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THE IMPORTANCE OF ACLS IN PROVIDING HIGH-QUALITY PATIENT CARE

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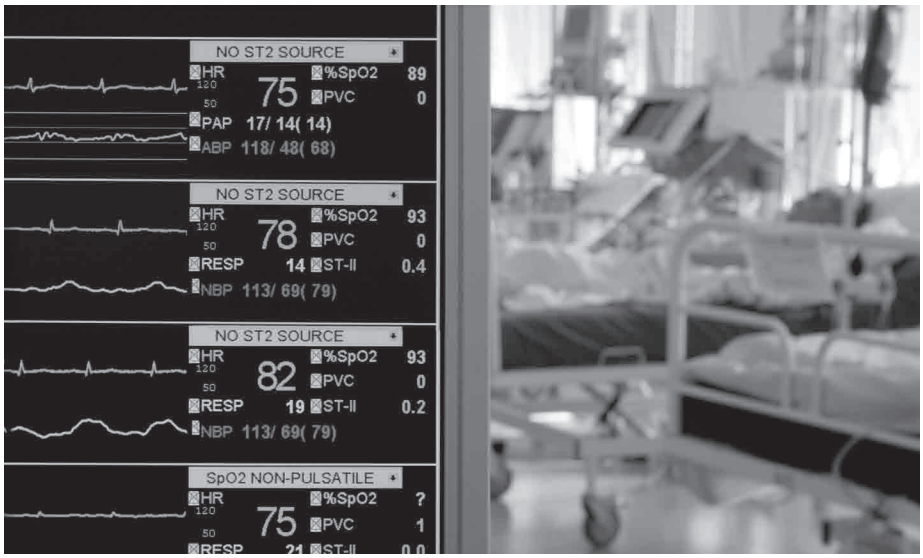
Association of Surgical Assistants Vice President

Since, its inception in the mid 1970s, the American Heart Association's (AHA) Advanced Cardiovascular Life Support (ACLS) training program has played a central role in the education of healthcare personnel by providing them with the knowledge, skills and critical thinking they need to effectively respond to cardiac and other emergencies appropriately.[6,7] Recent research has estimated that the survival to discharge rate for patients of cardiac arrests is four times higher for those patients cared for by healthcare professionals properly trained in ACLS.[4] Because the overarching goal of ACLS is to provide the arresting patient with safe, progressive care until he/she is stabilized and prepared for the next treatment level,[5] providers are explicitly trained in the management of emergent situations and learn a host of life-saving interventions that work in tandem to meet this goal. With an ever-increasing population of critically ill patients throughout the US, the demand for competent providers of ACLS never has been greater.



Who Should be Trained in ACLS?

Although decreased mortality rates have been directly linked to early access to providers of ACLS services, these individuals do not work alone. Hospitals must establish a team-based approach to effective resuscitation and that the burden of clinical expertise should not rest with one individual alone.[3] As each member of the resuscitation team plays an integral role in ensuring the stabilization of the patient, "It is appropriate that all members of the team know the theory that underlies the practice and are proficient in the skills required;" furthermore, "No single profession has a monopoly of the knowledge base required to deliver efficient patient care."[4] As such, the AHA has not set specifications on exactly which providers may certify in ACLS. Rather, the intended audience for ACLS instructional programs is defined as any healthcare professional involved in the management of events such as cardiopulmonary arrest, and cardiovascular emergencies.[2] Since many healthcare providers are involved in the care of the patient during such emergent situations, ACLS certification is open to physicians, nurses and allied health specialists alike. Since the surgical first assistant plays a central role in the care of the surgical patient and is readily available to assist in the management of perioperative arrests, he/

she is an ideal candidate for such training. Facility-specific recommendations should not preclude the surgical assistant seeking to advance his/her skill set for the betterment of patient care.

How is ACLS certification obtained?

Advanced cardiovascular life support certification is required for an increasing number of non-physician surgical assistants nationwide. This is especially true of practitioners working in specialty trauma facilities. A growing number of employers are providing this training to their employees and covering the associated costs. Due to the importance of the team approach to ACLS, surgical assistants working in facilities that do not require certification may desire to research local training programs and attend a course on their own time.

Certification is granted by the American Heart Association upon successful completion of an AHA-approved course in ACLS. Such courses are typically held over two days and generally consist of 10-12 hours of instruction, including classroom lecture, hands-on and simulation-based activities, skills practices and testing. Students should expect to learn practical information and skills related to the following:

- refinement of basic life support functions (ie, hard and fast chest compressions, proper use of a bag-valve mask, etc.)
- recognition of the early warning signs and peri-arrest conditions associated with a cardiovascular emergency
- effective strategies for airway management such as endotracheal intubation
- pharmacology-related to ACLS care
- acute coronary syndromes and stroke management considerations
- leadership skills
- effective and direct communication in a crisis situation
- team dynamics

Although each of these topics is discussed in detail, some prior knowledge of emergency response is presupposed. To ensure success, the prospective ACLS student should study and review all course materials that are received prior to the start of the course. These materials include a student handbook containing the emergency response algorithms, pharmacologic agents and assessment skills that must be committed to memory. Additionally, a working knowledge of cardiac rhythms is needed to facilitate proper patient assessment and evaluation. The AHA has a list of comprehensive ACLS study aids, course materials and supplemental courses on their website. Following instruction, practice and demonstration of practical and theoretical competency, testing consists of skills verification in CPR and AED use, bag-mask ventilation, code management and a written exam.[1]

Upon successful completion of the AHA ACLS course, the surgical assistant will be granted certification for a period two years; after which a five-hour recertification course is required. For students unable to attend a classroom-based course, an online-assisted program is available; however, surgical assistants must take care to avoid unaffiliated internet-based offerings. Approved courses can be identified by contacting the AHA.

Summary

As more and more critically ill patients enter the healthcare system, many are finding themselves under the care of qualified surgical first assistants in the operating room. Although most cardiac events occur in the critical or intensive care unit,[4] a significant number are reported in surgical suites each year. A team-approach to ACLS should therefore incorporate the knowledge and expertise of the assistant at surgery.

Resource List

- ACLS course materials: *http://www.heart.org/HEARTORG/CPRAndECC/HealthcareTraining/AdvancedCardiovascularLifeSupportACLS/Advanced-Cardiovascular-Life-Support-ACLS_UCM_001280_SubHomePage.jsp*
- ACLS course outline: *http://www.heart.org/HEARTORG/CPRAndECC/HealthcareTraining/AdvancedCardiovascularLifeSupportACLS/Advanced-Cardiovascular-Life-Support-ACLS-Classroom_UCM_306643_Article.jsp*
- ACLS online-assisted course: *http://www.heart.org/HEARTORG/CPRAndECC/HealthcareTraining/AdvancedCardiovascularLifeSupportACLS/HeartCodereg-ACLS-Part-1_UCM_307132_Article.jsp*
- ACLS rhythms and algorithms: *http://lane.stanford.edu/portals/cvicu/HCP_CV_Tab_1/ECG_Rhythms_for_ACLS.pdf*
- ACLS quiz: *http://medinfo.ufl.edu/other/gene/index.html*
- Find an AHA ACLS course in your area: *http://www.heart.org/HEARTORG/CPRAndECC/FindaCPRClass/Find-a-CPR-Class_UCM_303220_SubHomePage.jsp*

References

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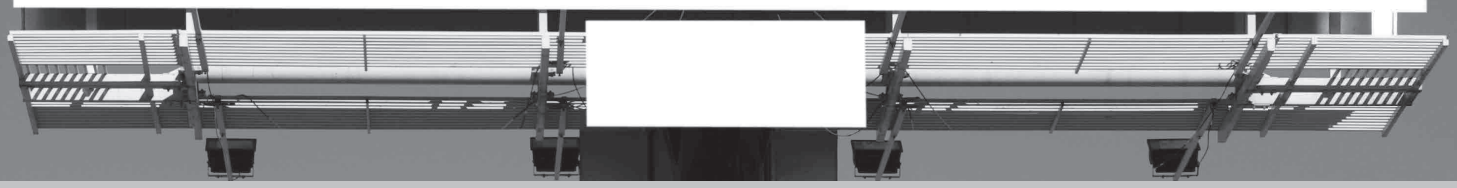
2. American Heart Association (AHA). (2011). HeartCode ACLS Part I. *http://www.heart.org/HEARTORG/CPRAndECC/HealthcareTraining/AdvancedCardiovascularLifeSupportACLS/HeartCodereg-ACLS-Part-1_UCM_307132_Article.jsp*
3. Cummins R O, Sanders A, Mancini E, & Hazinski M F. *In-hospital Resuscitation: A Statement for Healthcare Professionals from the American Heart Association Emergency Cardiac Care Committee and the Advanced Cardiac Life Support, Basic Life Support, Pediatric Resuscitation, and Program Administration Subcommittees.* Circ. 1997;95:2211-2212.
4. Hagyard-Wiebe T. *Should Critical Care Nurses be ACLS-trained?* Dynamics. 2007;18(4):28-31.
5. Hoadley T A. Learning Advanced Cardiac Life Support: A Comparison of Low- and High-fidelity Simulation. Nurs Educ Perspect. 2009;30(2):91-95.
6. Householder-Hughes S D. Advanced cardiac life support for the new millennium. *J of Cardiovasc Nurs.* 2002;16(3):9-23.
7. Kidd T, & Kendall S. Review of Effective Advanced Cardiac Life Support Training Using Experiential Learning. *J of Clin Nurs.* 2006;16:58-66.

2012 ASA CALL FOR CANDIDATES

in Washington, DC, May 25-27, elections will be held for ASA Secretary and three Board Positions. Each office is for a two-year term, 2012 through 2014.



Announced candidates who submit their Curriculum Vitae and Consent to Serve by February 1, 2012, will have their information published in *ASA News*. The Consent to Serve and Curriculum Vitae forms are available for downloading at http://www.surgicalassistant.org/index.php/about-asa.

For publication, candidates must also submit a photograph and a personal statement of involvement (not to exceed 500 words). If you have previously submitted a Consent to Serve and Curriculum Vitae, you will not need to send in duplicate copies.

Please send all documents to: Karen Ludwig, ASA 2012 Candidates for Office, Association of Surgical Assistants, 6 West Dry Creek Circle, Littleton, CO 80120. kludwig@surgicalassistant.org

According to the ASA Bylaws Article V

Section 1. Nominations

A. At least ninety days prior to the national meeting, the Credentials Committee shall present a list of candidates for each office to be filled at the national conference accompanied by a curriculum vitae and a written consent of the nominees to serve if elected. All nominees who meet the qualifications for office shall be placed on that list.

B. Nominations may be made from the floor provided written consent of the nominees has been obtained in advance and their credentials have been verified by the Credentials Committee.

Section 2. Elections

A. Elections shall be by ballot at the national conference, the date and hours to be determined by the ASA.

B. Election of officers shall be by a majority vote. In the event a second ballot is needed to establish a majority, the two candidates receiving the highest number of votes shall be placed on the second ballot.

C. Election of members of the Board of Directors shall be by plurality vote. In the case of a tie, a decision shall be by ballot of the tied candidates and plurality shall elect. In the event of a second tie, a decision shall be by lot.

A candidate must have been an ASA active member for one year immediately preceding nomination and maintain that active status, if elected.

According to the ASA Bylaws Article VI

Officers

Section 1. The officers of ASA shall be the following: President, Vice President, Secretary, and Treasurer.

Section 2. Eligibility of Officers

A. A candidate shall have been an active member for one year immediately preceding nomination and, if elected, shall maintain that active status.

PROPOSED BYLAWS CHANGE

According to the ASA Bylaws Article VIII

Board of Directors

Section 1. The Board of Directors shall consist of the officers and five other elected members of the Board of Directors.

Section 2. Eligibility of Board of Directors Members

A. A candidate for the Board of Directors shall ~~have been~~ be an active member ~~for one year immediately preceding nomination~~ and, if elected, shall maintain that active status.

B. A candidate shall not serve in any elected or appointed board position in any national accreditation, professional, or certification organization relative to surgical technology or surgical assisting practice.

(Note: for 2012 a proposed bylaws change (seen above) will be voted upon at the first business meeting in Washington, DC, in 2012. Eligibility of candidates will be determined by the adoption of the proposed bylaws amendment.)

All interested active ASA members who are interested in seeking election to the ASA Board are encouraged to send in their Consent to Serve, CV and picture for publication.

ASA
ASSOCIATION OF SURGICAL ASSISTANTS

EARN UP TO 17 CONTINUING EDUCATION CREDITS AT THE

2012 HOUSTON MEETING

FEBRUARY 24-25, 2012
SPONSORED BY THE ASSOCIATION OF SURGICAL ASSISTANTS

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CROWNE PLAZA

All CSTs, CSFAs, CSAs, SA-Cs, PAs and RFNAs are invited.

ASA February Meeting Agenda

FRIDAY, FEBRUARY 24, 2012	
7:30 am–4:30 pm	**da Vinci Hands-on Practicum** — **7 CEs** **Introduction to da Vinci System and Instrument Insertion** *(Memorial Hermann Hospital; limited to 20 registrants. Separate agenda includes breakfast and lunch. Details are posted on the ASA and AST websites. Must be registered for the ASA meeting.)*
5:30–7:20 pm	**Keynote Address** — **2 CEs** **Surgical Assistant Licensure: The Texas Experience** *Bob Kamm, JD*
7:30–8:30 pm	**Reception**
SATURDAY, FEBRUARY 25, 2012	**8 CEs**
7:45–8 am	**Welcome** *Dennis Stover, CST, CSA, ASA President*
8–8:50 am	**Becoming a Traveler** *Polly Thomas, CST, CSFA, SA-C*
9–9:50 am	**Business 101** *Christina Tuchsen, CST, CSFA*
10–10:50 am	**CPT Codes** *Christina Tuchsen, CST, CSFA*
11–11:50 am	**Contemporary Changes in Operative Management of Trauma** *Kenneth L Mattox, MD, FACS*
Noon–12:50 pm	**Lunch** *(provided)*
1–1:50 pm	**ASA Advocacy and Public Policy** *Vanessa Hannemann, ASA/AST Government Affairs Manager*
2–2:50 pm	**Introduction to Surgical Ethics** *Courtenay R Bruce, JD, MA*
3–3:50 pm	**Spine Surgery** *Ibrahim A Omeis, MD*
4–4:50 pm	**Clinical Topic**

Attendance is limited to 150. Confirmation will be emailed at least 20 days prior to the meeting, and onsite registration will be available on a space-available basis. All cancellations must be received in writing by February 10, 2012. Accommodations: Crowne Plaza Houston Downtown, 1700 Smith Street, Houston, Texas, 77002, 713-739-8800. Rates: $99/night plus tax, single or double occupancy. Reservation deadline: February 3, 2012. Room block is limited.

Register online at:
www.surgicalassistant.org, on the opening page click on ASA Houston Forum

Mail completed registration to: ASA, 6 W Dry Creek Cir, Littleton, CO 80120

Fax completed registration to: 303-694-9169

Register by phone: 800-637-7433, ext 2514 (8 am–5 pm MT)

ASA HOUSTON MEETING FEES (INCLUDES FRIDAY RECEPTION AND KEYNOTE, SATURDAY ED SESSIONS AND LUNCH)

Date _____ Member/Cert no _____

Name (please print) _____

Circle title: CST CSA CST CSA SA–C Other _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

Email _____

Credit card billing address (if same as above, leave blank) _____

City _____ State _____ Zip _____

☐ ASA member: $275 $ _____
☐ Nonmember: $300 $ _____
☐ da Vinci practicum, Friday, February 23: ($350 ASA member; $400 nonmember) $ _____
☐ Guest lunch ticket: _____ x $35 $ _____
Total: $ _____

☐ Money order/check enclosed for $ _____ (No purchase orders accepted)

☐ VISA ☐ MC ☐ AmEx Name that appears on card _____

No _____ Expiration date _____

Total amount charged: $ _____ Signature _____

ACCURACY AND FILING WITH THE NPI

ASA Government Affairs Department

Healthcare fraud is in the news everywhere: it is a serious problem, and a serious focus of health providers, insurers, state governments, Medicaid and Medicare. Every state, and federal law, has prohibitions against committing fraudulent acts to obtain financial benefit. Healthcare fraud is broadly defined as (1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on their behalf, with the knowledge that such deception or misrepresentation could resulted in some unauthorized benefit; or (2) filing or submitting a claim that is false or fictitious, including any statement that omits a material fact. The provider of the services is responsible for the actions of all individuals, who file a claim on behalf of the provider, such as billing services and personnel. Medicare describes fraud in a similar way, "Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms, including: (1) billing for services or supplies that were not provided; (2) misrepresenting services rendered or the diagnosis from the patient to justify the services of equipment furnished; (3) altering a claim form to obtain a higher amount paid; (4) misrepresenting one's provider status and entitlement to reimbursement; (5) soliciting, offering, or receiving a kickback, bribe, or rebate; and (6) use of another person's Medicare card to obtain medical care. State laws regarding health insurance reimbursement follow this general analysis. The US Department of Veterans Affairs defines fraud as "the intentional misrepresentation of information to gain undeserved payment for a claim." Private health care insurers, such as Blue Cross Blue Shield, define health care fraud as intentionally making any false statement or misrepresentation on a claim, billing, receipt or any other associated materials with the intent of obtaining unwarranted payment."

How does this affect surgical assistants? Those in private practice, or employed by physicians and surgeons, often seek private insurance, Medicare or Medicaid reimbursement for services rendered to their surgical patients, and in this endeavor they must obtain a National Provider Identifier (NPI) to facilitate this process. The NPI was mandated as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Centers for Medicare and Medicaid Services (CMS) began issuing NPIs in October 2006. HIPAA covered entities such as providers completing electronic transaction, healthcare clearinghouses, and large health plans were required by regulation to use only the NPI to identify covered healthcare providers by May 23, 2007.

The NPI is the required identifier for Medicare services, and it is used by other payers, including commercial healthcare insurers. All individual HIPAA-covered healthcare providers (such as physicians, physician assistants, nurse practitioners, chiropractors, physical therapists, athletic trainers, and surgical assistants) or organizations (such as hospitals, home health care agencies, nursing homes, group practices, laboratories, pharmacies, medical equipment companies) must obtain a NPI, even if a billing agency prepares the transaction. The NPI is used by health plans to process electronic transactions and communicate with health care providers and to coordinate benefits with other health plans. It is also used, significantly, by the Department of Health and Human Services to cross reference healthcare providers in fraud and abuse files and other program integrity files.

Accuracy in selecting and filing for an NPI is consequently critical for the self-employed or physician-employed surgical assistant. Misnomer or other

2012 HOUSTON ASA MEETING
DAVINCI PRACTICUM, FRIDAY, FEBRUARY 24 AGENDA
MEMORIAL HERMANN HOSPITAL

7:30–8 am	Registration and Breakfast
8–8:30 am	The Business Case for Robotics *P Herrera*
8:30–9:30 am	Fundamentals of Robotics *A Garcia*
9:30–10 am	Intraoperative Efficiencies
1–10:30 am	Break
10:30–Noon	Lab Session I: Draping *A Garcia; P Herrera; B Hall; and others*
Noon–12:30 pm	Lunch & Lecture: Future of Robotics *E Wilson*
12:30–2 pm	Lab Session II: Docking and Instrument Insertion *A Garcia; P Herrera; B Hall; and others*

misinformation on a NPI may subject the surgical assistant provider to civil and criminal fraud penalties under both state and federal laws and regulations, which can include imprisonment. Medicare has adopted elaborate taxonomy codes to identify various medical providers for purposes of identification and reimbursement, according to educational background, skills and work to be performed. For example, Taxonomy Code 3263L00000X defines a Nurse Practitioner as "(1) a registered nurse provider with a graduate degree in nursing prepared for advanced practice involving independent and interdependent decision making and direct accountability for clinical judgment across the health care continuum or in a certified specialty." The Code 363A00000X defines a physician assistant as "a person who has successfully completed an accredited education program for physician assistant, is licensed by the state and is practicing within the scope of that license. Physician assistants are formally trained to perform many of the routine, time-consuming tasks a physician can do. In some states, they may prescribe medications. They take medical histories, perform physical exams, order lab tests and X-rays and give inoculations. Most states require that they work under the supervision of a physician."

Significantly, surgical assistants are identified in the Taxonomy Code Group entitled, "Technologist, Technician, and Other Technical Service Providers" as, "246ZC0007X – SPECIALIST/ TECHNO0LOGIST, OTHER – CERTIFIED FIRST ASSISTANT." That section defines Certified First Assistant as follows, "As defined by the American College of Surgeons (ACS), the surgical first assistant provides aid in exposure, hemostasis, and other technical functions that will help the surgeon carry out a safe operation with optimal results for the patient. These functions include, but are not limited to, positioning of the patient, suturing, and closure of body planes and skin, and the application of wound dressings." Identification of the surgical first assistant under any section of the NPI Taxonomy Code other than 246Z0007X constitutes misrepresentation and may subject the surgical assistant to fraud charges.

In addition, a billing company is also liable if it is also using the wrong taxonomy code to misrepresent its clients when billing Medicare and secondary insurers.

As stated, although NPI is an identifier mandated by CMS, its reach extends beyond federal law. Although some states mandate reimbursement of surgical assistants (eg, Texas, Illinois and Kentucky) private insurance plans may establish their own rules and credentialing requirements for reimbursement for services provided by surgical assistants. For example, absent applicable state insurance law or mandate, private insurers may determine, as their prerogative, that only physician assistants and advanced practice nurses are eligible for reimbursement for surgical assistant services. Although surgical assistants may petition these insurers to reimburse certified surgical assistants, they may decline unless the law forbids such denial. Howsoever, the law is clear that obtaining a false or misleading NPI in order to claim provider reimbursement for surgical services constitutes insurance fraud.

The moral: be sure that the NPI that you are using relates to surgical assistant and not to any other health care provider. Failure to do so can lead to civil and even criminal penalties for deliberate misidentification in order to secure reimbursement.

NBSTSA ANNOUNCES NEW ELIGIBILITY OPTION FOR CSAs AND SA-Cs

Beginning January 1, 2012, Certified Surgical Assistants (CSAs) and Surgical Assistants–Certified (SA-Cs), who have current certification through the National Surgical Assistants Association (NSAA) or the American Board of Surgical Assistants (ABSA) may apply for the CSFA examination if they have 50 continuing education credits earned within the last two years, prior to the date of application for the CSFA credential.

THE NATIONAL BOARD OF SURGICAL TECHNOLOGY AND SURGICAL ASSISTING

Additional documentation required includes:

1. Evidence of 50 continuing education credits
2. CE credits must have been earned within the last two years prior to the date of application for the CSFA examination.
3. CE credits must meet the criteria as defined by the most current edition of the AST Continuing
4. Education Policies for the CST and CSFA.
5. Two Experience Verification Forms demonstrating operative case experience as defined by the most current edition of the ASA Core Curriculum for Surgical Assisting
6. Experience must have been acquired within the last two years prior to the date of application for the CSFA examination.

Official transcript showing successful completion of an Associate's degree or higher.
Experience verification forms are available at www.nbstsa.org

Mock surgery demonstrations help legislators understand the roles and responsibilities of the surgical team members.

LEGISLATIVE STRATEGY IN VIRGINIA: ONE BILL OR TWO?

ASA Government Affairs Department

As surgical assistants and surgical technologists move forward with their respective legislative initiatives in Virginia, all strategic aspects of the campaigns are proffered, rolled out, analyzed and evaluated, toward the goal of presenting and advancing the most successful attempt at legislative success. To that end, ASA's and AST's lobbyists, joined by Government Affairs staff, have identified and investigated the political and public policy considerations surrounding the initiatives. One of the early pivotal issues is whether or not to file two separate bills—one relating to licensure of surgical assistants and one relating to certification of surgical technologists.

Consideration of this issue involved discussions with representatives of the Virginia Department of Health Professions (DHP), which opened a study of the regulation of both surgical assistants and surgical technologists in 2009 and issued a Final Report in July, 2010, recommending regulation of both professions: licensure of surgical assistants and state-sponsored certification of surgical technologists. Additionally, discussions were conducted with members of the Governor's staff, House of Delegates and Senate leadership, proposed bill sponsor(s), leaders and key committee members on the House of Delegates Committee on Health and Human Resources and the Senate Committee on Health, Welfare and Institutions. Lobbyists also analyzed the potential impact of the 2011 state elections and likely winners and losers.

The results of this analysis points to the advisability and efficacy of filing a single bill, with two separate and distinct sections relating to surgical assistant licensure and surgical technologist certification respectively, both under the auspices of the Virginia State Board of Medicine and overseen by an Advisory Committee. The two professions would have separate definitions and separate eligibility requirements. Each profession would be regulated under Title 54 of Virginia law, as are physicians, chiropractors, nurses, pharmacists, psychiatrists and podiatrists.

The reasons for this determination are as follows:

- The Virginia DHP strongly recommends a single bill, since its consideration of the issue was predicated on a single study resulting in a single recommendation as to both professions. The DHP believes implementation could best be achieved through combined legislation. DHP's support will be critical to the success of the legislative effort;
- The two professions have a common underpinning, ie, both are members of the surgical team performing supporting and assisting surgical services to the attending surgeon;
- Legislators are confused, if not ignorant, of exactly who these surgical professionals are, and educating each legislator about each separate practitioner in one bill, and then the other, will be jeopardized by the limited time afforded proponents to meet with and inform decision-makers. The message is that this legislation will ensure patient safety in the operating room. Simplicity and clarity of message win the day in the General Assembly;
- In an anti-regulatory political environment such as Virginia, presentation of two bills may either confound and annoy legislators, or force them to choose between the two bills (either informed or not), or even reject both bills as overreaching;
- If the legislators even suspect any professional infighting in favor of one or another bill, they are likely, and prone, to reject both bills outright;
- The small number of surgical assistants subject to regulation under a proposed singular bill may trigger regulatory discomfort regarding the cost and manpower necessary to regulate the single profession, whereas combining the numbers of both surgical assistants and surgical technologists may avoid a fiscal note (and reduce regulatory fees) by demonstrating a critical mass of licensees and certificants. In Illinois, surgical assistants actively recruited surgical technologists to join their cause in order to gain a sufficient number of individuals to merit creating a new regulatory body. This effort was successful, and Illinois surgical assistants are now licensed.

The goal of this ASA initiative is to achieve licensure for surgical assistants in Virginia and require the CSFA, SA-C or CSA credential as a condition for licensure. ASA shall vigorously pursue the successful passage of this initiative. Education of the decision makers remains the biggest challenge in pursuing and achieving regulation of surgical assistants. The abbreviated amount of time afforded proponents of legislation to access, educate and persuade sponsors, Delegates and Senators to embrace and advance this critical patient safety legislation mitigates strongly in favor of presenting a simple, single but bifurcated, piece of legislation related to both surgical professionals.

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