lot of people say
6 who are you? And I say I'm an SA. What is an SA? And
7 you try and explain it to them that basically you are
8 the right hand of the surgeon. You have the skills and
9 the knowledge to assist that surgeon in anything that
10 they do, and it's not just book knowledge, it's
11 experience, years of actually hands on, and when the
12 surgeon walks in the room, they want someone that they
13 feel that is competent, not just another pair of hands.
14 So by having a certified assistant in the room that
15 they feel comfortable with, they know that that patient
16 will get the best care possible, and they have the best
17 hands assisting them when they are doing their job.
18 That's all I have to say.
19 DR. CARTER: When you say certified SA,
20 do you feel comfortable with anything where someone may
21 not have had that certification, like the situation
22 with Mr. Polson earlier indicating individuals who
23 didn't pass the test as it were, do you feel safe with
24 those individuals in work?
25 MR. JACOBS: I would not say that because

1 there are, I know quite a few that are not certified,
2 Mr. Polson and I have kind of gone the same roads
3 except I started a lot sooner than he did. I started
4 in '72. But there are plenty of people that are
5 actually out there that can't pass the exam. I tried
6 and tried and tried. I just, I'm not a paper person,
7 I'm a hands on. You put it in front of me, I can do
8 it, but put it on paper, I kind of freeze, but that
9 doesn't mean that I, that person can't do the job, it's
10 just that books is another thing.
11 So yes, there are qualified people out
12 there but not all of them are good.
13 DR. CARTER: Do you have any
14 recommendation apart from the certifications, national
15 certifications that are available, for the state to use
16 to ascertain that level of skill that makes them safe?
17 MR. JACOBS: Well, this may be out of my,
18 out of my realm, but the way that the doctors
19 recertify, they have a written and an oral board. For
20 those people that can't pass the written, they should
21 have an oral board, something to where they can
22 actually sit and explain. If you ask me to explain,
23 you know, a gallbladder procedure, a competent SA will
24 be able to go from start to finish, from
25 instrumentation to what's necessary, what they need to

1 look out for, how they need to look for different
2 things, being the eyes for the surgeon. They should be
3 able to verbalize that, and if they can't pass an oral,
4 then they should not continue.
5 DR. CARTER: Thank you.
6 MR. JACOBS: Thank you.
7 DR. CARTER: Mary Armstrong.
8 MS. ARMSTRONG: Good morning. My name is
9 Mary Armstrong. I am a certified first assistant,
10 certified surgical assistant, and a certified surgical
11 technologist.
12 I was basically just going to come up
13 here and see if you had any questions for me since I
14 spoke at the first meeting, but hearing from the 2
15 previous persons talking, I'd like to kind of address
16 certification.
17 I have been in the operating room for 25
18 years. I started out as a certified surgical
19 technologist. I went to an accredited school. From
20 there with OJT became a surgical assistant. I went on
21 to pass the CFA exam which is certified first assistant
22 exam, and then progressed and took the certified
23 surgical assistant exam. They are similar exams for
24 the same position offered by 2 different credentialing
25 bodies.

1 I feel that certification is the least
2 that we can do to make sure that people meet a
3 beginner's criteria in the profession, whether it be
4 certification for surgical technologist or
5 certification for surgical assistant, you have to some
6 base line of knowledge.
7 I can totally appreciate the inability to
8 sit down and take an exam, you get nervous, you can't
9 get your thoughts out on paper, but most of these exams
10 are multiple guess, I call it, you know, you have a
11 question, and if you have that knowledge that you could
12 be able to say okay, what do you do for a gallbladder,
13 you should be able to on a piece of paper say this is
14 what I'm ligating at this point, this is what I'm
15 ligating at this point, this is my next step. As an
16 OJT person in surgical assisting, I understand that you
17 can't always sit for every single exam, but around the
18 country now there are programs that are designed, and
19 surgical technology specifically, Sentara here in
20 Norfolk has a program for people who may not have gone
21 to an accredited school that have maybe been OJT, and
22 it allows them to get some more education on a limited
23 time so that they can sit for those exams, so there are
24 ways to be able to get the ability to sit for exams.
25 I think if we are going to go look at

1 legislation and look at regulation, we have to have
2 some base line criteria, and that would be
3 certification. Which certification, all the
4 certifications, you know, who knows what will
5 eventually come of that. I know that there are ways to
6 grandfather when you are looking at legislation, and
7 those all are things that need to be looked at down the
8 road, but right now we need to have some standards.
9 As a surgical assistant, I go into an
10 operating room and I have the ability to remove the
11 skull, put my fingers or a suction tip in a brain. I
12 have the ability to open up, help a surgeon open up a
13 belly, clamp the aorta which feeds your entire body's
14 blood supply. I'm able to do all these things in the
15 operating room, yet the public doesn't know that I
16 exist, don't know who I am, what I do. You would be
17 shocked and amazed to know that every person in that
18 field isn't a nurse.
19 DR. CARTER: Do you think that would make
20 a difference if they did know?
21 MS. ARMSTRONG: I think if they did know
22 that, they would demand that there's regulation, that
23 people that are working on themselves, their loved
24 ones, people most important to them, have basic skills
25 and basic knowledge to enter into the profession.

1 I think that it is cost effective, I
2 think with a good team you can produce more. You might
3 be able to do 5 procedures in a day, you might be able
4 to do 6 procedures if you have a competent team. And I
5 keep saying the word team because I think it's really
6 important that we understand that it's not one
7 profession that's in an operating room. There's a
8 surgeon and there's anesthesia, but the other 3 people
9 in that room are 3 different professions all designed
10 to work together to take care of a patient. You have a
11 registered nurse who's circulating, who watches over
12 that room getting you the things you need. You have a
13 surgical technologist who opened up your field and is
14 making sure everything is sterile and taking care of
15 all the proper instruments are there, everything is in
16 working order. There's a surgical assistant who comes
17 in and helps position the patient, open, do the
18 surgery, close, and many times the surgeon is not in
19 the room when we are doing things like positioning,
20 closing, applying dressings. So with everybody in that
21 room taking care of that patient, but yet only one of
22 those 3 other people have any kind of mandatory
23 licensure, certification, whatever. I think it's just
24 really important that everybody has to be regulated to
25 take good care of that patient on the table.

1 DR. CARTER: Do you think that you could
2 find some level of equivalency with experience for the
3 certification? Is there a way, say, 5 years
4 experience, 2 years, whatever it is, would there be a
5 way to safely do that in your opinion?
6 MS. ARMSTRONG: In my opinion, no,
7 because certification is for entry level. So if you
8 are telling me that you have got 15 years of
9 experience, the certification exams are built for
10 people coming out of school just entering into your
11 profession, so somebody with a lot of experience should
12 be able to go in there. You don't have to ace it, you
13 just have to have a minimal competency, and I think
14 with experience you should be able to do that. I
15 understand people get nervous, oh, my God, it's a test,
16 all of a sudden every bit of information in their brain
17 is gone, but it's not like you have a half an hour to
18 take the test, you know, you can get your mind
19 together. Jake, who said he doesn't do well on tests,
20 we sat for the CSA exam on the same day. We all
21 passed. He did well, so it is a possibility.
22 As far as being able to sit for those
23 exams, like I mentioned previously, there are some
24 stopgap measures that can be done. There are schools
25 that are attuned to those people who need to have a

1 certain level of education to take the exam, so instead
2 of a year or 2 year course, you might have a 3 or 4
3 month course.
4 DR. CARTER: Could I follow up with you
5 on that? You indicated Sentara has such a program?
6 MS. ARMSTRONG: For surgical
7 technologists.
8 DR. CARTER: Do you have access to other
9 programs, can we get a listing of other programs that
10 might be able to offer stopgap --
11 MS. ARMSTRONG: I'm not sure if there are
12 other programs here in the state in Virginia. I work
13 for Sentara, I'm very active in the school, sit on
14 their board, so I know about their program. Now at one
15 point I had a flyer for them. Don't know if I still
16 have that or not. So it's considered pathway to
17 certification is the way they put it.
18 So there are options out there that can
19 be done. And whether or not we allow 5 years of
20 experience or 3 years or whatever, that's something I
21 guess we'll have to look at down the road before this
22 goes like to official legislation, before anything is,
23 that's, I'm assuming, I assume that's the way things
24 move. But does it need to happen in some way, shape,
25 or form? Absolutely, for both professions. It needs,

1 something needs to be regulated so that we are assured
2 that you get the same level of care at one hospital
3 that you might get at another, that when you come in to
4 have your baby and you need a C-section, that oh, my
5 God, we need somebody to hold the retractor, let's get
6 Susie who just got done cleaning the room to hold that
7 retractor. And it happens, it happens all over the
8 state. You see people shaking their heads. It
9 happens. And because there's no regulations, they can
10 do those kinds of things. Hospitals can do it to save
11 themselves money. They can do it so they don't have to
12 have as large a staff, and that's the scary part for
13 me, because when my loved one goes into that operating
14 room, I want to be sure people taking care of them have
15 met all the criteria to give my loved one good care.
16 DR. CARTER: Anything further?
17 MS. ARMSTRONG: No, other than if you
18 might have any more questions that I can answer. I
19 kind of, I'm kind of at an advantage. I have several
20 certifications and kind of represent a lot of different
21 organizations.
22 DR. CARTER: Would you recommend any one
23 of those other certifications? Like your first
24 assistant, would that be, is there, how different is
25 that from your CST?

1 MS. ARMSTRONG: The CST is a totally
2 different job. CFAs and CSAs are the same, and there
3 is also a third certification, AS-C, and as a member
4 and on the legislative committee of the Virginia
5 Association of Surgical Assistants, we incorporate all
6 those into our association, and we feel strongly about
7 all of those certifications, so we are not saying you
8 have to be certified by one body.
9 As far as surgical technologists go, I
10 have an alliance with AST. I feel strongly their
11 certification is tried and true, it's a national
12 certification, it's not just something statewide or
13 hospital or systemwide. I feel strongly about their
14 certification. Is it worth looking at other
15 certifications before we pass any kind of legislation?
16 I would say yes. Look at theirs, see what their exam
17 is like, is it along the same lines as AST and to be
18 included? That's a possibility. What you want to call
19 them in the end, you can call me Fred, I don't care, as
20 long as I know that everybody that's doing Fred's job
21 is educated and is skilled at what they are doing.
22 DR. CARTER: You mentioned state level
23 testing. Are you aware of any studies or reviews that
24 look at equivalency of the state level exam to the
25 nationals?

1 MS. ARMSTRONG: No, I am not. Kathy, who
2 is speaking later, might be able to, from ASC, our
3 national organization, so she may be able to have some
4 data on that, but I'm not sure about the competency
5 levels of the test. I am more aware of the test for
6 first assistants because I have taken 2 out of the 3,
7 and they are comparable, they all have sections that
8 are comparable to our skills and entry level.
9 DR. CARTER: Okay, thank you.
10 MS. ARMSTRONG: Thank you.
11 DR. CARTER: Theresa Cooper.
12 MS. COOPER: Basically I was going to say
13 a lot of things along the same line as Mary, but I did
14 come this morning to read you an article which I'm
15 going to give to Mr. Crow so he can add it to the rest
16 of his stuff, but it's from the Edge Newsletter which
17 is put out by the National Board of Surgical Technology
18 and Surgical Assistants, very good article, it's called
19 what you do -- What You Don't Know Could Kill You, 2
20 pages. It's written by Margaret Rodriguez who is a
21 CST, a CFA, has a Bachelor's in Science, and she is the
22 vice president of AST. Was that enough initials? It's
23 a little bit overwhelming.
24 DR. CARTER: We are with the government,
25 we are use to that.

1 MS. COOPER: I was going to read this to
2 you but I'm just going to give it to you at the end.
3 The question of certification thing
4 really kind of bothers me. I think, and you should all
5 know, if you are going to have a surgery, don't you
6 want somebody going to be working on you that had at
7 least the minimum qualifications for the job? I mean
8 really? I know if I have surgery I can pick who my
9 nurse is, who my surgical assistant, who's my surgeon.
10 I can pick anyone. If my loved one has surgery I can
11 do the same thing. I'm going to give them the best of
12 the best. Don't you want that every day? Shouldn't
13 the people of Virginia know that when they go in that
14 operating room, those people with the masks, the hats,
15 the gowns, the gloves, are not somebody that was
16 cleaning the floor the day before yesterday and is on
17 the job trained right now, the first time they have
18 done the surgery, don't know what they are doing, don't
19 know the difference between the 250 instruments they
20 have up on the table and have to decide which one the
21 surgeon wants.
22 You know, as a surgical assistant, I can
23 cut your skin, I can get cautery and burn you in the
24 wrong place. Mary said I can do brain surgery on you,
25 I can help the surgeon. If I get that suction, put it

1 on to your brain tissue, I can suck up parts of your
2 brain by mistake. By mistake. I can work on your
3 spinal column and paralyze you by the wrong movement.
4 There is so many things I can do to hurt you, but
5 because I have been trained, I do have the minimal
6 education requirements. You are going to be assured in
7 some way, shape, and form I know the difference between
8 your brain tissue and non brain tissue. I know the
9 difference between the dura and maybe the fat sitting
10 next to it.
11 If you have heart surgery, who is the
12 person that takes out your saphenous vein to do the
13 bypasses? The surgical assistant is the one that cuts
14 your leg open, removes that vein, and that vein is used
15 on your heart for the heart surgery. We do that. Yes,
16 the surgeon's in the room most of the time. When we
17 open they are not necessarily there for taking a vein,
18 they are not necessarily there when we close the
19 surgery. We close all layers of the body.
20 Think about we have a hole in our glove.
21 We have a surgical conscious that says to us, oh, my
22 God, I have got a hole, I need to change my glove.
23 Someone might say it doesn't matter, I can continue. I
24 may have MRSA. You may even end up in the hospital for
25 days with infection no one is going to pay for.

1 When I position you on the bed, if I
2 don't pad you properly, you may end up with a bed sore
3 that may take weeks, months to recover from. There are
4 so many mistakes that we can make. You are never going
5 to hear about it because right now who cares? Who I
6 am? Nobody cares who I am. I can fo in there and do
7 the job, but I could have worked at Wendy's last week.
8 You know, I could have been serving burgers. No
9 offense to anybody serving burgers, but that's how it
10 is right now.
11 It's up to us right now to police
12 ourselves. There's people that want to be policed,
13 there's people that don't want to be policed. We need
14 to be policed. There is so much we can do to hurt
15 people that we have to be policed, and for people to
16 say that oh, it doesn't matter, someone is looking
17 after them, someone is watching over them. No, not
18 necessarily all the time. And the state needs to step
19 in. You know big brother is watching us, they need to
20 watch us, they have to watch us. Because it's only the
21 people that have pride in their job like the people
22 showed up today, the people that care about their job
23 that are going to police themselves. Without the state
24 looking out for us, nothing is going to be done, and
25 I'm sure if the public, God forbid, knew that when they

1 come in that operating room, those 4 people standing
2 there, I mean 2 of them have a license, come on, they
3 would be outraged. And this article is very good for
4 that. It's trying to let the public know. We should
5 put this in every paper in Virginia. People would be
6 writing and saying what is going on? I don't want to
7 go to the hospital anymore.
8 We are behind closed doors. Nobody sees
9 us, nobody knows who we are. If we were up on the
10 floor where your bed was, your family come to visit
11 you, when I come in your room, oh, hello, my name is
12 Nancy Nurse, I'll be looking after you today, or I'm a
13 nursing assistant, I'll be looking after you today, I'm
14 your LPN, I'll be looking after you today. They always
15 have to tell you who they are, what they do. You have
16 some idea. You know you can go on the computer, pull
17 up their license, find out who they are, if they are
18 drug addicts that's still allowed to work. Hi, I'm
19 Teresa, I'm going to be your surgeon's assistant today.
20 Huh? A what? You know, doesn't help they are already
21 on drugs, but you are not a nurse? No, I'm not a
22 nurse. Surgical, this is Nancy your surgical tech.
23 You are not a nurse? No. And lately because of the
24 JCAHO thing, we are making a big point of introducing
25 ourselves a lot more now, and people are more aware

1 when they come back into the room. People go you are
2 not a nurse? You are not a doctor? No. And frankly I
3 think I would scare the bejeezers out of the people if
4 they really knew. That's all I have got to say.
5 Any questions, I'm up for it.
6 DR. CARTER: You mentioned the Wendy's
7 people.
8 MS. COOPER: Sorry.
9 DR. CARTER: That's okay, no offense.
10 Are you aware personally of people who have taken that
11 quick transition?
12 MS. COOPER: Yes. Yes. Especially
13 people that were cleaners, mainly, you know, operating
14 room, they were cleaning the floor one day, got the
15 opportunity to stand and hold a retractor, or they
16 were -- I know in my hospital it's normally people on
17 the periphery clean up for us or put instruments
18 together in another floor, so they know the
19 instruments. They know nothing about the body, the
20 layers and, you know, the anatomy and physiology behind
21 anything, but hey, come up here, do this, we'll gown
22 and glove you, just give the doctor what he wants. The
23 whole any monkey can pass an instrument, I can't tell
24 you how many times I heard that. It's absolute
25 garbage.

1 DR. CARTER: Speaking of access and the
2 number of people that are available, and this is again
3 I'm asking your opinion. Are there enough certified
4 surgical assistants and surgical technologists
5 available in Virginia?
6 MS. COOPER: I'm going to say off the top
7 of my head, because I have seen plenty of lists of
8 who's been members of our organizations who have let
9 their certification drop, I'm going to say that many
10 have been certified, and because they don't have to be
11 certified, they have let it drop, so those people will
12 be coming back into the fold pretty soon.
13 We have plenty of schools that are
14 putting out techs, and most of them get their
15 certification within weeks of graduating.
16 I don't think it would be a problem. The
17 only problem is people been doing it 20, 30 years with
18 no certification. But now, you know, as Mary said,
19 there's a school that does, you know, but as far as I
20 was concerned I thought I heard that the state has to
21 do some sort of grandfathering.
22 DR. CARTER: We intend to do that so you
23 don't take away someone's livelihood.
24 MS. COOPER: Exactly. I agree you can't
25 take someone's livelihood away. If they have been

1 doing it that long, chances are they are pretty good at
2 what they are doing. I agree you say if you are coming
3 out of school now, you don't get certified, you don't
4 get a job. That's it. The people that are in, are in,
5 but if you are coming out of school, you have every
6 opportunity to take those exams. I have taken all 3
7 exams in the state and they are not that difficult.
8 Yes, I don't like taking exams either, and I was well
9 over the age of 40 when I took my CSA exam and did it
10 with Jake and Mary on the same day, the 3 of us, and we
11 all did fine.
12 I don't think there's going to be a
13 shortage, I really don't. Surgical assistants, there's
14 a lot of us in the same sort of thing, people take the
15 certification, realize they don't have to have it,
16 hospital doesn't really care, so they let it go.
17 DR. CARTER: And you said the hospital
18 doesn't care, I have to follow up on that.
19 MS. COOPER: Yeah, you can, no problems.
20 DR. CARTER: Why would that be in your
21 opinion?
22 MS. COOPER: In my opinion? I would like
23 to say it's just down to money, but I don't think it's
24 really that bad. I earn the same whether I'm certified
25 or not certified, whether I have the education or not,

1 I still get the same money, so it's not coming out of
2 their pocket per se. I don't know why they don't. I
3 think a lot has got to do with nurses -- sorry, I know
4 RNs are in the house, and we all agree the nurse should
5 be the circulating RN in the room, but ORs are run by
6 nurses. The manager is normally a nurse, the director
7 is normally a nurse. Nursing counts. We are allied
8 health professionals, so we really, you know, we are
9 not under their jurisdiction per se. I don't know why.
10 I don't think it costs the hospitals any more money.
11 If we were licensed, they could probably
12 bill for us which would probably bring in more money or
13 more revenue to the hospitals I would have thought.
14 Right now we are in a package billing system.
15 DR. CARTER: I'm saying if, if you were
16 regulated, it would be unlikely given the small number
17 that you would have your own specific board bringing
18 the 2 professions together, it would again, speaking
19 out of turn, it would probably go under the Board of
20 Medicine or Board of Nursing?
21 MEMBER OF AUDIENCE: Board of Medicine,
22 please. We are not nurses.
23 MS. COOPER: It's surgeons that tell us
24 what to do. I am the surgeon's assistant. The surgeon
25 tells me to cut, the surgeon tells me to tie, surgeon

1 tells me what sort of sutures he likes to use, so when
2 I do my job and he's not there, I use the suture he
3 wants me to use versus the ones I would choose to use.
4 DR. CARTER: As a surgical assistant?
5 MS. COOPER: As a surgical assistant.
6 DR. CARTER: Okay. What about
7 technologist, Board of Nursing or Board of Medicine?
8 MS. COOPER: Like to say the Board of
9 Medicine too. We have RNs in the house and they would
10 like it to be under the Board of Nursing, but I think
11 medicine would be the better one because it's not
12 nursing. What we do is not nursing. We are not touchy
13 feely people, you know. Nursing has a lot to do with
14 touchy feely, we are not touchy feely. We like you
15 asleep. I don't think we are nurses.
16 DR. CARTER: Anything further?
17 MS. COOPER: I don't think so.
18 DR. CARTER: Thank you.
19 MS. COOPER: I would like to give this to
20 Mr. Crow.
21 DR. CARTER: Rebecca Music.
22 MS. MUSIC: Good morning. Thank you all
23 for having us here today.
24 My name is Rebecca Music. I'm an
25 associate degree certified surgical technologist, and

1 I'm here representing not only myself but the board
2 that I sit on in the State of Virginia, the Virginia
3 Commonwealth State Assembly of the Association of
4 Surgical Technologists.
5 And I don't really have anything further
6 to say. Theresa and Mary really summed it up very
7 well. They have hit on all the key points, so kudos to
8 those ladies.
9 Other than patient care, good patient
10 care and patient outcome is the focus. It shouldn't be
11 about fear of taking exams, and I understand the
12 grandfathering, and I'm sure that that clause will be
13 included because we don't want to interrupt the
14 livelihood of people who have been doing it for many
15 years, but the main focus of why we go to school and
16 why we seek out the profession itself initially is we
17 want to be good providers and caregivers to people, and
18 when those people come into the OR and they lay on the
19 operating room table and they are looking into those
20 bright lights and they see all the people standing
21 around that table, we owe it to them to provide the
22 best patient care, and for best patient outcomes I
23 believe that the profession of surgical technology
24 should be regulated.
25 And that's really all that I have to say.

1 DR. CARTER: I have a question.
2 MS. MUSIC: Sure.
3 DR. CARTER: Are you aware of any
4 studies, are you aware of any studies on outcomes,
5 patient outcomes, having surgical assistants, surgical
6 technologists, 2 different roles, I understand it,
7 there versus not? Is there any outcome data that you
8 know? I know JCAHO doesn't require, I'm not sure, just
9 a question of throwing it out there.
10 MS. COOPER: I believe there are some
11 studies have been done by AST. I would have to find
12 them and I'll be more than happy to research that and
13 get it to Justin Crow and yourself. I don't know the
14 specifics of that data but I do know that there have
15 been studies to suggest that there is a difference when
16 you don't have a certified person versus a non
17 certified person or an OJT and that type of thing, so
18 there have been studies done.
19 DR. CARTER: That would be very helpful.
20 Okay, anything else?
21 MS. MUSIC: No. Any questions?
22 DR. CARTER: Thank you.
23 MS. MUSIC: Thank you.
24 DR. CARTER: Catherine Sparkman.
25 MS. SPARKMAN: My name is Catherine

1 Sparkman. I am not any of these credentialed people,
2 which I am a licensed attorney which sort of qualifies
3 me for just about nothing.
4 I am currently the director of government
5 and public affairs for the Association of Surgical
6 Technologists. Prior to that I was the director of
7 government and public affairs for the Association of
8 Operating Room Nurses, and prior to that I spent 30
9 years as a trial lawyer practicing medical malpractice
10 defense, enterprise liability mostly for hospitals, and
11 not necessarily physicians, and part of that career was
12 spent as vice president and general counsel at Blue
13 Cross Blue Shield, so I kind of circulate in and out of
14 various aspects of the medical industry, clearly a lot
15 of time spent definitely in the operating room, I'll
16 knock on wood, I have never been in one except to have
17 2 children, but certainly involved in all of the issues
18 surrounding the delivery of surgical care and the
19 liability for the non delivery of appropriate surgical
20 care.
21 I had submitted after our last hearing a
22 position paper on the elements of supporting
23 regulation, and in that were answers to some of the
24 questions you presented, and I know now that you are
25 interested I can furnish some other data. You asked

1 me, I'm sort of doing these in descending order, you
2 asked about the availability of certified surgical
3 technologists and trained surgical technologists.
4 There are 400, now there's 424 accredited surgical
5 technology schools in the United States. They are
6 accredited by the Commission on Accreditation of Allied
7 Health Education Programs, the CAAHEP, and there is an
8 Accrediting Bureau of Health Education Schools, ABHES,
9 which also accredits schools. Both of those
10 accreditations and those programs are eligible to sit
11 for -- graduates from those programs are eligible to
12 sit for a national certification exam administered by
13 the National Board for Surgical Technology, Surgical
14 Technology and Surgical Assisting, NBSTSA. Just
15 putting out all those letters at the end. And there
16 are 6 CAAHEP accredited schools in the State of
17 Virginia.
18 DR. CARTER: In Virginia?
19 MS. SPARKMAN: Yes. I can give you the
20 demographics of the graduates. They graduate anywhere
21 from 18 to 45 to 65 students per class.
22 DR. CARTER: That would be very useful.
23 MS. SPARKMAN: Sure. I would be happy to
24 do that.
25 The other thing that was changed since I

1 was here before is that first of all my position at the
2 Association of Surgical Technologists is to advance the
3 public policy of the certification and education of
4 surgical technologists in the operating room in every
5 hospital, in every ambulatory surgical center in every
6 state in the United States. That's my job.
7 As you know, being a lawyer, we say well,
8 I can do that, and so we have started. Since we met
9 last time, we have passed legislation in 2 more states,
10 the State of Texas, and that's House Bill 643. It was
11 sponsored by Robert Zerwas (phonetic) who is a
12 practicing orthopedic surgeon in Hermann Hospital in
13 Houston, and Senate Bill 1593 in Indiana, and that bill
14 was sponsored by Pat Miller who is a registered nurse
15 and chairman of the health committee for, the Senate
16 Health Committee in the State of Indiana.
17 We currently have bills pending in 10
18 other states pending or about to be filed in Michigan,
19 4874 -- 4834 which is sponsored by representatives
20 Donnegan and List, both registered nurses; State of
21 Wisconsin, State of Minnesota, Oregon, State of
22 Massachusetts which is Senate Bill 797, which is
23 sponsored by the chairman of the Senate Public Health
24 Committee, Senator Brewer's bill will, are about to be
25 filed and pending in Missouri, Ohio, New Jersey,

1 California, and in Nebraska, another sunrise process is
2 underway in the State of Nebraska.
3 We are busy, and we are clearly committed
4 to the proposition that everyone behind the mask, a
5 mask, in the operating room have credentials and be,
6 demonstrate an objective major of competence, which is
7 graduation from an accredited educational program and
8 completed the certification exams administered by the
9 National Board for Surgical Technology and Surgical
10 Assisting. The NBST itself again is not a subset of
11 the professional association. AST is committed to the
12 separation that you do not certify your own members.
13 It becomes a potential, although not an existing
14 conflict of interest.
15 The national board is accredited itself
16 by the National Credentialing and Competency
17 Association. It is a rigorous 7 year process to
18 accredit those credentialing organizations, and they
19 are very proud of their achievement, and they have been
20 an accredited credentialing agency since 1984, so they
21 are very good at what they do.
22 I think the incidence of public harm was
23 touched on, and I know that that is very important to
24 this body, and rightly so. I am becoming a student of
25 this topic and am involved in gathering and analyzing

1 data involving these issues.

2 I talked briefly last time about never

3 events, and that Medicare has made it a pocketbook

4 issue, if I may be so blunt, to encourage competency in

5 the delivery of surgical -- of all patient care. The

6 initiatives that I was very much involved with Bonnie

7 Vencill over there, and we can certainly talk to this

8 if you like, but the issues of patient safety and

9 patient care are paramount, and some of the legislative

10 responses to those issues have been in the form of

11 error reporting, hospital acquired infection reporting,

12 adverse events reporting. At the present time that is

13 in its nascent stages.

14 Most error reporting that is done is not

15 available to the public. HAI, hospital acquired

16 infection reporting is now recently becoming available.

17 Federal legislation, pending legislation now is

18 addressing the public dissemination of at least MRSA

19 and other hospital acquired infection reporting and

20 some other adverse events.

21 The CMS got into this arena from a

22 financial standpoint, and encouraging hospitals as

23 their facility's participating providers to focus more

24 attention on preventable medical errors, an issue that

25 certainly operating room nurses, surgical technologists

1 and other professionals have been involved with for
2 quite sometime, so now as you know 8 never events have
3 been identified by the Center for Medicare and Medicaid
4 Services, among them, 60 percent of them are, occur in
5 the OR. But among them are wrong side surgeries,
6 there's 3 different kinds, retained instruments,
7 surgical site infections, patient falls. Now patients
8 fall all over the hospital, but an unconscious patient
9 doesn't fall of his or her own accord, so in the
10 hospital it is definitely a preventable medical error.
11 Catheter infections, whether they are cardiac catheters
12 or other catheters, medication errors, are all being
13 identified by CMS as preventable medical errors, never
14 events, ones that should never happen, and they have
15 put their money or lack thereof where their mouth is,
16 and in the Medicare reimbursement system now, Medicare
17 will not reimburse for, it's a DRG 418 right now, which
18 is postoperative and post traumatic infections.
19 Virginia, by the way, has a lot of data
20 on this. And this is completely unreadable in the form
21 I have, but I'm going to summarize it, but Medicare did
22 a study, and Virginia has done a study or at least has
23 published the statistics involving how much a surgical
24 site infection costs the patient and costs the facility
25 and costs the people of Virginia, and it varies. On

1 the average, a surgical site infection increases
2 inpatient stays from 4 to 5.9 days. The cost per day
3 varies anywhere from, the lowest I think I was Augusta
4 Medical Center at $1,900 a day and it goes up to
5 $4,887, $6,200, 5393 from Henrico Doctors' Hospital,
6 the cost of a patient stay to cure a surgical site
7 infection. So it is a significant financial cost to
8 patients, to the system, to the hospitals, to public
9 health, surgical site infections.
10 And there is data in a number of states.
11 There is very little outcome data with respect to
12 certified and uncertified surgical technologists
13 chiefly because they are not regulated and there is no
14 way to collect that data. We make, at AST I make the
15 collection of data an inference therefrom. For example
16 in the State of Minnesota, which is one of the early
17 states to require adverse events reporting, we are
18 taking data and we are analyzing at these never events,
19 not all of them are reported in Minnesota, but wrong
20 sided surgeries and infections and others are, and we
21 are collecting that data as to the incidents, and we
22 are comparing that data to hospitals who require all
23 their surgical technologists to be certified versus
24 hospitals who have no such policy, and there is so far
25 a statistical significance. Almost 2 to 1.

1 DR. CARTER: Are you holding other
2 factors constant?
3 MS. SPARKMAN: Only the ones that we
4 know.
5 DR. CARTER: Right. The size of the
6 hospital --
7 MS. SPARKMAN: Exactly. There are a lot.
8 But we are choosing that because, to see, and yes,
9 there's a variety of, it could be, you know, it could
10 be the educational qualifications of the surgeon, it
11 could be the facility, it could be the competency of
12 the central supply and, you know, who provides all the
13 sterilized instruments, but we picked those 2 to see if
14 there was any statistical relationship, and that's
15 about as far as we could go.
16 Linda Akin who is a Ph.D. registered
17 nurse has done an exciting study. It should come as no
18 surprise, and I'll be happy to furnish her results.
19 She's been researching, and I think she was at Johns
20 Hopkins, I'm not sure where she is now, but she studied
21 the incidence of patient mortality to education level
22 of the circulating nurse, again all other factors being
23 equal, and the results of that statistical study was
24 published in 2004 is a statistically significant
25 decrease in patient mortality when the education level

1 of the nurses increase.

2 By, you know, lawyers deal in analogies
3 all the time, and I think it comes as no surprise, you
4 can analogize that the higher the education level of
5 the caregivers in the surgical setting may lead to a
6 lower incidence of surgical patient mortality. It
7 seems not too much of an illogical leap.

8 The singular of data is anecdote, and
9 that is really because of the situation that surgical
10 technologists and surgical assistants are in now which
11 is an unregulated profession. The anecdotes who you
12 have heard today, I hear in my office. I hear of the
13 surgeon who wants to give his niece a summer job, I
14 heard the surgeon in Baltimore who needed a surgical
15 assistant and picked the head of the deli cart, manager
16 of the deli cart on the first floor because he might
17 have a familiarity with knives.

18 These are not, some of that is the
19 singular of that is anecdote. And we know that is not
20 to disparage those surgical technologists who may have
21 on the job training and have come to this, this
22 profession as capable people over time, but a minimum
23 of justified level of competence is really one of the
24 few things you can do to assure that everyone operating
25 on a patient who slumbers on who cannot make decisions

1 for their own health care is appropriately treated, and
2 to that end, AST as it supports these grass roots,
3 because they are pretty much grass roots legislative
4 efforts throughout the country, we provide a mock
5 surgery in the capital of every state where legislation
6 is pending, and we bring -- and it's done at the local
7 level, but they bring a surgeon and an anesthesiologist
8 and a patient, and I'm dying to be the patient but they
9 won't let me be the patient, and surgical assistant, an
10 anesthesiology assistant, the surgical technologist,
11 the second assist, an RN circulator, our wonderful
12 colleagues that collaborate with us on these
13 initiatives in the states, and we put on a mock surgery
14 and we stop and we say who is not regulated here? They
15 are all passing hundreds of instruments. It is a
16 daunting thing.
17 And if I am permitted one item of levity,
18 one thing I learned when I was in Indiana is that the
19 classic, the surgeon's technical response or request in
20 the middle of surgery is, and the surgical technologist
21 knows what this is, there are 90 different kinds of
22 whatever that is, he goes like this (indicating with
23 hands), he goes like this, and the relationship of the
24 people in that operating venue is really so seamless
25 and really so these are, but as I said, we ask the

1 legislators assembled or the public assembled, who here
2 has absolutely no requirement to demonstrate competency
3 at all, no minimum level, and it is, it is an
4 astonishing thing that it is not.
5 We are gratified that Texas unanimously,
6 both House and Senate, have now required surgical
7 technologists to be graduates of accredited programs
8 and nationally certified. They have grandfathered in
9 everyone who is working on the day that the bill
10 becomes effective, because no one wants to be out of a
11 job.
12 Similarly in Indiana, an overarching
13 surgical safety bill was passed, OR safety, and both RN
14 circulator and surgical technologist competencies and
15 precedents were addressed in that bill, and that did
16 not pass the House unanimously, there were 2 no votes,
17 but it went unanimously throughout the process, the
18 committees on out.
19 We take this seriously, we take patients'
20 safety as seriously as possible, and it's a minimum
21 level of competency, it is certainly something every
22 surgical patient deserves.
23 So I would be happy to answer questions.
24 I will be giving you this. The last thing I want to
25 say is we are not alone. The National, the American

1 College of Surgeons has a resolution, I believe I
2 mentioned this last time, supporting the education and
3 certification of all surgical technologists, that was
4 our, the surgeons that these talented people work with
5 every day. The Association of Operating Room Nurses
6 has similarly through their president issued a
7 position -- a letter. There is a position statement as
8 well but there is a letter addressing just
9 certification and accreditation and supporting both
10 concepts of surgical technologists.
11 And our colleagues recognize the great
12 strides the association has made in demanding that
13 their members be the competent professionals that their
14 patients demand or expect, and we have taken that
15 burden not lightly, and as a matter of public policy,
16 the chief public policy off the association is to
17 assure that competency. That's what I do.
18 DR. CARTER: I have a question for you as
19 an attorney. Are you aware of malpractice cases
20 involving medical assistants or medical technologists
21 or aware of any malpractice cases against those
22 individuals or does it go through the surgeon's
23 malpractice if its exists at all?
24 MS. SPARKMAN: No -- yes, I'm aware more
25 on the surgical assisting than surgical technology.

1 DR. CARTER: Yes.
2 MS. SPARKMAN: Surgical assistants may be
3 employees of the hospital, they may be employees of the
4 physicians. A surgical assistant is performing
5 delegated medical functions by and large, medical
6 tasks. Surgical technologists are performing medical
7 tasks, nursing tasks, surgical tasks, a variety of
8 tasks, but the surgeon clearly is charged with the
9 responsibility of any actions by a surgical assistant
10 whose tasks he has delegated, so that does not insulate
11 them from litigation, and in fact AST offers as a
12 benefit of membership professional liability insurance
13 for surgical assistants through, and I can't remember,
14 there are 2 insurance companies, professional insurance
15 companies that AST has negotiated liability insurance
16 for surgical assistants. They are under respondeat
17 superior, under vicarious liability. The chain is
18 normally to the hospital. The surgeon will be in
19 litigation.
20 Now I'm going back to my years as a
21 litigator, you know, the surgeon is charged with the
22 actions of the surgical assistant, and but that doesn't
23 mean the hospital is off the hook, because I represent
24 most of the, mostly hospitals, and because they are
25 employees of the hospital, the hospital essentially

1 assumes the liability and responsibility for any
2 malpractice performed by their employees unless they,
3 it is reckless and takes them, you know, but any
4 violation of the standard of care of an employee of the
5 hospital is attributable to the hospital, does not
6 relieve the employee, surgical technologist or
7 assistant or RN circulator or anyone who is in the
8 surgical arena from liability.
9 The practical matter is often the
10 plaintiff's bar does not sue or enjoin all the
11 professionals in it because they are interested in the
12 bottom line, and surgical technologists, I think I sent
13 you, make an average of $16.80 an hour. They are not
14 exactly the deep pocket that a plaintiff is seeking,
15 but the legal principles are the same.
16 DR. CARTER: Thank you.
17 Bonnie Vencill.
18 MS. VENCILL: My name is Bonnie Vencill.
19 I'm a registered nurse. I work at Southside Regional
20 Medical Center in Petersburg, Virginia, have 30 years
21 of peri-operative nursing experience. I'm also a CNOR.
22 I am here representing myself and VCOPRN which is the
23 Virginia Council of Perioperative Registered Nurses and
24 also an affiliate to the national organization, the
25 Association of Perioperative Registered Nurses.

1 We submitted a letter. Did you get a
2 copy of this, Justin? It was addressed to Mrs. Carter.
3 It had information on it.
4 MR. CROW: Uh-huh.
5 MS. VENCILL: Okay. So hopefully you all
6 have read it, and glad to hear you are having another
7 meeting August 11th.
8 This too is my first hearing, and you all
9 are a very important part of the perioperative team,
10 and we are supporting education and certification. If
11 you look on that back page, the national organization,
12 which of course our VCOPRN Virginia chapter also
13 supports our national organization, they say that, and
14 we agree, surgical technologists should be graduates of
15 accredited educational programs and/or have
16 successfully completed the national certification
17 process. So we are in agreement that, you know, they
18 do need to be graduates and they do need to be
19 educated, and they don't need to be pulling people off
20 the streets and just saying okay, and we also believe
21 that the registered nurse at the current time is,
22 that's one of our responsibilities is to supervise the
23 entire team, and we would like to continue doing that,
24 and we don't want it to be a turf war. We want to work
25 together.

1 So did you have any questions?
2 DR. CARTER: Do you have any concern over
3 grandfathering for anyone practicing or continuing to
4 do that for some period of time?
5 MS. VENCILL: No.
6 DR. CARTER: You are fine with that?
7 MS. VENCILL: Because it goes both ways.
8 I'm a registered nurse, I don't have my BSN. They
9 could change the law, say if you don't have a BSN, you
10 can't be a registered nurse. Well, I have got 30 years
11 of experience, I'm certified, stay abreast with my
12 practice. I think the same thing would apply to them.
13 DR. CARTER: Thank you.
14 MS. VENCILL: Okay, thank you.
15 DR. CARTER: Kevin Brown.
16 MR. BROWN: My name is Kevin Brown and I
17 am a certified surgical technologist.
18 I was one of those people who got pulled
19 out of another job to work in the OR. It does happen.
20 I liked it enough that I decided I wanted to go to
21 school and do it. That was my decision to do.
22 I have a degree in it. I have done it
23 for 20 years. I decided 2 years ago that it was time
24 for me to do something a little different, and so now I
25 teach it, and I teach it here in Richmond. We

1 currently have 33 students. We are an accredited
2 program. Our students are trained both in laboratory,
3 the classroom, and in the hospital setting. And we can
4 only take 12 in class at a time, do 3 classes a year,
5 and the last class we had 7 more people on the waiting
6 list, so we are having more people apply than we can
7 actually take.
8 And I can go on with stories like all my
9 colleagues, but one of the things that's also important
10 about certification is maintaining your certification,
11 and one of the things we are required to do is either
12 retest or maintain a certain level of certified
13 continuing education credits, and we can do these a
14 number of different ways. You can do independent
15 study, do them through conferences, you can do them,
16 the State of Virginia just had a conference down in the
17 southern part of the state a couple months ago where
18 people could pick up CEUs. You have a number of years
19 to get them. But with medicine changing as fast as it
20 does, and I worked in neurosurgery the last 8 years,
21 with it changing fast as it does and with all the
22 electronics and things like that coming in, you have to
23 keep yourself abreast if you are going to do your job
24 and do it right. By just going to school once and
25 never having to do anything again in an on the job

1 class, you don't keep yourself abreast of what's new.
2 And that's mandatory to give good patient care.
3 And to keep a certification you have to
4 keep your CEUs up, and I think that's very important.
5 Doctors have to keep their CEUs up, and nursing, I'm
6 married to an operating room nurse who learned to scrub
7 from 2 certified nursing technologists when we were
8 working at University of Florida. She's now working at
9 our state university hospital in Charlottesville, and
10 yesterday she scrubbed 3 back surgeries. So, you know,
11 it carries on. We teach the nurses, the nurses teach
12 us, we work together. Sometimes we work together
13 better. We met over a crani. That happens to work out
14 that way. Everybody said so many good things, but the
15 point to me is the CEUs are also important in keeping
16 your certification.
17 DR. CARTER: You can obtain those CEs
18 where?
19 MR. BROWN: Every month the association
20 offers CEUs, just like AOR, different states. I was
21 the president of the Florida state assembly until I
22 moved up here last year. We offered in Florida I think
23 it was 60 the year I was president CEUs, and I'm
24 talking about where you could go to a meeting on a
25 Saturday, you paid 10 to $20, you got a hot lunch, and

1 you got 10 CEUs for the day, so it's not a big over
2 expensive thing.
3 We offer a national conference annually.
4 This year it's in Texas, in Dallas Forth Worth, and I
5 go to the national conference. You can pick up as many
6 as 25 CEUs at that over a week's period of time.
7 There's packages you can buy from companies that
8 provide CEUs, so there's a number of outlets for CEUs
9 available.
10 DR. CARTER: And the hospitals?
11 MR. BROWN: And the hospitals. There's a
12 certain amount of CEUs that the hospitals offer.
13 DR. CARTER: Okay. Anything further?
14 MR. BROWN: No, that's it.
15 DR. CARTER: Thank you.
16 Some individuals came in subsequent to
17 getting the listing. Would anyone else care to speak?
18 Yes, sir, would you come forward, let us know who you
19 are and who you are representing.
20 MR. FELDMAN: My name is Boris Feldman.
21 I'm a surgical, certified surgical assistant. I work
22 for Inova Fairfax Hospital but now I represent a group
23 of surgical assistants, it's 11 assistants who belong
24 to Capital Surgical Services Company, business person,
25 like professional person. So we are serving one of the

1 biggest in the nation in Fairfax Hospital, so unit
2 provides care for almost 20,000 women in the year
3 annually, 12,000 deliveries and more than 4,000
4 Cesarean sections actually, with actually my group
5 taking care of more than 100 physicians whose
6 privileges to provide service in this unit in Inova
7 Fairfax Hospital. So this is the level of the unit.
8 They have all kinds of labor delivery
9 process and complications from all Northern Virginia,
10 so this is show description of qualification that you
11 must have to provide proper care for this unit.
12 But we have no license. 10 from -- 9 to
13 11 who work with physicians who experienced in surgery,
14 very different circumstances, certification process,
15 they change and become certified surgical assistants.
16 To assist, they have substantial experience and train
17 immediately, so they are both excellent.
18 We have different background but we have
19 the same job profile. We perform the same service for
20 that physicians and patients and with excellent
21 outcome. We have our own web site, Capital Surgical
22 Services Company, and testimony of physicians who work
23 with us show clear how much our professional dedication
24 and level of skills contribute surgeries and contribute
25 patients, and but we always face some difficulties in

1 operating room because we are not great, we have no
2 license, and it just restricts our ability to show our
3 expertise to provide some expertise to nurses,
4 technologists, sometimes physicians, because we invest
5 in that, you know? This is kind of, kind of restrict
6 our ability to help, no regulations, and I don't like
7 to just introduce different conversations going on at
8 this point in operating room, but believe me, it's not
9 comfortable to be in this position, this no license in
10 operating room performing care, because you always
11 think you cannot, you cannot provide a full capacity of
12 your expertise and your knowledge and your skills.
13 DR. CARTER: And why is that? What's
14 going on in that operating room that doesn't allow you
15 to do that?
16 MR. FELDMAN: Because if you try to
17 benefit case, benefit physician by some suggestion or
18 some little changes, it just not available in the
19 situation. Your skills stop. You are nobody here, you
20 have no license, you have to do what I'm telling you to
21 do. That's it.
22 Yet this is nurse's second week in
23 operating room, she never work before, she's just too
24 up by administration and like that, you know, and she
25 believes she's in charge for everything, and those are

1 people who has no license have to obey everything what
2 she's telling us, and sometimes it's dangerous. It's
3 dangerous, yet, and I believe surgical assistant who's
4 remove from the surgery like a first assistant, so we
5 are doing 50 percent of the case, particularly in
6 obstetrical care, it's like that. So they'll open the
7 wound, close the wound, help physician with
8 complications, sometimes it's dangerous complication,
9 like obstetrical bleed, patient can lose half of
10 circulating blood in a few minutes, and we are not
11 under any direction. It's the same as surgical
12 assistant malpractice insurance, 2 million per case and
13 600, okay, if I have no responsibility here, for what I
14 have to pay malpractice insurance?
15 DR. CARTER: So do you all contract with
16 the hospital?
17 MR. FELDMAN: Yes.
18 DR. CARTER: Do you also contract with
19 individual surgeons?
20 MR. FELDMAN: No.
21 DR. CARTER: It's always through the
22 hospital?
23 MR. FELDMAN: Through the hospital.
24 DR. CARTER: And only Inova?
25 MR. FELDMAN: Inova Fairfax Hospital.

1 DR. CARTER: But your are a separate
2 contractor, you are not --
3 MR. FELDMAN: Yeah, we have employment
4 before. I work for this hospital since 2000, and
5 almost 2 years ago we become contractors, and by these
6 changes we just created perfect group, because people
7 who was not able to work in this level, they just left.
8 The other are people highly qualified care, and this
9 benefit everybody, physicians, everybody for service.
10 DR. CARTER: Are there any other
11 companies like yours? Are there other companies that
12 contract with hospitals or with physicians to do --
13 MR. FELDMAN: I know a few of them,
14 uh-huh.
15 DR. CARTER: If we could get a list, that
16 would be wonderful. That way we would have some sense
17 of those independent practices out there that are
18 practicing in Virginia.
19 MR. FELDMAN: Yes, I think it's big help
20 to hospitals and help assistant to stay in certain
21 level of certification and be competitive. So, and I,
22 I actually am speaking for surgical assistants because
23 it's like, for me, it's like issue to provide this
24 quality of service which we already do. Thank you.
25 DR. CARTER: Thank you very much.

1 MR. JENNETTE: Good morning again. Thank
2 you. I apologize. I'm the reason the board is late.
3 I gave them the wrong time. Thank you.
4 My name is David Jennette. I live in
5 Suffolk, Virginia. I work as a certified surgical
6 assistant at Sentara Obici Hospital. I'm also the new
7 president of the National Surgical Assistants
8 Association as well as the president of the Virginia
9 Association of Surgical Assistants, and prior to the
10 March 6 deadline, I sent in an exhausting 13 page
11 letter. I hope you retain that for your records. I
12 won't really go into the same detail that was in that.
13 Sitting here, I tell you going over the
14 years of trying to get some sort of recognition, it is
15 exhausting what we have run up against, and to sit here
16 and reiterate everything that everybody else has said
17 in support of some sort of regulation would be time
18 consuming.
19 I just ask that you picture yourself
20 along with the rest of the people in Virginia 7:30 in
21 the evening watching Jeopardy, and a category comes up
22 there under Virginia Health Care Regulations, and the
23 answer would be the inclusive category for someone who
24 assists surgeons in the operating room or who perform
25 significant surgical tasks during the surgical

1 procedure. Alex could let the first person answer and
2 they may think they have the right answer by saying it
3 would be a physician assistant, and he would say sorry,
4 that's wrong. The next contestant might say that it's
5 a certified surgical assistant, so sorry, that would be
6 wrong again. He could sit there and let them answer 2,
7 3, 4, 5 times each, they would all be wrong. What they
8 would be looking for is anyone, because Virginia
9 doesn't have regulations for surgical assistants that
10 do that, provide those significant surgical tasks in
11 the operating room.
12 I think you'd hear forks hit the plate, I
13 think you'd hear deep sighs from the people watching
14 Jeopardy when they reveal that, they provide
15 information about that.
16 I bore you with that because that's about
17 the extent to where I have gotten taken on this, and
18 that's where I get my new thoughts of how to correlate
19 what we do and the importance of what we do into
20 people's daily lives.
21 I urge the board members to come and
22 visit hospitals, visit operating rooms and see the
23 important job that both the surgical technologists and
24 the surgical assistants do. I'm here today to extend
25 an open invitation to my hospital, Sentara Obici in

1 Suffolk. My administration shares that invitation, and
2 we would welcome you there, and I think at that time
3 you would be able to interview physicians, directors,
4 other, you know, operating room staff and personnel
5 that might be beneficial to give you a better
6 perspective exactly what both professions do. And I
7 can take your questions. I hope to see you there at
8 our hospital as a guest, not a patient. But I'll take
9 questions.
10 DR. CARTER: Thank you. Do you have, is
11 there a formal position relating to grandfathering for
12 people who may not have certification?
13 MR. JENNETTE: Is there a formal
14 position?
15 DR. CARTER: Would you be willing to
16 accept a grandfather position for people who have been
17 practicing for years --
18 MR. JENNETTE: If it's a yes or no
19 answer, I would say yes. I would base that on the fact
20 that on a national level our organization, which we
21 have our exam for, there are pathways that allow those
22 that have been doing the job so long to sit for an exam
23 if they have had a credential before, any of the other
24 credentials that are out there for a period of time, we
25 allow them to sit for the exam.

1 I think, you know, those are things on a
2 national association that we try, we tended to stay
3 away from them by having just an open door, done this
4 for 20 years, come sit for an exam, we have had that
5 category for a long time, and seemed that, you know,
6 there's no incentive at that point for someone to join
7 your organization if that open door is there, we can
8 come do it whenever we want to. So with an
9 announcement, I think it was more than a year and a
10 half, we stipulated on there that that avenue would
11 close, and you would have to have gone through a CAAHEP
12 program, which now we approve or own programs in house,
13 but there's certainly the, we certainly don't want
14 anybody to lose their job over some sort of regulation
15 if they have been doing it for some, for so many years,
16 but no, we would not be opposed to it.
17 DR. CARTER: Is there any provision where
18 you would accept the military's training of
19 individuals?
20 MR. JENNETTE: Absolutely. We have an
21 avenue for that.
22 DR. CARTER: Individuals here, you have
23 heard this before?
24 MR. JENNETTE: Yes. I think, not looking
25 at the, our requirements, they need to provide us with

1 the DD1214, I think it's certificate of training
2 certifying surgical assisting, one letter of
3 recommendation from the surgeon you have assisted
4 within the last 3 years, and they have currently added
5 the case logs.
6 DR. CARTER: Yes.
7 MR. CROW: I just want to ask you, I know
8 the NSAA doesn't accept all CAAHEP approved programs or
9 accredited programs.
10 MR. JENNETTE: Correct.
11 MR. CROW: Just looking at those
12 programs, it seems to be a wide range, I think Eastern
13 Virginia Medical School which is the graduate level
14 education, and then you also have proctor cases with
15 supplemental and on line modules, it just seems to be a
16 wide range of education. Can you just speak to why
17 that is and how --
18 MR. JENNETTE: Yes. In fact I sat on the
19 subcommittee on surgical assisting which is the
20 subcommittee underneath the ARC-ST, without looking at
21 it in front of me, couldn't tell you what it is, that
22 govern what CAAHEP approves, in other words, we are
23 like the first in line and then we make a
24 recommendation as a committee to the ARC-ST which in
25 another month will be the ARC-STSA, and then they pass

1 those recommendations on to CAAHEP. In January of this
2 past year NSAA decided that we would approve our own
3 programs instead of relying on CAAHEP, and that was
4 based primarily on the fact that the standards that
5 were written that CAAHEP was, that they started out, I
6 think they started in 2004 were the first standards for
7 surgical assisting programs. They have been amended
8 once. The progression for this amendment has taken,
9 was so slow, the minimal standards for these programs
10 were not where NSAA wanted their programs to be at, and
11 certainly we did not think that total distance learning
12 is a pathway for surgical assisting, so that's why we
13 mandated that in January this year, because CAAHEP has
14 recognized 2 on line programs for the CAAHEP
15 accreditation, and we felt that we would do a
16 disservice to the public by allowing those individuals
17 to sit for our exam that graduated from an on line
18 program.
19 DR. CARTER: I have a question about
20 that. So do these folks doing on line programs, is it
21 purely through computer or perhaps by telephone, but
22 there's no wet lab, no hands on?
23 MR. JENNETTE: Well, that's part of it,
24 and I, without having the information in front of me, I
25 don't know exactly where my position was on that

1 subcommittee. We can only comment on the information
2 that was in front of us. The information in front of
3 us provided to us by site visitors that would go out to
4 these programs and review the programs and look and
5 make sure everything was in place, if that individual
6 site reviewer did not pick up on the fact that the lab
7 was in the basement of an individual's home, that he
8 brought students to check them out, then it didn't get
9 put in the report as a red flag, and so even if we
10 raised the issue during our committees, we couldn't
11 comment about it because it second guesses the site
12 reviewers.
13 It's a difficult thing to do. We want
14 programs and we want them and we want the standards for
15 those programs to be more in line with what's actually
16 happening in the operating field. The difference in
17 the programs, there is a program that NSAA approves
18 that has on line modalities in it. You take an
19 experienced person in the operating room, allow them to
20 get their clinical hours at an off site location of the
21 hospital or so forth, and do a lot of the on line
22 educational components, and then when you have
23 completed a certain amount of those segments, you
24 travel to, I want to say Tennessee where there's a
25 skills lab there, and you demonstrate for them your

1 skills and -- not having been there, I don't know
2 exactly how long it is. I think it's 6 to 10 days?
3 MS. ARMSTRONG: 50 hours in the lab and
4 it's very very intense. You kill your pig, you are
5 done for the day.
6 MR. JENNETTE: So there's a, that we feel
7 is something that all of the students who go through
8 that program go through that same location and are
9 viewed, you have to demonstrate for the same type of
10 people, where the total distance learning programs they
11 set up their little skills labs at the Holiday Inn,
12 they rent a room, and people come in there for a couple
13 hours over the weekend and sew some fake tissue and so
14 forth and do a demonstration like that, and that's the
15 conclusion of the program. They need to find their own
16 clinical hours, set it up with the surgeon or the
17 hospital or whatever and try to do it.
18 But there's a thing in -- the difficult
19 thing that CAAHEP has for the requirements is standards
20 that are written are so difficult to understand that
21 they have to write an interpretation guideline to go
22 along with the standards. For instance an example,
23 there's a line in there similar to the student may not
24 be substituted for paid personnel. The implication of
25 that is that you are in school, you are not to be paid

1 while you are a student. Medical students don't get
2 paid while they are in medical school. The gray area
3 in that is that it depends on how you interpret that.
4 If I have someone who is say a surgical tech on paper
5 that I pay them as a surgical tech and show up in my
6 operating room at 7:00 o'clock in the morning and 10:00
7 o'clock I need a surgical assistant, this person is
8 enrolled in the on line program, I can put that
9 surgical tech in that position, that case, and the
10 length of that time of that case will constitute
11 clinical hours for that student. Depending on how you
12 interpret the guidelines that are in the CAAHEP
13 standards, that's either good or not good, and that's
14 one of the things that I have struggled with, knowing
15 some of the programs that are out there, knowing some
16 of the individuals in the programs, where they work,
17 and they look to be future surgical assistants in
18 several months bothered me because I know those people
19 are on the clock, and the way that I interpret that is
20 similar to a medical school is that if you are in
21 school, you are not paid to be getting your training.
22 So we had some issues with that, and
23 that's why we have kind of deviated from -- we
24 certainly look at CAAHEP accredited programs very
25 strongly, but we also look at the components of it as

1 well.

2 And also CAAHEP does not accredit

3 in-house programs. For instance the Mayo Clinic in

4 Rochester, Minnesota has a surgical assistant training

5 program that is strictly for their in-house, it is only

6 open to in-house employees. CAAHEP does not approve or

7 accredit in-house programs, and there are several other

8 places like Mayo that we looked at as well, and I think

9 the others for surgical technologists, the ABHES is the

10 other one that are the accrediting bodies that accredit

11 in-house surgical tech programs, but currently I don't

12 think that they have standards in place for surgical

13 assistant programs.

14 DR. CARTER: Are you aware of any program

15 that has no outside accrediting, quote unquote,

16 diploma, might be out there? Are there programs you go

17 on line, say you become surgical assistant 2, 3 weeks,

18 whatever, you know?

19 MR. JENNETTE: Prior to January and

20 February of this year, there were 2 programs that were

21 out there that say you can be a surgical assistant in 2

22 to 3 days or 6 days or something like that because they

23 had not been accredited yet. They are accredited by

24 CAAHEP now, but the program didn't change, just the

25 lawyer's fees.

1 If there was some sort of state
2 regulation, and certainly there are some states that
3 require that you go to a CAAHEP accredited program.
4 However, in addition to that, they also require that
5 you have, you can provide I guess 2200 hours of
6 clinical case work which would negate somebody
7 graduating from one of these CAAHEP programs and being
8 able to work directly right away in that state. They
9 may have changed it. That was one of the issues that
10 came back to us as a national association of not really
11 looking at the CAAHEP program.
12 DR. CARTER: Question. Given that you
13 are talking about CAAHEP's not sufficient in terms of
14 your belief of basic competence, and I will say that
15 most of us, most of the professions will accept CAAHEP
16 accreditation or something along those lines, and you
17 are saying in order to sort of meet the bar, you need
18 experience. Where will that place brand new people
19 coming in? And I ask that because we also dealt with
20 this issue for dialysis, not only grandfathering but
21 some provision of time to obtain some patient care,
22 actual hands on care part of your tutelage.
23 MR. JENNETTE: Right. Well, currently
24 there is credentialing organizations for them. NSAA
25 represents one of a handful of credentialing bodies

1 that are out there. AST with their CFAs, they
2 currently list graduates of CAAHEP programs to be
3 eligible to sit for the exam.
4 MS. SPARKMAN: Well, AST is totally
5 separate from the credentialing organization. It's
6 NBSA which don't credential our own people.
7 MR. JENNETTE: And there isn't -- that
8 credential, there's American Board of Surgical
9 Assisting, they accept the CAAHEP program as well, so
10 you can walk away with a credential out of one of those
11 programs, you just can't walk away out of those
12 programs with a CSA.
13 DR. CARTER: Right. Thank you.
14 MR. JENNETTE: Thank you. I do have a
15 packet I will leave.
16 DR. CARTER: That would be great.
17 As I indicated earlier, we are extending,
18 going to have another in a series of formal public
19 hearings on August 11th at 9:00 a.m. for anybody else
20 who would be interested, and the reason we are doing
21 it, we had problems getting, we had electronic signal,
22 we thought it made it to Town Hall and to Commonwealth
23 Calendar and didn't transfer, so we wanted to make sure
24 everybody gets a chance to speak to this issue, so we
25 will have another public hearing. You don't have to

1 come but you can.

2 MEMBER OF AUDIENCE: The next hearing in

3 August, will you all be able to have a computer that

4 projects --

5 DR. CARTER: If you ask us for it, yes,

6 sure, be happy to do that.

7 August 11th is when our next full board

8 meeting is, we have this scheduled at 9:00 then our

9 regulatory research meeting at 10:00 and then the full

10 board at 1:00. Again you don't have to come to all but

11 again certainly welcome to do that. And again the

12 written comment we'll now accept, it was originally the

13 31st of July, we'll continue to accept comments until

14 August 15th, the 15th of August, so anything you want

15 to bring up as an update to what you have given us

16 before such as what's happened in Texas and Indiana,

17 that kind of stuff is very helpful, so that's where we

18 are, and we do have a report right now, can't release

19 it because the committee hasn't seen it, but it's

20 pretty extensive. We'll get that out and let the

21 committee look at it. If they want to have that go out

22 for additional public comments, you'll get a chance to

23 look at it, that that may happen as well, but we'll

24 probably have the committee make some recommendation at

25 this meeting, and then if we need to have our meeting

1 subsequent to that, which will be in November, I think
2 our final recommendation will probably come out then if
3 that helps.
4 MEMBER OF AUDIENCE: One final question.
5 Other than the data you spoke about, is there anything
6 else you feel like you should see or want to see at
7 this next meeting that perhaps we can bring?
8 DR. CARTER: I think bringing up the
9 issue of the examinations, it would be lovely to get a
10 better understanding of what's being required. A lot
11 of the states are accepting CAAHEP, you know, and I'd
12 like to know more about the part where we don't really
13 have the hands on, how are you ascertaining competency
14 by not having a hands on competent to something that is
15 hands on. Just passing that cognitive exam is a
16 concern to me as a consumer.
17 MR. JENNETTE: We ask for affidavits from
18 surgeons, surgical directors, things like that
19 attesting to the individual's capabilities.
20 DR. CARTER: Right.
21 MR. JENNETTE: It's difficult to
22 challenge that, so you have to go on that word, and
23 it's, depending on the need, it may not be that
24 difficult to get that data.
25 DR. CARTER: Right.

1 MEMBER OF AUDIENCE: There were 2 factual
2 questions that you had, and I will be back on the 11th
3 too. One was the military program and the position of
4 AST, and the position of AST that graduates of military
5 programs should be grandfathered in or continue to be
6 considered as an entry for practice for surgical
7 technology. The reason that some military programs
8 aren't accredited by CAAHEP is a cost issue. It's a
9 government cost issue and the government backed out of
10 paying part of the cost for accrediting those programs.
11 The Air Force program is back in, and the Navy also, so
12 they have done it with some accommodations, so we do
13 support graduates of military programs be considered as
14 appropriate for surgical technology entry to practice.
15 And the second thing you asked about was
16 certification mills, and there are some, I'll give you
17 some. We call them trailer park mills, trailer park
18 certificates, and you mail to a P. O. Box and then
19 they'll meet you at the Days Inn and ask you, they'll
20 give you the answers to 12 questions, you have to
21 answer half of the 12 questions and you get your
22 certificate. We at AST as a national organization
23 pursue that on behalf of the national board as well.
24 And the last thing I wanted to say is the
25 governance structure of a number of institutions, there

1 are 5 or so accrediting or certifying institutions for
2 surgical assistants, not so. There's not so many for
3 surgical technologists of which AST is 95 percent of
4 our members are surgical technologists. I will furnish
5 Justin and the board a breakdown of the governance
6 structure of all of those for you just for your
7 background information.
8 DR. CARTER: That's fine. Thank you.
9 Thank you all.
10
11
12 ---Conclusion---
13
14
15
16
17
18
19
20
21
22
23
24
25

1

2

3 CERTIFICATE OF COURT REPORTER

4

5 I, Lynn Aligood, hereby certify that I was the

6 Court Reporter for the public hearing conducted by

7 the Department of Health Professions in re need to

8 license surgical assistants and surgical technologists.

9 I further certify that the foregoing transcript

10 is a true and accurate record of the hearing to

11 the best of my ability.

12 Given under my hand this 17th day of July

13 2008.

14

15

16

17 Lynn Aligood, RMR

18

19

20

21

22

23

24

25