Surgical Technologist
Application for Sunrise Review
HB 2414: June 1, 2012

Submitted by:
The Washington State Assembly of the
Association of Surgical Technologists
SUMMARY AND APPLICANT INFORMATION

- Legislative proposal being reviewed under the sunrise process (include bill number if available):


- Name and title of profession the applicant seeks to credential/institute change in scope of practice:

  Surgical Technologists

- Applicant’s organization:

  Washington State Assembly of the Association of Surgical Technologists

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- Number of members in the organization: 525 members

- Approximate number of individuals practicing in Washington: As of May 15, 20212, the Washington Department of Health records show 2,981 registered surgical technologists in Washington State. The Bureau of Labor Statistics (BLS) estimates the number of surgical technologists in the State to be 2,140. However, the actual number of practicing surgical technologists may be less than either figure, as these data may capture more practitioners than actually serve as the surgical technologist member of the surgical team.

- Name(s) and address(es) of national organization(s) with which the state organization is affiliated: Association of Surgical Technologists

- Name(s) of other state organizations representing the profession:

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APPLICATION FOR SUNRISE REVIEW

Pursuant to RCW 18.120.030 the Washington State Assembly of the Association of Surgical Technologists hereby submits its Application for Sunrise Review addressing the following factors:

(1) Define the problem and why regulation is necessary:

Surgery is invasive by nature and has inherent risks. The surgical patient is unable to make decisions or act on his or her own behalf and must instead rely on the members of the surgical team performing and assisting in the surgical procedure. Allowing under trained or inappropriately trained health care professionals to be used in operating rooms puts the patients at risk of unintended consequences that may include physical harm or even loss of life. The public assumes that everyone in the operating room has the proper training and skills. However, the surgical technologist is the only member of the surgical team that has no objective requirements of education, skill or competency. Potential errors of an unskilled, unregulated surgical technologist may include: higher incidence of infection, excessive and sometimes avoidable blood loss, allergic reactions, damage to major organs, disfiguring scars, loss of function of any limb or organ, paralysis, brain damage and even loss of life. The Institute of Medicine conducted studies that reveal that at least 44,000, and up to 98,000 patients die annually because of preventable medical errors.¹ These errors include adverse drug events, surgical injuries, wrong-site surgery, falls, burns, infections, and mistaken patient identities, with the highest error rates with serious consequences in intensive care units, operating rooms and emergency departments. Over half of the preventable medical errors (“never events”) occur in the operating room. The two chief causes of harm related to the role of the surgical technologist are surgical site infections and foreign objects left in surgical patients.

In 2006, surgeons performed almost 46 million inpatient procedures in the United States. Even more were performed at ambulatory surgery centers. Procedures range from simple outpatient procedures, to complex and highly invasive surgeries such a coronary artery bypass surgery or neurosurgery. Surgical technologists perform in the scrub role at all levels of surgical complexity.

Surgical Site Infections. The surgical technologist is responsible for maintaining the integrity of the sterile field. The sterile field is a notional area surrounding invasive or surgical procedures. Rather than a dedicated area, the sterile field refers to surfaces that sterile objects, such as surgical instruments, may contact. Protecting the sterile field involves carrying out specific procedures known as aseptic technique.

Nosocomial or hospital-acquired infections (HAIs) are a growing concern in the healthcare field. A 2007 U.S. Public Health Service (PHS) study estimated that approximately 1.7 million patients developed HAIs in 2002, resulting in an estimated 98,987 deaths. The study estimated that 22 percent, or approximately 290,000, of the infections were surgical site infections.

¹ To Err is Human: Building a Safer Health System (National Academy Press 1999)
infections.\textsuperscript{2} The cost of treating HAIs is estimated to be $37 to $45 billion annually. The Center for Disease Control and Prevention (CDC) estimates that 22 percent of hospital acquired infections are surgical site infections.

In addition to the direct risk of harm to patients, health care workers and the public at large are also at risk from nosocomial diseases. Hospitals use antibiotics to treat and prevent infections in vulnerable patients. The use of antibiotics encourages bacteria to develop resistance. They also kill less harmful bacteria, providing a non-competitive environment where resistant bacteria can flourish. These resistant strains can spread to health care workers and to the public.

Methicillin-resistant Staphylococcus Aureus (MRSA) is the most common drug resistant bacteria associated with nosocomial infections. The incidence of MRSA has grown rapidly over the past few decades. In 1974, MRSA caused only 2 percent of Staph infections. By 2003, that number had jumped to 64 percent.\textsuperscript{3} The CDC estimates that there were 94,360 MRSA cases in 2005 (85 percent were healthcare related) resulting 18,650 deaths.

Foreign Objects. Along with the circulating nurse, the surgical technologist is responsible for keeping track of all objects used during the surgical procedure. This includes performing counts of objects, especially sponges, and ensuring that no pieces have broken off instruments. Even though the circulator and scrub person are responsible for counts, the surgeon retains primary responsibility for ensuring no objects are left inside patients. Retained foreign objects (RFO) can lead to multiple problems, including pain, infection, internal damage, additional surgeries or even death. Occasionally RFOs are asymptomatic for years, or create non-specific symptoms.

Estimates of retained foreign objects after surgical procedures range from 1 in 8,000 to 1 in 18,000 inpatient operations. A notably thorough study of surgical cases performed at the Mayo Clinic, Rochester found that 1 in 5,500 inpatient operations resulted in foreign body retention. In abdominal cavity operations, incidence rate estimates rise to one in every 1,000 to 1,500 procedures.\textsuperscript{4} RFOs may be underreported, however.

Benefits to patients. Consumers of surgical services (patients and their families) will benefit from a more qualified and competent workforce. The education, training and assurance of competency of this vital member of the surgical team will reduce the incidence of surgical site infections and retained surgical instruments and other foreign objects, resulting in a reduction of readmissions and surgical complications. Healthcare facilities hiring only competent, educated personnel should experience a reduction in costly surgical errors (often not reimbursable by Medicare, Medicaid and private insurance) and surgical site infections.


Autonomous practice. Surgical technologists work collaboratively with the surgeon and other health care team members to achieve optimal patient outcomes. Surgical technologists assist in surgical procedures under the direction and supervision of surgeons and other licensed medical personnel. While their practice is not completely autonomous as other licensed medical professionals, surgical technologists are held accountable and governed by: surgical conscience, individual policies and procedures established by their employing institutions, and best practices, policies and procedures promulgated by the Association of Surgical Technologists (AST), the Association of periOperative Registered Nurses (AORN), the Occupational Safety and Health Administration (OSHA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other professional and regulatory agencies and organizations. Moreover, surgical technologists are specifically trained to utilize their knowledge of anatomy, pathophysiology, microbiology to anticipate the needs of both the surgeon and other members of the surgical team.

(2) The efforts made to address the problem:

Health regulatory and professional organizations have elevated infection control to a policy issue. Health care facilities have increased procedures and safeguards, such as hand washing and instrument sterilization techniques, to combat the rise of HAIs. The 2009 American Recovery and Reinvestment Act directed $50 million in stimulus funding to state efforts to reduce HAIs. The Joint Commission has made reducing the risk of health care acquired infections one of its Patient-Safety goals for hospitals and ambulatory surgery centers, specifically including reducing the risk of surgical site infections. The Patient Protection and Affordable Care Act includes several provisions aimed at reducing HAIs, including financial penalties for providers with high HAI rates and increased measurement and reporting of HAIs. However, the incidence and cost of surgical errors and surgical site infections continue to have a significant adverse impact on medical costs and outcomes.

Voluntary efforts to assure the education and competency of surgical technologists are inadequate, not enforceable, and inconsistent. They fail to afford patients the security that a surgical technologist participating in their care meets even minimal competency standards. Hospital employed surgical technologists are only obligated to comply with the requirements of their job descriptions. These requirements will vary from one hospital to another. They may even be different among similar facilities within the same organizational ownership.

Existing Washington law (RCW 18.215.005 et seq.), enacted in 1999, only partially regulated the practice requiring persons performing surgical technology tasks and functions to register. While this effort may identify practitioners and elements in the applicant’s background, such as criminal convictions, the regulatory scheme did not require either education or professional certification, or establish any measure of competency or accountability of surgical technologists, as House Bill 2414 provides. Building on this existing regulatory framework by requiring appropriate accredited education and certification constitutes the most effective and efficient means of assuring competency of surgical technologists.
(3) The alternatives considered:

An alternative to amending RCW 18.215.010 *et seq.* that requires education and certification would be the enactment of entry-to-practice legislation requiring hospitals, ambulatory surgical centers and other healthcare facilities performing surgical procedures to employ only surgical technologists who have completed a nationally accredited surgical technology program and hold and maintain a certified surgical technologists credential issued by a nationally accredited credentialing organization. This entry-to-practice approach has been proposed in several states, and implemented in six. However, refining the regulatory scheme in place since 1999 – surgical technologist registration – is consistent with the approach taken with regard to other allied health practitioners and would cause the least divergence from existing Washington law.

(4) The benefit to the public if regulation is granted:

Patient safety requires that all surgical personnel meet minimal educational and competency requirements. The surgical patient does not pick their surgical support team ahead of time. During the procedure, the patient is under anesthesia and unable to make decisions or act on his or her behalf. Surgical patient care is enhanced when all members of the surgical team are appropriately educated. This legislation will ensure that all personnel caring for surgical patients are qualified and meet minimum continuing education standards. A competent surgical team can prevent and reduce surgical errors and surgical site infections. Documented evidence from other states indicates that preventable surgical errors were reduced by over 30 percent in facilities where only appropriately educated and credentialed surgical technologists were utilized. And in Virginia, the cost of treating trauma and surgical site infections was reduced 11 percent in facilities hiring only certified surgical technologists. It is axiomatic that increased educational and professional competency impacts positive patient outcomes.

(5) The extent to which regulation might harm the public:

Registration requiring nationally accredited education and private certification will not substantially restrict entry into the profession of surgical technology. First, the proposed regulation (RCW 18.215.030) grandfathers currently practicing surgical technologists, surgical technology students, and military trained surgical technologists; and grants a 12-month period for new surgical technology programs to become accredited. Currently there are seven accredited programs in the State of Washington; and there are 475 programs accredited by the Commission on Accreditation of Allied Health Programs (CAAHEP) and 29 programs accredited by the Accrediting Bureau of Health Education Schools (ABHES). Because CAAHEP and ABHES accreditation is a national function, those program graduates from other states would qualify to register as a surgical technologist in Washington. Accredited surgical technology programs graduate over 5,500 students annually, including more than 100 students in Washington. Because Washington hospitals serve as the clinical training sites for surgical technology students, the pathway to employment is direct and immediate. The certification examination is administered by the National Board for Surgical Technology and Surgical Assisting (NBSTSA) and is offered as part of the curriculum of every CAAHEP accredited surgical technology program. And, similar to accredited programs, certificants from other states will meet the requirements of the proposed registration act. A national catchment for prospective surgical
technologists practicing in Washington is supported by national program accreditation and national certification.

Licensed practitioners who perform surgical technology tasks and functions are exempted from the registration provisions. RCW 215.18.030(4).

(6) The maintenance of standards:

Currently existing law (RCW 18.215.0005 et seq.) provides for the adoption and enforcement of disciplinary standards based on unprofessional conduct or impairment. The core curriculum of every accredited surgical technology program contains a course of study on medical ethics, medical conscience and legal standards for the surgical technologist practitioner. Continuing education is necessary to maintain certification.

The legal and professional liability standards that will apply to surgical technologists will be the same as for all other medical practitioners: the violation of the standard of care required of surgical technologists in the same or similar circumstances. The health care facility, as the employer of the surgical technologist may incur vicarious liability (under the doctrine of respondeat superior) for the actions of the surgical technologist when performing his or her duties. Additionally, under the “captain of the ship” doctrine or the legal doctrine of “borrowed servant,” the surgeon may incur liability for the actions of the surgical technologist under the surgeon’s delegation, direction or control.

As stated, the guarantee of competent, educated, credentialed surgical technologists as valuable members of the surgical team will serve to reduce preventable medical errors and surgical site infections, promote positive surgical outcomes, solidify and support the surgical team.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice.

The regulation will govern all practicing surgical technologists who are not otherwise licensed to perform surgical technology tasks and functions. As stated, the exact number of actual practicing surgical technologists is unknown, although 2,891 persons are currently registered. It is estimated that the number of persons affected by the new regulation will be approximately 2,000 persons. The Washington State Assembly of the Association of Surgical Technologists has approximately 500 members.

(8) The expected costs of regulation:

Currently, the Department of Health exacts a fee of $65 from each registered surgical technologist. Washington law requires that registration fees underwrite the entire cost of regulation. Hence, registration costs under the amended statute should have no appreciable economic effect on the registrants. The current fee will defray costs of regulation and oversight. A database easily accessible to registrants, the Department and the public already exists; and verification of credentials is available online.
The increased cost to the public should also be negligible. According to BLS statistics, surgical technologist wages and compensation in states that require certification are not appreciably higher than in states that do not. Wages for certified surgical technologists continue to parallel the general rise in wages due to overall inflation. The cost of an accredited education program varies with the type of program offered, whether the program is associated with community colleges or technical schools or with private proprietary institutions. Surgical technology courses of study vary from a 2-year associate’s degree program to a 14-month certificate program. All accredited programs offer didactic and clinical education (the latter in conjunction with hospitals and health care facilities), based on a 257-page Core Curriculum. As stated, the certification examination administered by the NBSTSA is offered at every accredited program as a performance outcomes indicator.

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:

HB 2414 summarizes the authorized tasks and functions of a surgical technologist in its amended definition section, RCW 18.215.010-(3). A more comprehensive definition follows:

Surgical technologists perform important tasks before, during and after operative and other invasive procedures. Before an operation, surgical technologists help prepare the operating room by setting up surgical instruments and equipment, sterile drapes, and sterile solutions. They assemble both sterile and non-sterile equipment, as well as check and adjust it to ensure it is working properly. Technologists also get patients ready for surgery by washing, shaving, and disinfecting incision sites. They transport patients to the operating room, help position them on the operating table, and cover them with sterile surgical drapes. Technologists also observe patients’ vital signs, check charts, and help the surgical team put on sterile gowns and gloves.

During surgery, surgical technologists participate in the surgical pause (or “time out”), pass instruments and other sterile supplies to surgeons and surgeon assistants, hold retractors, cut sutures, transfer and pour fluids at the sterile field, and sponge and suction the operative site. They help count sponges, needles, supplies and instruments. They help prepare, care for, and dispose of specimens taken for laboratory analysis and help apply dressings. Some surgical technologists operate sterilizers, lights, or suction machines and help operate diagnostic and laparoscopic equipment.

After an operation, surgical technologists may help transfer patients to the recovery room and clean and restock the operating room. The Association of Surgical Technologists has prepared a job description of the surgical technologist, which details the tasks, roles and functions in the surgical technologist scope of practice. The knowledge and skills necessary to perform these functions are rigorously taught in accredited programs in well-defined and comprehensive curricula. On-the-job training by hospitals and other healthcare facilities cannot offer the same assurances.

5 See link below