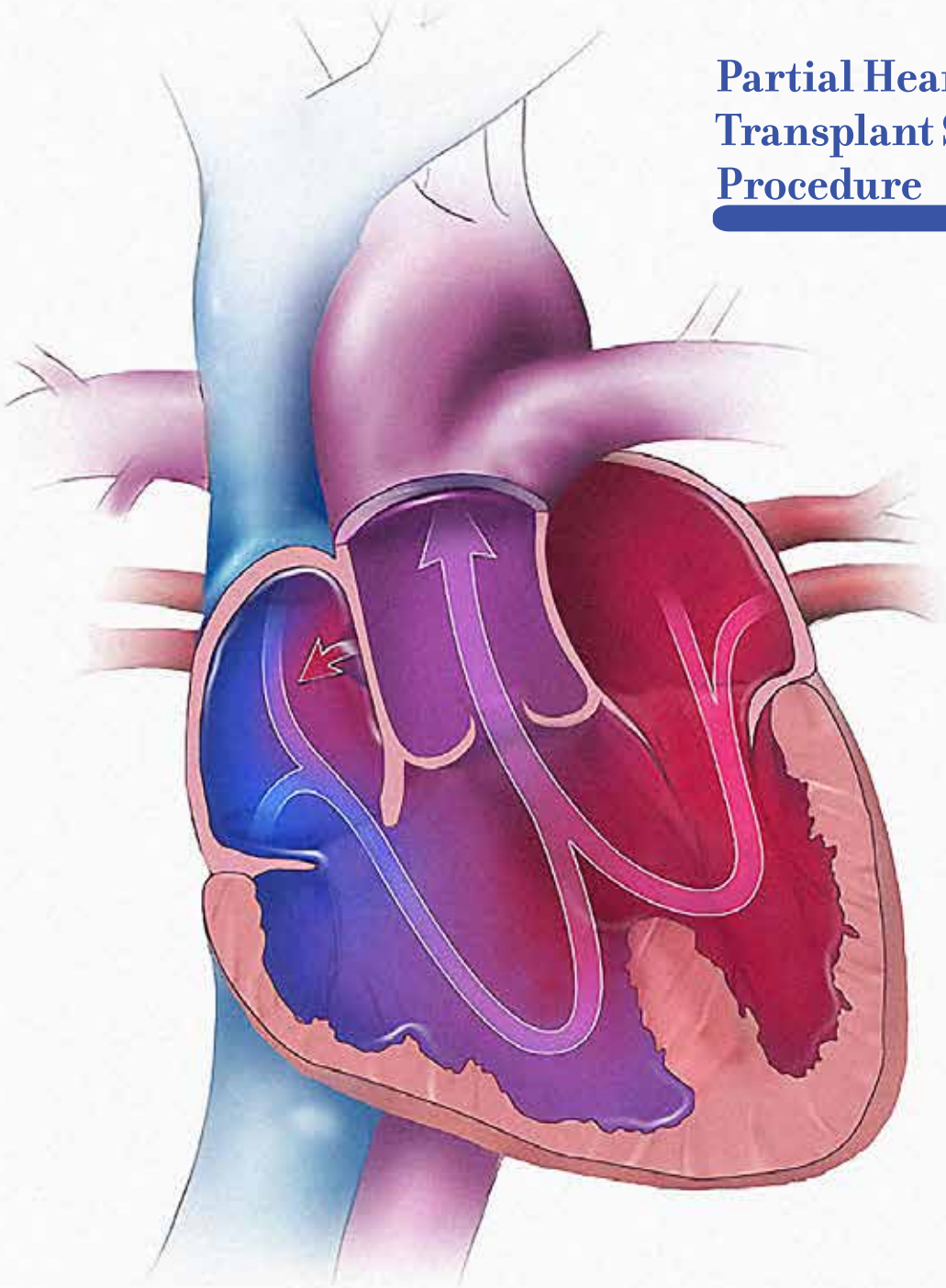
OCTOBER 2025 VOLUME 57 NO 10

THE SURGICAL TECHNOLOGIST

OFFICIAL JOURNAL OF THE ASSOCIATION OF SURGICAL TECHNOLOGISTS, INC.



Partial Heart Transplant Surgical Procedure

Part 1 of 2

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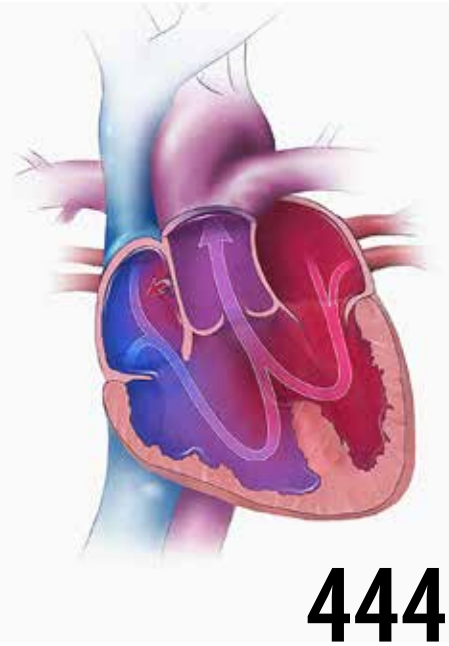

Partial Heart Transplant Surgical Procedure, Part 1 of 2

Kevin B. Frey, CST

Truncus arteriosus, a rare congenital heart defect where a single blood vessel arises from the heart instead of separate pulmonary and aortic vessels, has traditionally been treated with complex surgical repairs. However, an emerging approach uses partial heart transplantation, where only the living heart valves and related tissue needed for repair are transplanted rather than the entire heart. This method offers the advantage of providing growing, functional tissue for infants, reducing the need for repeated surgeries as the child develops, and improving long-term outcomes.

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In This Issue

In Every Issue

The Foundation for Surgical Technology: Supporting the Future of the Profession

DUSTIN CAIN, CST, CRCST, CHL, FAST, AST VICE PRESIDENT, FFST CHAIR

BOARD MESSAGE

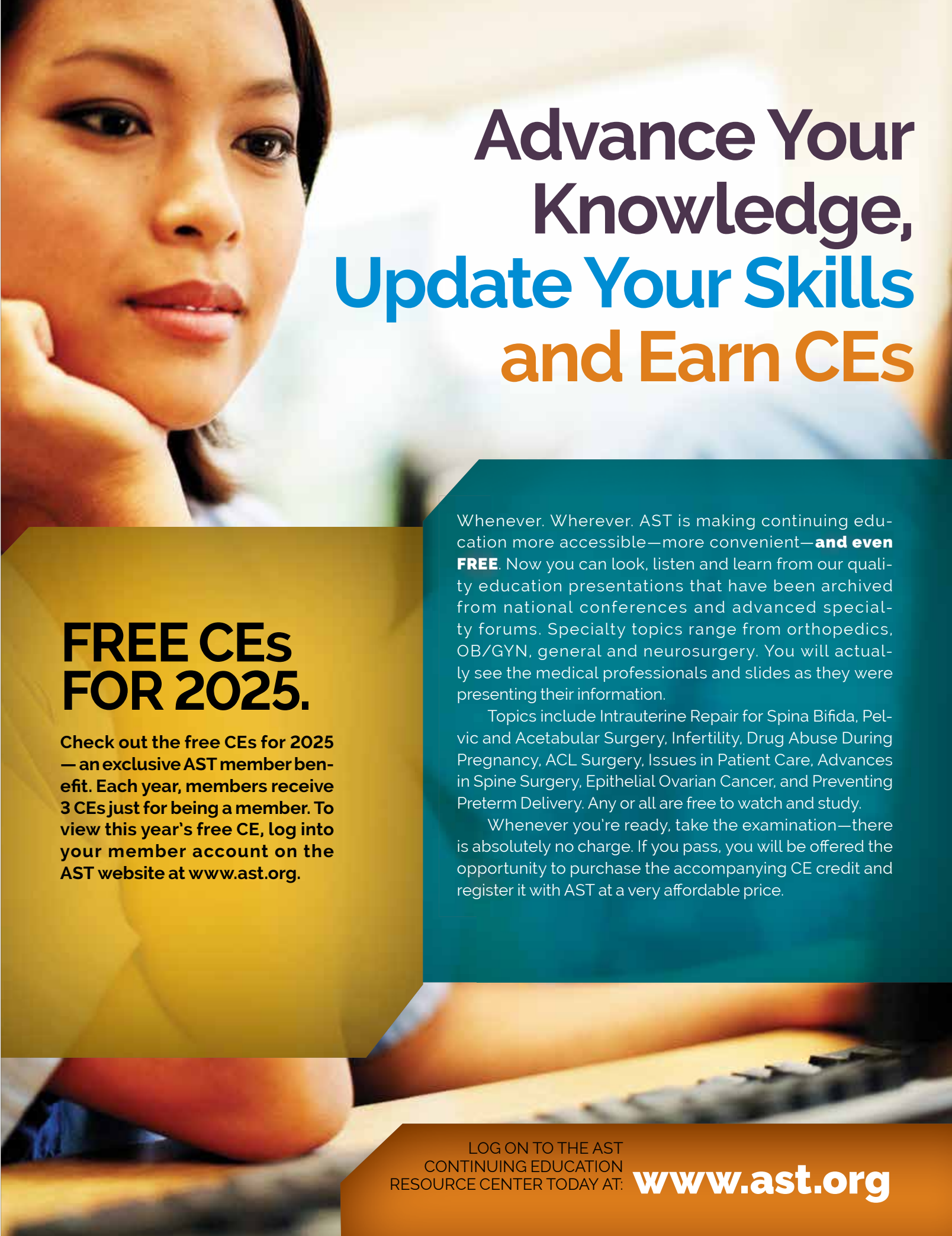
The Foundation for Surgical Technology (FFST), established under the leadership of the Association of Surgical Technologists (AST), plays a critical role in fostering professional growth, education, and recognition within the field of surgical technology. Through scholarships, awards, and initiatives, the Foundation works to uphold the mission of AST by providing support to students, educators, medical mission volunteers, and military members in the surgical technology community.

The Foundation is guided by a dedicated leadership team committed to advancing its mission, including Chair Dustin Cain, CST, CRCST, CHL, FAST; Vice Chair Chris Blevins, BS, AAS-ST, CST, FAST; and Foundation members Lisa Day, MA, CST, CSFA, FAST, and Jaime Lopez, CST, CSFA, RN, FAST. Together, they steer the Foundation's direction, ensuring all initiatives align with AST's values and strategic objectives. Financially, as of the 2024 midyear report, the Foundation manages $103,684 in total liabilities and net assets, supported by a $20,000 annual AST donation, contributions from state assemblies primarily for student scholarships, fundraising at key conferences, and year-round membership donations—all of which are tax-deductible. These funds sustain scholarship programs, operational needs, and future fundraising efforts. Foundation members are responsible for key activities such as reviewing and scoring scholarship applications with fairness and adherence to deadlines, developing and updating application materials, and actively managing the Foundation's financial sustainability to ensure ongoing success.

The Foundation proudly offers a comprehensive range of awards and scholarship programs designed to recognize excellence and provide vital financial support. The Constellation Awards, presented annually at the Educators Conference, feature three categories—Rising Star, Shining Star, and Guiding Star—with each recipient receiving a $1,000 prize that includes registration for the next year's conference. Military scholarships, reviewed beginning February 1, provide $1,000 awards to assist military personnel attending their first AST conference. The Medical Mission Scholarships are available year-round, offering reimbursement for mission-related expenses not covered by AST, with a total of $8,300 awarded in 2024 through quarterly reviews. The largest annual initiative, student scholarships, accepts applications from December 1 to March 1, and in 2024, awarded $43,000 to 36 students from 170 applications, with awards presented around the time of the annual AST Surgical Technology Conference. Together, these programs underscore the Foundation's commitment to supporting education and professional growth within the community.

Looking ahead, the Foundation is focused on expanding its impact through strategic fundraising initiatives aimed at supporting continued education for surgical technologists. Key future programs include the CST to CSFA Scholarship, designed to help CSTs cover tuition costs as they advance to CSFA school, and a CST Higher Education Scholarship to assist CSTs pursuing advanced degrees. These initiatives will shape the Foundation's outreach, engagement, and financial strategies, ensuring sustained support for professional growth and education within the community.

The Foundation for Surgical Technology stands as a testament to the AST's commitment to supporting its members at all stages of their careers. Through scholarships, mission-based aid, and recognition of outstanding professionals, the Foundation ensures that excellence in surgical technology continues to thrive. With continued support from the AST community, its reach and impact will only grow in the years to come.



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Topics include Intrauterine Repair for Spina Bifida, Pelvic and Acetabular Surgery, Infertility, Drug Abuse During Pregnancy, ACL Surgery, Issues in Patient Care, Advances in Spine Surgery, Epithelial Ovarian Cancer, and Preventing Preterm Delivery. Any or all are free to watch and study.

Whenever you're ready, take the examination—there is absolutely no charge. If you pass, you will be offered the opportunity to purchase the accompanying CE credit and register it with AST at a very affordable price.

LOG ON TO THE AST CONTINUING EDUCATION RESOURCE CENTER TODAY AT: **www.ast.org**

AST News

AT A GLANCE

A HEART FOR THE MILITARY

In June, the AST Military Affairs Committee spent the week leading up to the 2025 AST Surgical Technology Conference honoring and connecting with military-affiliated surgical technologists. The week began with a presentation to the surgical technology staff at NAS Jacksonville Hospital—conducted for the first time inside one of the operating room suites—with special thanks to Robert Torres, CST, for his assistance.

The Committee then partnered with the Volunteer Services Organization at the Lake Nona Veteran's Hospital in Orlando to share coffee, pastries, and camaraderie, joined by AST President Joseph Charleman, DBA, CST, CSFA, FAST, AST Director Monica Thulon, CST, CSFA, FAST and Ron Shaffer, CST.

At the conference, the committee hosted the FSS/FSOHG Honor Guard for the Presentation of Colors and Flags during the Opening Ceremony, set up an Exhibit Hall table to connect with attendees, and awarded a $100 gift card to one recipient. A special reception, co-hosted by President Charleman, honored military members in attendance and featured an emotional reading of an original poem by Peter Beckett, CST, that moved many to tears.

We look forward to further honoring our military members during the month of November.

SAVE THE DATE! EDUCATORS CONFERENCE

AST EDUCATORS CONFERENCE

The 2026 Educators Conference is happening February 6–7, 2026, in Nashville, TN! Mark your calendars and get ready for two days of inspiration, collaboration, and professional growth. Stay tuned—more details and registration information will be coming soon!

SCHOLARSHIPS

EDUCATORS – APPLY FOR A CONSTELLATION AWARD!

The Constellation Awards presented by the Foundation for Surgical Technology recognizes the profession's hard-working surgical technology educators at three different career levels: early, mid-level and veteran.

Educators nurture our techs-to-be and mentor practitioners. It is a difficult step to move outside the OR and into the classroom. The Foundation hopes that these recognized professionals will share their successes, provide insights on avoiding pitfalls and offer encouragement to other CSTs who are considering making the leap to academia.

Educators can qualify in three categories. One recipient will be selected at each level.

- **RISING STARS** - Educators with 1-5 years of teaching experience
- **SHINING STARS** - Educators with 6-14 years of teaching experience
- **GUIDING STARS** - Educators with 15 or more years of teaching experience

Each award, valued at $1,000, will include registration for the AST Educators Conference in February and monetary support.

Applications are due December 1.

To view more details and to apply online, visit ffst.org – Constellation Awards.

APPLY FOR A MEDICAL MISSION SCHOLARSHIP

Have you recently served on a medical mission? If so, you may be eligible to apply for a medical mission scholarship.

Eligibility

To be eligible for a mission scholarship you must:

- Be an active AST member with currency.
- Complete and submit the Mission Medical Application and the Medical Mission Verification Form by December 31, of the year of your mission.
- Provide a description of your membership history—join date and any AST involvement.
- Upload official documentation of the mission program you have described.
- Upload official receipts documenting the costs incurred by the individual and all costs must be shown in dollars. All assistance is determined after the medical mission trip has occurred and the appropriate documentation has been provided.
- Upload two articles of recommendation including writing an article describing your experience with related photos to be published in The Surgical Technologist. This is required before you are reimbursed.

MILESTONES

Congratulations to the following state assemblies as they celebrate an anniversary this month! AST appreciates your hard work, dedication and all your years of service for making our state assemblies the backbone of this organization.

- Indiana – 25 years
- Kentucky – 21 years
- Louisiana – 24 years
- Massachusetts – 24 years
- Minnesota – 25 years
- New Jersey – 19 years
- Oregon – 25 years
- Texas – 25 years
- Utah – 19 years

Celebrating Our Work, Our Impact, Our Future

AMY WHITACRE, CST, FAST, AST STATE ASSEMBLY LEADERSHIP COMMITTEE

STATE ASSEMBLY

It starts with an early alarm and ends when the last suture is tied, and the last room is turned over. In between, we're there: gloved up, focused, and ready for anything. Surgical technologists are the quiet heartbeat of the operating room, and as another year comes to a close, it's worth reflecting on the impact we have made.

This career is not easy. It's a skilled, demanding, and highly detail-oriented profession. First in and last out, we check setups, anticipate the surgeon's needs, and make sure the patient is safe before, during, and after the initial incision. Such work merits more than a short holiday break; it deserves respect and recognition.

So, here is your reminder to appreciate yourself and those around you. Thank a coworker who always has your back. Reach out to your mentor and let them know their advice still sticks with you. And if you're feeling stretched thin, take a breath. You have done great work this year, don't forget all those lives you've touched.

Now is also a perfect time to give back to the profession. There are so many ways to do it: offer to precept a new tech, donate old textbooks, or volunteer in your community. Some surgical technologists even travel on medical missions, lending their skills to areas where surgical care is limited. However you choose to give back, it's a way to reconnect with why you started.

Want to go a step further? Volunteer with the Association of Surgical Technologists (AST). AST is our profession's voice, advocating for standards, providing education, and helping us with resources to grow. Attend a state assembly meeting, get involved in a committee, or simply come and network. You don't necessarily need the title "leader" in your job to make a difference; being present is what matters.

AST's motto is *Aeger Primo*,"The Patient First." Those words are at the center of everything we do. Every careful count, every sterile field, every moment of teamwork puts that promise into action. And when we encourage one another, stay focused, and continue to improve, we honor that motto.

So, as you wrap up this year, whether it's been filled with back-to-back cases or difficult milestones, know this: you have made a difference. You've worked hard, stayed sharp, cared deeply and that matters. We don't hear it nearly enough, so I am going to say it to you all THANK YOU for all that you do!

Here's to continued growth, more thanks, and more chances to give back next year. As surgical techs, we not only make surgery possible, but we also make it better. And that is something to be celebrated.

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Stulberg Leg Positioner

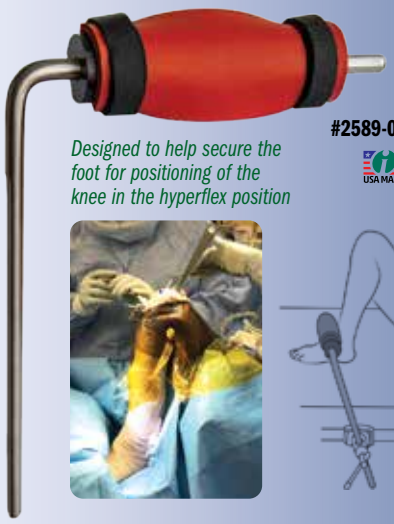
USA MADE

Designed by S. David Stulberg, MD

Provides stable positioning of the knee during surgery

Hyperflex Foot Positioner Assembly

Designed by Morteza Meftah, MD and Ira Kirschenbaum, MD



#2589-00

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Designed to help secure the foot for positioning of the knee in the hyperflex position

George Arthroscopic Knee Positioner

#2735

Provides lateral as well as superior support which allows valgus stress to open the medial compartment

Designed by Michael S. George, MD

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Designed by James McGrory, MD

A foot bolster designed for knee surgery that allows for quick and easy adjustment of the flexion angle as surgery progresses

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Also Available Individually

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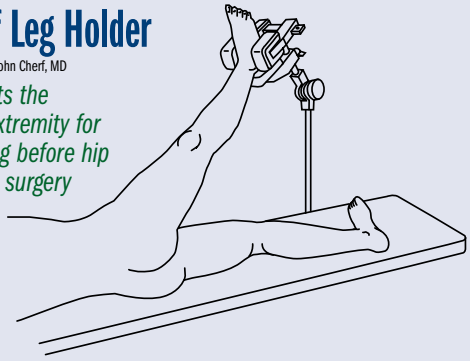

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Designed by S.E. Fromm, MD
Extra Small size designed by S.E. Fromm, MD & Kenneth Merriman, MD

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How to Properly Implement Policies and Procedures in Your State Assembly

JaLynda Buckingham, CST
BYLAWS, RESOLUTIONS AND PARLIAMENTARY PROCEDURES COMMITTEE

A well-written Policy and Procedure Manual ensures smooth leadership transitions, clarifies officer duties, and safeguards the integrity of the assembly. Proper implementation transforms bylaws into practical tools for effective governance.

Strong governance relies on clear rules and consistent practices. While national bylaws serve as the "constitution" of the Association of Surgical Technologists (AST), state assemblies cannot create their own bylaws. Instead, they develop policies and procedures that align with national bylaws and provide operational guidance.

Bylaws vs. Policies and Procedures

Bylaws at the national level serve as the foundational rules of the organization, amended only by AST's House of Delegates, and establish both organizational structure and member rights. Policies and procedures, on the other hand, are created at the state level to provide operational guidelines that explain how work is carried out. These may cover areas such as finances, elections, communication, and leadership roles. Put simply, bylaws set the structure, and policies and procedures put that structure into action.

Purpose of a Policy and Procedure Manual

A Policy and Procedure Manual functions as the organizational roadmap for the assembly. It defines officer and committee responsibilities, ensures consistency during leadership transitions, provides planning tools for meetings, conferences, and elections, and reinforces compliance with AST bylaws. By providing clear expectations and operational guidance, the manual safeguards the assembly's credibility while helping members understand their roles and responsibilities.

Key Contents of the Manual

For an assembly to function effectively, a manual must include detailed descriptions of leadership duties and committee responsibilities, eligibility criteria for elections, nomination and voting processes, and procedures for conducting business meetings, including quorum requirements and reporting. Financial guidance is also essential, covering reimbursement rules, budget responsibilities, and audit processes. Equally important are ethics and communication policies, which outline professional conduct, social media guidelines, and proper digital correspondence. Finally, membership guidance, including orientation for new members, master delegate files, and standing rules, ensures continuity and smooth operation regardless of who holds office.

Drafting and Adopting Policies

When drafting or updating policies, assemblies must ensure that all content aligns with AST Bylaws. Committees and leadership should be involved in the drafting process, and members should be given opportunities to review and provide input. Policies should then be formally approved through board or assembly votes, with all decisions properly documented. This transparent process builds trust and encourages active member involvement in governance.

Oversight and Accountability

Policies only serve their purpose when consistently enforced. Assemblies should assign oversight to a governance or policy committee and monitor compliance, particularly in ethical and financial practices. Establishing clear corrective procedures for violations is essential to maintaining integrity. Common pitfalls, such as outdated officer descriptions, vague reimbursement rules, or missing communication guidelines, can be prevented through consistent enforcement and regular monitoring.

Maintaining and Updating the Manual

Policies and procedures are living documents that require regular review. Best practices include conducting annual reviews to ensure accuracy, maintaining version control with each revision dated, providing digital access for all officers, and submitting updated manuals to AST's State Assembly Office for recordkeeping. This consistent review process keeps the manual relevant and ensures continuity across leadership changes.

Support and Resources

State assemblies are not alone in developing and maintaining effective policies and procedures. Resources such as AST Leadership Tools, sample templates, and guidance from Bylaws, Resolutions and Parliamentary Procedures Committee (BRPPC) and the State Assembly Leadership Committee (SALC) provide valuable support. Master membership and delegate files also assist in tracking eligibility and participation, helping assemblies maintain strong governance practices.

In Summary

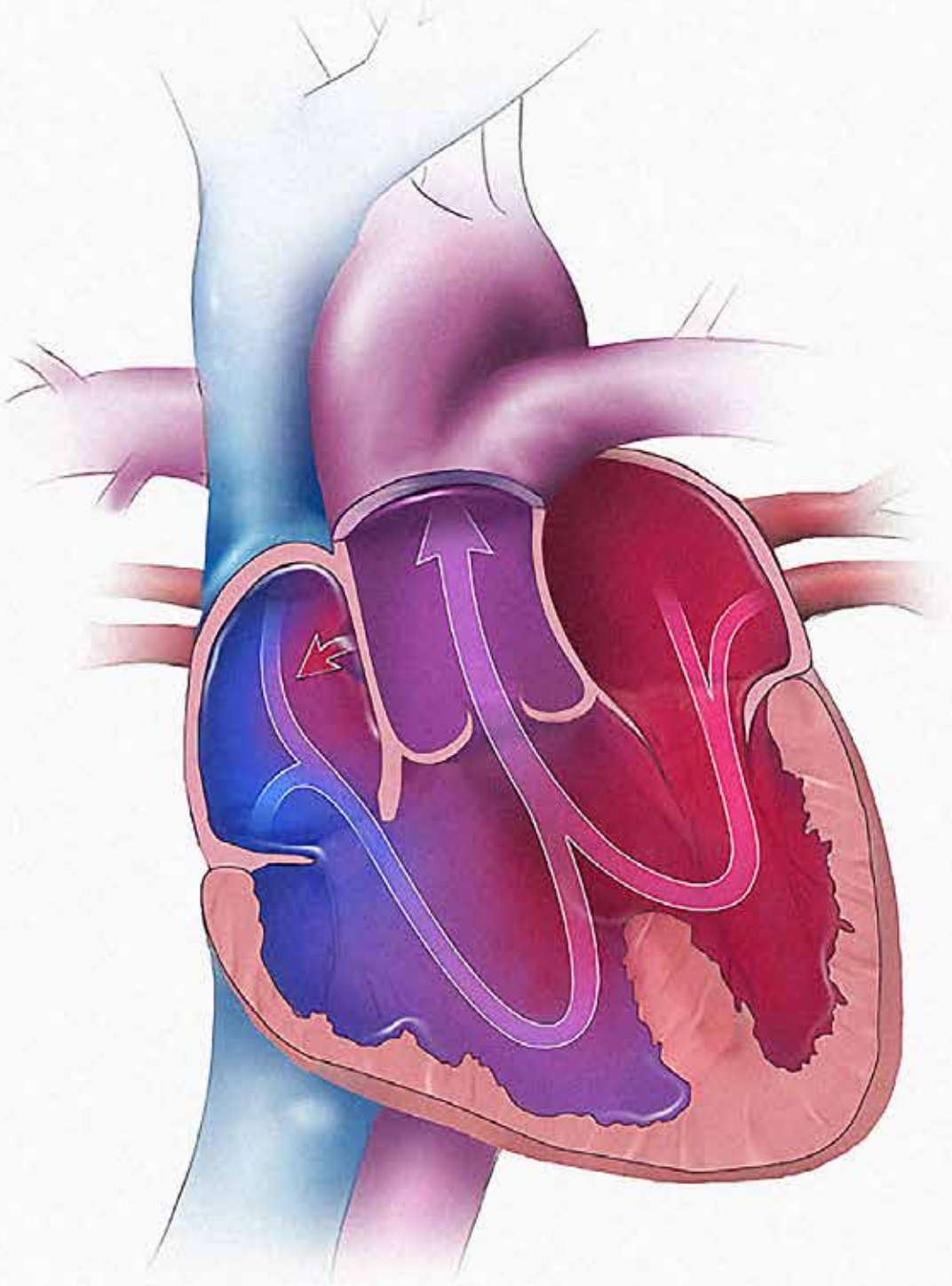
While state assemblies cannot create bylaws, they play a vital role in governance by developing and implementing policies and procedures that align with national standards. A strong manual ensures consistency, accountability, and integrity, guiding assemblies through leadership transitions, elections, and member engagement. By committing to clear drafting, transparent adoption, consistent enforcement, and regular review, assemblies bring national bylaws to life and maintain strong, ethical governance.

In short, bylaws set the structure, but policies and procedures make it work.

Learn more about the AST Bylaws

Learn more about the State Assembly Bylaws

Learn more about the AST Bylaws, Resolutions and Parliamentary Procedures Committee



Partial Heart Transplant Surgical Procedure

Part 1 of 2

Kevin B. Frey, CST

In April 2022, the world's first partial heart transplant surgical procedure was performed by pediatric surgeons at Duke University Hospital. This groundbreaking surgical procedure prevents the patient from having to undergo multiple cardiac procedures as they grow because the implanted living tissue grows with them. Ever since the procedure was performed, 30 surgeries have been performed worldwide.[1] This article provides a description of the surgical procedure and discussion of related issues.

ANATOMY OF SEMILUNAR HEART VALVES

The function of semilunar heart valves requires the synchronized activity of several anatomical structures (Figure 1). The leaflets consist of an extracellular matrix organized into three layers – fibrosa, ventricularis, spongiosa. The fibrosa is located on the distal aspect of the valve, consisting of type I and III collagen that is circumferential and provides stiffness to the valve.[2] The ventricularis consists of elastic fibers formed radially that provide for valve leaflet motion. The fibers travel from the valve hinge near the valve annulus to the coapting edge.[2] The spongiosa is the middle layer that consists of proteoglycans.[2] This layer provides integrity to the valve as well as enables tissue flexibility.

LEARNING OBJECTIVES

- Describe the anatomy of heart valves
- Discuss the pathological reason for why the procedure is performed
- Discuss the surgical options that have been available
- Explain the process that was completed in developing the PHT procedure

The leaflets attach to the arterial root near the annulus. The annulus consists of fibrous collagen that also provides integrity and stability to the valve. The semilunar heart valves are avascular and gain their nourishment from the blood flowing through the heart, whereas the leaflets of the atrioventricular valves contain capillaries.

The two cells of the valve leaflets are interstitial and endothelial. The interstitial cells are similar to fibroblasts and smooth muscle cells and are located throughout the valve leaflet tissue.[2] They produce the extracellular matrix. The endothelial cells are located on the entire surfaces of the valve and are positioned at a right angle to blood flow.[2] The interstitial and endothelial cells are important towards maintaining the physiology of the valves including growing as a child gets older and extracellular matrix turnover.[2]

Valves grow through annular dilation and leaflet elongation that must occur together. If the growth does not occur at the same time, valvular dysfunctions occur. For example, when annular dilation does not occur, but the leaflets continue to elongate it causes redundant coapting tissue that can either obstruct the outflow tract, causing stenosis, or prolapse, causing insufficiency.[2]

TRUNCUS ARTERIOSUS PATHOLOGY

To understand why a partial heart transplant is performed, truncus arteriosus pathology must first be discussed. When the heart of an infant is forming, there is a single blood vessel leading out of the heart called the truncus arteriosus. During development, the truncus arteriosus splits into two vessels – the aorta and the pulmonary artery. As a review, in a healthy heart, the pulmonary artery carries deoxygenated blood from the right ventricle to the lungs, while the pulmonary vein carries oxygenated blood from the lungs to the left atrium. The oxygenated blood is pumped through the mitral valve into the left ventricle where the blood is then pumped through the aortic valve into the aorta which carries the oxygenated blood to be circulated throughout the body (Figure 2).

Truncus arteriosus is a rare congenital, cyanotic heart defect where the truncus arteriosus vessel did not split into the aorta and pulmonary arteries and therefore, the single blood vessel emerges from the heart (Figure 3). The systemic venous blood travels to the right atrium and flows into the right ventricle. The pulmonary veins carry oxygenated venous blood into the left atrium and the blood flows into the left ventricle. The ventricular septal defect (VSD) allows deoxygenated and oxygenated blood to mix before it exits through the common truncal valve into the truncus arteriosus artery to be transported to the body.[3] The other complication is truncal valve regurgitation allowing blood to regurgitate into the heart.[4]

The mixing of deoxygenated and oxygenated blood and changes in the pulmonary vascular resistance (PVR) and pulmonary blood flow (PBF) cause the pathophysiological symptoms to begin once the infant is born. The PVR

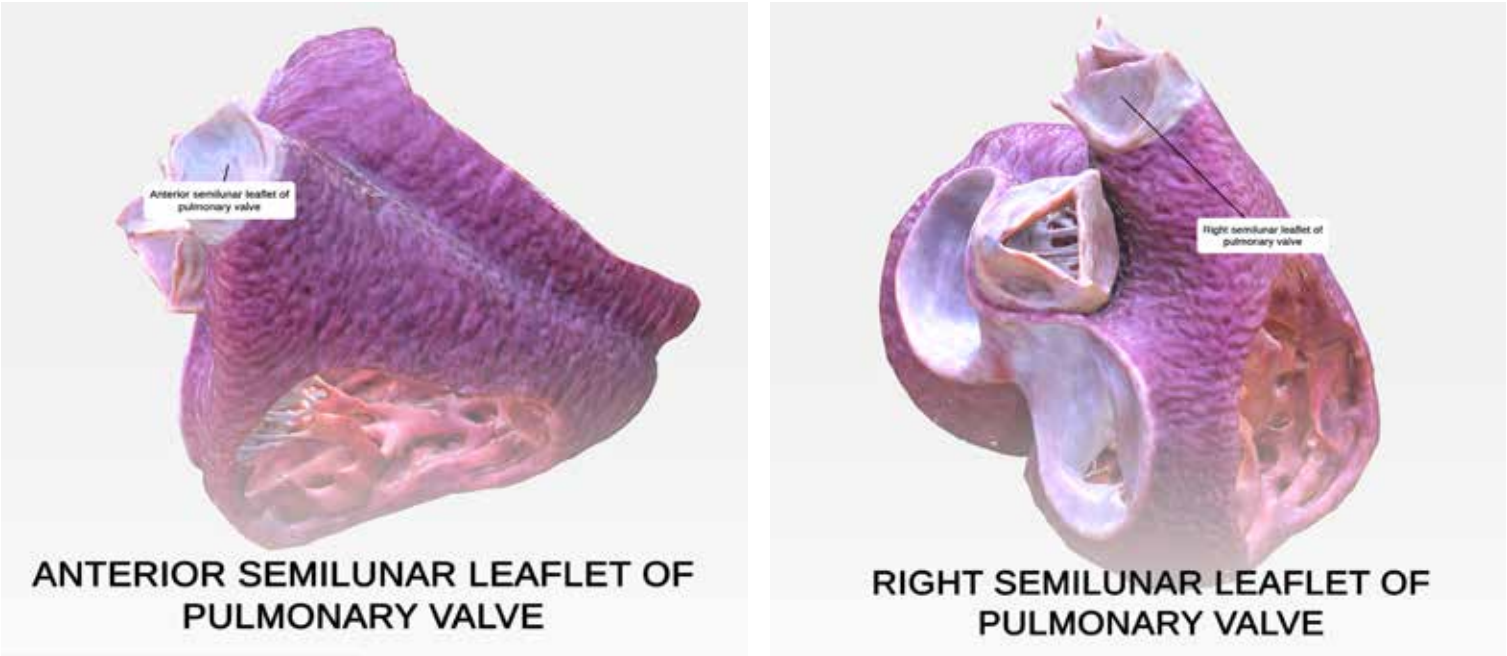


Figure 1. Semilunar Leaflets

is immediately abnormally high, pulmonary hypertension, during the first week of life.[4] The blood with mixed oxygen that enters the systemic circulation causes cyanosis, hence the term "blue baby syndrome" because of the blueish color of the infant's skin due to low blood oxygen level. Pulmonary over circulation leads to congestive heart failure as the PVR decreases and the PBF increases.[3] If left untreated, irreversible cardiac failure occurs.

Symptoms include rapid breathing, shortness of breath, sweating, pale skin that is cool to the touch, and rapid heart rate.[3] These are indications of the heart having to work harder to compensate for the mixed blood and the lack of oxygen reaching the vital organs. Echocardiography is used to diagnose truncus arteriosus, though cardiac catheterization and other advanced imaging techniques may be performed to provide additional diagnostic details.[3]

The cause of truncus arteriosus is unknown. However, genetics may play a role in its formation. Truncus arteriosus is associated with 22q11.2 microdeletion, referred to as DiGeorge syndrome, in 12% to 35% of patients.[3] Additionally, abnormalities in the cardiac neural crest cells are strongly associated with truncus arteriosus.[3] Truncus arteriosus occurs in approximately 7 per 100,000 live births or about 230 cases per year.[3,5] While the condition occurs in less than 1% of all congenital heart defects, it accounts for approximately 4% of all critical congenital heart defects.[3]

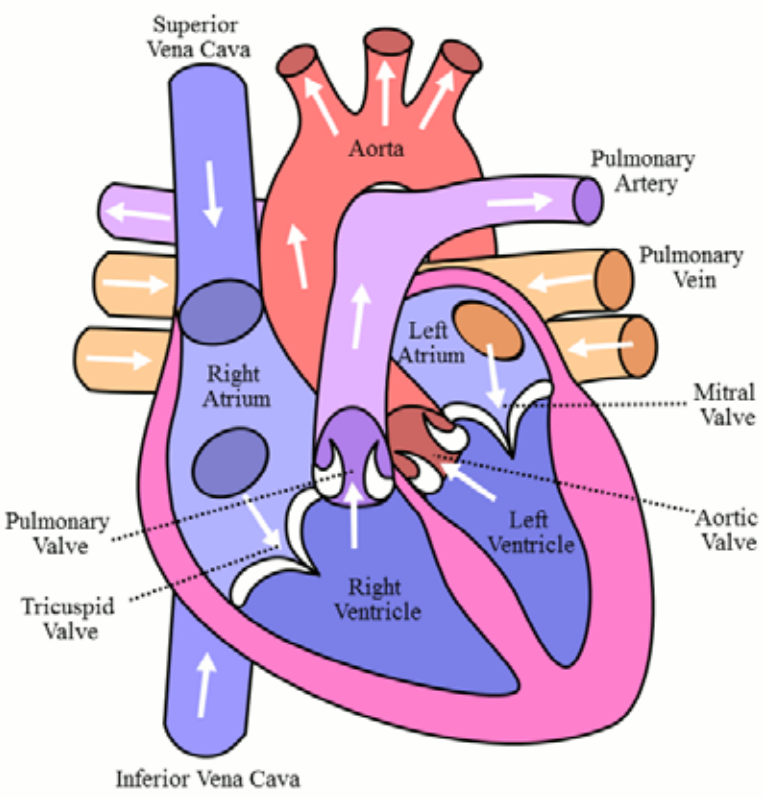


Figure 2. Cardiac Blood Circulation

Figure 1 cont.: Semilunar Leaflets

Truncus arteriosus is a rare congenital, cyanotic heart defect where the truncus arteriosus vessel did not split into the aorta and pulmonary arteries and therefore, the single blood vessel emerges from the heart (Figure 3).

DEFINITIONS

Cardiac neural crest cells: Neural crest cells are a specialized type of cell in embryos that originate from the neural tube during the early stages of development. The cells migrate and differentiate into a variety of specific cell types, thereby serving an important role in the development of various tissues and organs. Cardiac neural crest cells (cNCCs) are one type of neural crest cells that contribute to the formation of the heart and its structures. Abnormal development of cNCCs can cause congenital heart defects.

Coapting edge (of valve leaflets): Refers to the area where the valve leaflets contact each other and overlap during valve closure.

DiGeorge syndrome: Genetic condition caused by a deletion of genetic material on chromosome 22 that can affect the development of multiple body systems in the fetus, including causing congenital heart defects.

Lymphoproliferative disorders: Group of conditions characterized by the excessive production of lymphocytes. The disorders can be benign or cancerous affecting various organs such as the liver and spleen. The disorders can be caused by genetic factors, immunodeficiency disorders, and complications related to organ transplantation.

Orthotopic: Located in the normal, anatomical position. In relation to transplant surgery, the donor organ or tissue is placed in the same anatomical location where the original organ or tissue was located.

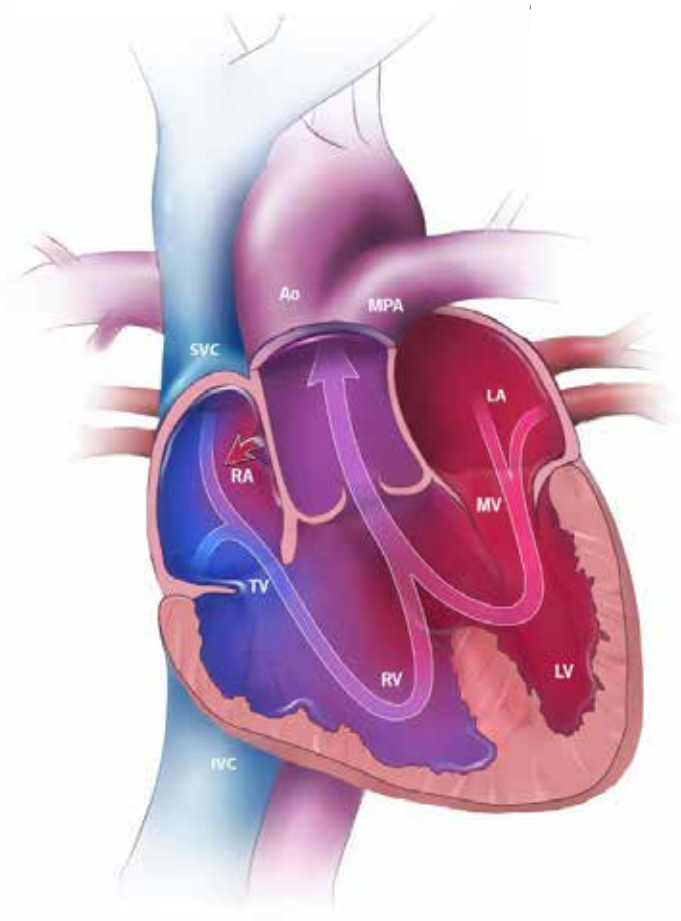
Proteoglycans: A class of complex molecules called glycoproteins that are particularly found in the extracellular matrix of connective tissues.

SURGICAL OPTIONS

Up to this point, the only option in treating irreparable heart valves in neonates has been with cadaveric heart valve homografts obtained from other newborns. Cryopreserved homografts keep the valve extracellular matrix that preserves the ability of the leaflets to ensure unidirectional blood flow.[6] However, the viability of the majority of the valve cells is not preserved, which prevents them from growing or self-repairing.[6] Therefore, the homograft valves eventually stenose as the child grows, placing the child in the position of having to undergo multiple surgical procedures with exposure to all the risks each time to replace the valve until an adult-sized valve can be implanted.

An analysis of the Society of Thoracic Surgeons Congenital

Figure 3. Truncus Arteriosus Pathology



RA: Right Atrium
RV: Right Ventricle
LA: Left Atrium
LV: Left Ventricle
SVC: Superior Vena Cava
IVC: Inferior Vena Cava
MPA: Main Pulmonary Artery
Ao: Aorta
TV: Tricuspid Valve
MV: Mitral Valve

Heart Surgery Database showed a 40% early mortality in neonates and infants that received an aortic valve homograft.[6] Additionally, Dr. Rajab completed a meta-analysis that showed truncal valve replacement has an early mortality of 49% and 15% late mortality annually.[6]

One popular method in young adults is the use of mechanical valves. However, the smallest commercially available valve is 16 mm making it impossible to use in infants or small children because it is too large.[7]

As discussed in the July and August editions of *The Surgical Technologist*, the Ross procedure involves replacing a diseased aortic valve with the patient's own healthy pulmonary valve (PV). The native PV is replaced with a homograft PV. The Ross procedure has the following shortcomings.

- Because the pulmonary valve is placed under systemic pressure, it can eventually result in autograft dilation and regurgitation in some patients.[6]
- The procedure can only be performed if the native pulmonary valve is functioning normally. Children with truncus arteriosus or aortic and pulmonary valve disease are excluded.
- The pulmonary valve is replaced with a homograft. As previously indicated, the homograft does not grow with the child's heart subjecting the patient to multiple surgeries until receiving an adult-sized valve.

CONTINUING SHORTAGE OF PEDIATRIC DONOR HEARTS

Orthotopic heart transplant (OHT) is an option for treating congenital heart diseases. Approximately 600 pediatric OHTs are performed across the world, with the majority occurring in the U.S.[7] The low number of OHTs performed as compared to the number of pediatric patients on the waitlist is due to the shortage of pediatric and infant heart donors. In 2021, 1,087 pediatric patients were on the waitlist in the U.S. with 30% less than one year of age.[7]

The development of and successful use of immunosuppression has been critical towards the success of transplant surgery, including OHT. However, immunosuppression is associated with significant morbidity and mortality in pediatric OHT patients because of its connection to causing postoperative lymphoproliferative disorders and malignant lymphoma.[6,7]

Lastly, a high discard rate of pediatric hearts for transplant has contributed to the continuing shortage of donor hearts. A 2020 consensus statement published by the International Society for Heart and Lung Transplantation showed results from a survey sent to organ procurement organizations that reported a discard rate of pediatric donor hearts to be 57%.[7] However, there have been efforts towards addressing the shortage. In 2018, the United Network for Organ Sharing implemented a new allocation policy to improve the use of high-risk donor grafts and organ access for critically ill patients.[7] Additionally, comprehensive research studies showing the use of certain types of high-risk donor hearts is feasible. For example, donor hearts from influenza A-positive donors incompletely treated with oseltamivir (brand name Tamiflu®) have been transplanted into pediatric patients with favorable outcomes when the recipient has undergone postoperative influenza treatment.[7]

DEVELOPMENT OF THE PHT CONCEPT

T. Konrad Rajab, MD, pediatric cardiac surgeon at Medical University of South Carolina (MUSC) Shawn Jenkins Children's Hospital and Assistant Professor, Department of Surgery, MUSC, was determined to find a way to improve the surgical treatment of infants and children with valve defects. He developed the hypothesis based on clinical evidence that if an OHT grows with the patient as well as the pulmonary valve grows after a Ross procedure, this could be applied to transplanting only the part of the heart containing the valves, while preserving the native ventricles, thus preserving the viability of the donor cells like in OHT.[6,8] Dr. Rajab named the concept "partial heart transplant" (PHT).[6]

Reactions to the hypothesis were not initially positive. Dr. Rajab proceeded with establishing experimental evidence to support the hypothesis before being able to get approval for clinical trials. He obtained the funding and put together a team of experts in echocardiography and pediatric clinical trial design, as well as animal experts and an academic perfusion team to perform experimental open-heart surgery replacing the pulmonary valve with PHT in piglets.[6,8] Over a 60-day period, echocardiograms showed that the heart valve in three piglets grew as the animals doubled in size.[8] The results were therefore definitive in proving growth of the valve in immunosuppressed piglets. This cleared the way for obtaining institutional review board approval to move forward with the first human clinical trial.

FIRST PHT

After sharing the data obtained from the experiments on piglets with several colleagues, Joseph Turek, MD, PhD, Chief of Pediatric Cardiac Surgery at Duke University Hospital identified an 18-day old, five-pound infant diagnosed with persistent truncus arteriosus and severe truncal valve dysfunction who was not a candidate for OHT because of an anticipated poor prognosis.[6]

During pregnancy, Nick and Taylor Monroe learned Owen had truncus arteriosus during an ultrasound examination at his 20th week of development. Typically, the surgery to treat truncus arteriosus involves needing to replace only the pulmonary valve and the single valve the infant has serves as the aortic valve. However, shortly after birth the truncal valve dysfunction was discovered.[9]

Dr. Turek told the parents that their son had only a 50% chance of survival if frozen heart valves harvested from a cadaver were used. Additionally, Owen was already in heart failure and ECMO could not be used because the damaged heart would not have been able to function. Dr. Turek offered the parents the option of Owen being the first patient in the world to undergo PHT.

Obviously, not ever having performed the procedure on a human infant, the two surgical teams used 3D-printed heart models and piglet heart specimens, both without valve defects and with the specific defects of Owen's heart, to practice various approaches to the procedure.[6,8]

On the morning of April 22, 2022, the news was given to the parents that a matching heart had been located and the blood vessels and heart valves were appropriate for transplant. The donor was a neonate with hypoxic ischemic brain injury, but a normal heart. Dr. Rajab's team procured the heart that was transported to Duke Children's Hospital.[6,8] The surgery began at 3:00 p.m., lasting eight hours. His recovery went well, being able to leave with his parents seven weeks postoperatively.[9] During checkups, it showed that he attained all the normal infant developmental targets as well as his heart functioning normally and growing with him with no heart valves leaking.[9] As a result, Owen avoided the necessity of multiple cardiovascular surgeries and less immunosuppressive drug therapy as compared to an OHT patient.

Part 2 will be published in the November issue of The Surgical Technologist.

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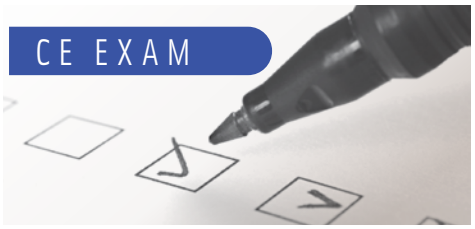

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Partial Heart Transplant Surgical Procedure, Part 1

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1. **Which of the following is the middle layer of the semilunar heart valves?**
a. Ventricularis
b. Interstitial
c. Spongiosa
d. Fibrosa

2. **How do the leaflets of atrioventricular valves obtain their blood supply?**
a. Arterioles
b. Capillaries
c. Coronary arteries
d. Cardiac blood flow

3. **Which of the following permits deoxygenated and oxygenated blood to mix?**
a. Atrial septal defect
b. Valve stenosis
c. Pulmonary blood flow
d. Ventricular septal defect

4. **What is the most common imaging technique used to diagnose truncus arteriosus?**
a. Echocardiography
b. Angiography
c. Plethysmography
d. Computed axial tomography

5. **Which of the following syndromes is associated with the formation of truncus arteriosus?**
a. Marfan
b. Down
c. Turner
d. DiGeorge

6. **What is the smallest commercially available mechanical valve in millimeters?**
a. 14
b. 16
c. 18
d. 20

7. **During normal development the truncus arteriosus divides into the:**
a. aorta and pulmonary arteries.
b. right and left coronary arteries.
c. right and left ventricles.
d. aortic and pulmonic valves.

8. **What is the estimated discard rate of pediatric donor hearts?**
a. 51%
b. 54%
c. 57%
d. 60%

9. **Which of the following is immunosuppression associated with causing?**
a. Cancer
b. Thrombocytosis
c. Chronic constipation
d. Erythrocytosis

10. **What percentage chance did Owen have for survival if cryopreserved heart valves were implanted?**
a. 45%
b. 50%
c. 55%
d. 60%

PARTIAL HEART TRANSPLANT SURGICAL PROCEDURE, PART 1
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Meet Your SALC Representatives

The State Assembly Leadership Committee (SALC) is a standing committee of the Association of Surgical Technologists. The committee members shall be appointed by the AST President with approval from the Board of Directors for a term of two years with the possibility of reappointment of a second and third term . The committee members are selected by evaluation of their leadership skills, expertise and talent within the state assembly arena.

THE MISSION STATEMENT OF THE STATE ASSEMBLY LEADERSHIP COMMITTEE IS:
"To encourage and oversee growth and leadership of the State Assemblies of AST through education, membership and guidance."

SOME OF THE RESPONSIBILITIES OF THE COMMITTEE MEMBERS INCLUDE:

- State assemblies
- Exchange professional knowledge through networking to stimulate continued interest within the state assemblies
- Recruit qualified candidates to run for elected positions in their states
- To represent each state with accuracy, professionalism and confidentiality
- Follow strict adherence to all AST State Assembly Bylaws and procedures
- Maintain open communication with AST Board of Directors and the AST staff

The SALC consists of nine members who represent individual states.

The State Assembly Leadership Committee is currently composed of:

Marsha Lyles, CST, CSFA, FAST, CHAIR
mnmcst@yahoo.com
Represents Alaska, California, Hawaii, Oregon, Washington

Marsha is serving her fifth year, third term on the State Assembly Leadership Committee and was recently reappointed as the Chair for the State Assembly Leadership Committee. She began her career in the U.S. Navy in 1991, directly upon graduating from high school and served 10 years on active duty, being honorably discharged in November 2000. She is a Disabled American Veteran and a huge supporter of that organization. She started her civilian career at St. Vincent's Healthcare in Billings, Montana. After 12 years in Billings, she began work at Logan Health, in the northwest corner of the state, in Kalispell, Montana. Marsha has been employed at Logan Health for over 13 years. She serves as a preceptor for both first assistants and surgical tech-

nologists at Logan Health. She is the Surgical Services Lead for surgical oncology, trauma, general, cardiac, vascular, and thoracic services as well as robotics in those services. Specializing with several decades of experience in surgical oncology, cardiac, trauma, general, thoracic, vascular and robotic surgery in both the CST and CSFA roles.

Marsha has served on the Board of Directors for the Montana State Assembly, noting that her passion for the future of Montana and the profession is at the forefront of her service. She has sat numerous terms as director, treasurer and vice president. She will be terming off this year as the President of the Montana State Assembly. Marsha attended her first National Conference in 1997 while in the Navy and has attended seven since then. As one of the SALC representatives and the Committee Chair, Marsha works alongside the state assemblies to help keep them active and keep each student, practitioner, OR and facility educated and knowledgeable about the need for continuing education, certification, and involvement in this profession.

Marsha and Mike, her husband of 33 years, enjoy their free time at their home on 15 forested acres in northwest Montana. They are the proud parents of their adult children, Michael 32, who is a Detention Officer with Flathead County Sheriff Department, and Jessica 28, who is a Trooper with the Montana Highway Patrol. Marsha enjoys fishing in the many lakes, rivers and streams Montana offers as well as hunting, gardening, canning and food preservation.

Raetta Coleman, BAS, CST, FAST
rscoleman35@aol.com
Represents Alabama, Florida, Georgia, Louisiana, Texas

Raetta is honored to serve on the State Assembly Leadership Committee. She celebrates 30 years as a Certified Surgical Technologist. She graduated from Florence-Darlington Technical College in Florence, South Carolina, in 1995 and began working for McLeod Regional Medical Center. In 2003, she began working for McLeod Dillon in Dillon, South Carolina. In 2010, she began working at Robeson Community College in Lumberton, North Carolina, as a clinical coordinator and shortly thereafter became the program director. She has been in the role for 11 years. Her passion is surgical technology and teaching what she loves.

Raetta has served on the South Carolina State Assembly Board since 2011. She has held the positions of vice president and president and is currently serving as treasurer. She has been a member of AST for many years and was awarded the Fellow of the Association of Surgical Technologists designation in 2016. She also completed a Bachelor of Applied Science in Surgical Technology from Siena Heights University.

When she isn't scrubbing or teaching, she spends time with her husband, three boys, and special friends. Traveling, shooting sports, and boating are just a few of her hobbies. Raetta enjoys anything that includes her family. She is excited to serve on the State Assembly Leadership Committee.

Donta Davis, CST, FAST, CRCST
ddonta40@yahoo.com
Represents Colorado/Wyoming, Indiana, Nebraska, New Mexico, Ohio, Oklahoma

Donta Davis has been a member of AST since 2011 and retains her CST and CRCST credentials. She has been a surgical technologist for 15 years. She currently works as a clinical coordinator and lab instructor at Angelina College in Lufkin, Texas. Donta was a 2009 graduate of the first surgical technology class at Angelina College and received her associate degree from Trinity Valley Community College in Athens, Texas. She is currently pursuing her bachelor's degree in surgical science. Donta received her FAST designation at the AST National Conference in May 2024.

Donta served as a member of the Texas State Assembly Board of Directors (2019 – 2023) and currently volunteers and serves on various committees within the Texas State Assembly, including the Education and Professional Standards Committee, Teller's Committee, Policies Committee, Scholarship Committee,

and Workshop Committee, also having the privilege of setting up, organizing, and managing the first-ever Lufkin workshop. She also volunteers and serves her community whenever she can. She serves on the Advisory Board at one of her local high schools and on the Curriculum Committee at Angelina College, Lufkin, TX.

Donta has participated in various activities on the national level, which include presenting at the AST Educators Conference in 2020. She represented the state of Texas as an alternate delegate at the AST National Conference in May 2021 and was elected as a delegate at the AST National Conference in May 2023 and May 2024. Donta is passionate about volunteering and speaking to youth in her community about the surgical technology profession, whether it is at career fairs or college tours. She is pleased to serve as the new SALC representative.

Allison Lacey, CST, FAST
sunrise267@yahoo.com
Represents Idaho, Massachusetts, New Hampshire/Vermont, Rhode Island, West Virginia

Allison has been an AST member for 19 years. She is a graduate of the 2006 Maine Medical Center School of Surgical Technology and obtained her associates of applied science in surgical technology from Southern Maine Community College. Prior to moving to Maine, she grew up in Vermont, where she still visits family as much as possible.

She works as a Certified Surgical Technologist in the operating room at Northern Light Mercy in Portland, Maine. Allison is in her final year on the AST State Assembly Leadership Committee and has served on the Maine State Assembly in the past as president, secretary, and director positions. She was honored to receive the FAST designation in 2019. In her free time, Allison enjoys searching for sea glass and sand dollars on Maine beaches, jewelry making, playing games, spending time with family, fishing with her husband, floating in inner tubes in the summer, and skiing in the winter.

Lori Newman, CST, FAST
lori.newman72@gmail.com
Represents Arizona, New Jersey, North Dakota, South Dakota, Utah, Wisconsin

Lori has been a surgical technologist for 33 years, graduating from St. Cloud Technical College in St. Cloud, Minnesota. After graduation, she worked as a CST in the Minneapolis area before returning to the St. Cloud area where she worked as a CST at the St. Cloud Hospital. While working as a CST, Lori realized that she enjoyed the teaching/precepting role and decided to pursue a degree in education, graduating with an elementary education degree and later her master's degree in curriculum and instruction. In 2006, she began her career as a surgical technology instructor and program director with Rasmussen University and in 2021, she joined St. Cloud Technical & Community College as a professor and its surgical technology program director.

Lori has served on the Minnesota State Assembly board since 2014. She has held the positions of president, vice president, secretary, director, and state delegate. Lori received the FAST in 2021. Lori feels that instilling a sense of commitment and pride in her students and other CSTs is the foundation of growing as professionals. Writes Lori, "We have an important, amazing role and patients put their trust in us. We need to live up to it!" As a SALC member, Lori hopes to be able to guide and support other state assemblies the way that the SALC has supported her state board. Lori enjoys adventures with her fiancé, David, and tries to be a fun mom to Carter (20) and Madelyn (18) but is sometimes incredibly embarrassing.

Olalekan Olakanmi, CST, FAST
leyit2001@yahoo.com
Represents Kansas, Mississippi, South Carolina, Tennessee, Virginia

Olalekan has been a CST and a member of AST since 2007. He graduated from Brooklyn Community College with an associate degree in surgical technology and a Bachelor of Science in health services administration at New York City College of Technol-

ogy. Because of his passion for education and patient care, he pursued his MBA (Health Care Management) at St. Joseph's College, Brooklyn, New York. While in New York, he served as a BOD and continues to serve as BOD, 2nd Term, currently on the Texas BOD. He enjoys being at conferences and served as a delegate for both the New York and Texas State Assemblies multiple times. He received the FAST award at the 2024 AST Surgical Technology Conference in Denver and is currently appointed as State Assembly Leadership Committee representative, overseeing five states.

He enjoyed teaching and imparting knowledge and has helped many to become surgical technologists and members of AST. He was a clinical instructor at Sanford Brown Institute, New York, and later at Swedish Institute Manhattan before moving to Houston, Texas. While in Houston, he worked at HCA Houston Healthcare Medical Center, Park Plaza, and later became Program Director Surgical Services at Fortis Institute and Fortis College. He worked at MD Anderson as a contractor and used the golden opportunity to elevate the profession of surgical technology and AST. He had the privilege of organizing an AST Houston workshop in 2023 with professors from MD Anderson and is currently working on the 2025 conference.

He enjoys being with his girls, traveling, and cruising. He loves his African dishes, especially Amala with ewedu and jollof rice. He is pleased to accept the privilege of working with the other SALC members and looks forward to supporting the assigned state assemblies.

Kristen Urbanek, CST, FAST
rdsox805@yahoo.com

Represents Connecticut, Illinois, Maine, Nevada, New York, North Carolina

Kristen has been working as a surgical technologist since 2003 after graduating from Bunker Hill Community College. She started working at Massachusetts General Hospital after graduation and still works at MGH on the night trauma team. After a chance meeting in 2012 with her former clinical instructor, Kristen joined the Bunker Hill Community College surgical technology program as a lab instructor and clinical instructor. This summer, she accepted a full-time assistant professor position with the college.

After much encouragement from her program director at Bunker Hill, Kristen ran for the position of director for the Massachusetts Assembly in 2016. She also held the position of vice president for two terms and is the current president of the Massachusetts Assembly. In 2022, Kristen was awarded the FAST designation. She has attended AST's National Surgical Technology Conference and Educator Conference over the last several years. She enjoys time at conference, meeting and networking with CSTs from around the country and learning about new techniques and procedures.

When she isn't scrubbing and teaching, Kristen enjoys traveling, Aruba and Myrtle Beach, being her favorites. She also enjoys attending concerts and sporting events.

This is Kristen's first term with the State Assembly Leadership Committee. She is honored that she has been appointed to this committee and is eager and excited to get to work.

Amy Whitacre, CST, FAST
amywhitacre88@yahoo.com

Represents Maryland/Delaware, Michigan, Minnesota, Montana, Pennsylvania

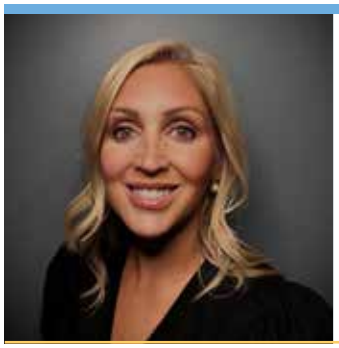
Amy has been a member of AST since 2018 and a surgical technologist for eight years. She received her associate's degree from Miller-Motte Technical College and her bachelor's degree in psychology from Southern New Hampshire University. She will complete her master's degree in education from Liberty University in December 2025. Amy received her FAST designation in 2024.

She currently works at Reynolds Community College, where she has been a lab and clinical instructor for the last year. She will be making the transition to full-time faculty and is looking forward to her new role. She really enjoys teaching, and the best feeling is when the students have that "A-HA moment". She also works PRN at Southside Regional Medical Center in Petersburg, Virginia.

Amy has served for the last five years on the Virginia State Assembly, holding the roles of director and treasurer, and is currently in her second term as vice president. She has served as a delegate at the AST National Con-

ference four times and as an alternate once. Amy is currently starting her second term on the State Assembly Leadership Committee, where she enjoys helping other state assemblies with their membership growth and leadership development.

Amy lives with her husband and six hound dogs in Amherst, Virginia, but spent most of her life in Hanford, California. Amy also spent eight years serving in the US Army as a 91R, which is the Army equivalent of an LPN/LVN. Amy states, "I have worked in the medical field in some capacity for the last 30 plus years, and I love it! I can honestly say, however, that being a CST has been the most fun so far!" In her (not so) spare time, she enjoys "murder tv", podcasts, reading, and spending time with her grandbabies (one girl and five boys… so far).



Ellen Wood, CST, FAST
ellennwood@gmail.com
Represents Arkansas, Iowa, Kentucky, Missouri

She has dedicated 17 years to the field of surgical technology, serving as a surgical technologist at The Eye Surgery Center in Oak Ridge, Tennessee. She views her profession as a true calling, driven by a passion for patient care and surgical excellence. Throughout her career, she has been actively involved with the Tennessee Association of Surgical Technologists (TNAST), taking on various leadership roles. Currently, she proudly serves as the Vice President of TNAST, contributing to the advancement of the profession and supporting her fellow technologists.

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FOUNDATION *for* SURGICAL TECHNOLOGY

2025 Scholarship Recipients

The Foundation for Surgical Technology funds various awards during the year, but it is best known for the academic scholarships that assist students entering the field. This year we awarded $49,000 in student scholarships.

KATHLEEN MURRAY, CST
IVY TECH COMMUNITY COLLEGE
VALPARAISO, IN

$1,500

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From a young age, I have been fascinated by science. I remember being in high school and taking a science class as an elective. That's how much love I had for science. It was not until recently that I was told about the surgical technology program. I became intrigued. I did a little research and knew this was my calling. Surgical techs play a critical role in the operating room, assisting the surgeons, and ensuring the safety of the patients. This combination led me to pursue this career.

I thrive when working as a team. I didn't realize until I started my clinical rotations, how many different fields and departments work together just to complete a single patient's surgery. It is impressive and I am honored to be a part of that team.

I hope to specialize in plastic surgery. I have a love for art, and I believe this specialty blends art and science in a way that few other specialties do. While many surgical specialties focus solely on function, plastic surgery restores and/or enhances form. This helps patients not only heal physically but emotionally, as well. I wouldn't be just assisting with surgery, but I'd be helping improve someone's quality of life, someone's confidence, and maybe even someone's dream. One of my passions is helping people in any way that I can, so this specialty brings me the greatest satisfaction.

I have a deep willingness to learn, and I am committed to continuous growth. I view every case as an opportunity to improve. I want to master this profession. I'm dedicated to becoming the most reliable and prepared surgical tech I can be. I will welcome all feedback from the surgeons, nurses, and fellow surgical technologists. This is how I will learn and grow in this profession. I can't wait to get started.

JENNA SMITH, CST
MOUNT ALOYSIUS COLLEGE
DUNCANSVILLE, PA

$2,000

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Ever since I was little, I knew that I wanted to be in the medical field, but I struggled with where in the field I should go. I originally wanted to become a veterinarian, but I realized that I loved helping those around me and that I wanted to make a difference in people's lives. It wasn't until I did a project where I researched several careers during my senior year that I discovered surgical technology. As soon as I learned about the career, I was immediately drawn to what they accomplish to help others. Because of this interest I decided to do a job shadow, which furthered my desire to pursue surgical technology. One of the main things that stuck out to me about surgical technologists is that they will do anything to ensure that the patient is receiving proper care during their surgical procedure. My favorite part about my job is being able to help people, and learning the procedures on a deeper level, especially when it comes to participating in neurosurgery and orthopedic surgery. I have been able to develop many professional goals, including always bringing my best to the operat-

ing room every day, being as efficient as possible while maintaining sterility, anticipating what the doctor needs in a quick manner, and always putting the patient first. I aspire to work on a neurosurgery team because I love being involved during the entire procedure, handling the variety of hardware, and I have the desire to help patients improve their mobility. With these long-term goals in mind, I plan to contribute my time by dedicating myself to continuously improving my skills. I also want to contribute my time by attending state assembly meetings, and even go on medical missions trips that AST is involved in.

JASMINE MOLINA
THE COLLEGE OF HEALTH CARE PROFESSIONS
DALLAS, TX

$1,000

SPONSORED BY TEXAS STATE ASSEMBLY SCHOLARSHIP

I have chosen surgical technology as my career because I have a strong desire to help change and save lives by ensuring surgeries are safe and successful as possible. As a current surgical technology student, my main goal is to become certified. I want to gain experience in different types of surgeries to expand my skills. In the future, I hope to specialize in a specific area like neurosurgery. I also want to be someone the surgical team can rely on for support and efficiency. One day, I would like to mentor new students and help them grow in this field. I hope to continue learning and improving throughout my career. My biggest aspiration is to make a difference in patients' lives by being a valuable part of their surgical care. What I think I'll enjoy most about this career is knowing that I will help save lives. I will enjoy being part of a skilled surgical team that works closely together while also keeping the operating room safe, sterile, and organized. Every surgery is different, and I am excited to keep learning with each one. Most of all, I will enjoy knowing that my work truly makes a difference. In conclusion, becoming a surgical technologist is more than just a career choice for me, it's a chance to be part of something meaningful. I'm excited for the learning, as well as the teamwork that comes with working in surgery. I know this job requires focus, dedication, and compassion, and I'm ready to give my absolute best every day. I look forward to growing in this field and using my skills to help others. With each procedure, I'll know I played an important role. This career gives me purpose, and I'm truly blessed and grateful for the opportunity to follow this path and make a difference.

MCKENNA GEIGER
BISMARCK STATE COLLEGE
MANDAN, ND

$2,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

Hello, my name is McKenna Geiger. I am from North Dakota and have lived here my whole life. My grandma is the one who inspired me to go into the medical field. She would bring me to all her medical appointments which made me interested in healthcare at a young age. Sadly, she is no longer with us, but she always inspired me to work hard and achieve my goals.

I am beyond grateful to be a chosen applicant for one of the Foundation scholarships. I chose surgical technology for my career because I love getting to see all types of procedures, helping people, and just being in the medical field. Surgical technology was not my first choice as a career. I wasn't happy with what I was previously studying in college, and I happened to stumble upon surgical technology when trying to find other options. It is amazing how a person feels when they are finally learning about something that excites them and that is definitely how I feel about surgical technology.

I am very pleased that I found surg tech because it really fits what I wanted to do in healthcare and I can see myself happy in this career for a long time. I have been working in the medical field since 2019 and have experience with loads of different people. Of course, not all the patients that I have interacted with have been happy, but that's okay, you just have to try and make the best of it. I have worked in hospitals, clinics, and nursing homes. All

of which have taught me how to handle different situations and see some amazing, sad, and happy moments.

For the future, I hope that I will have experience with many types of surgeries, learn new techniques, and work with some amazing people. I personally am very excited to see a Da Vinci robot surgery. I think that the Da Vinci systems are amazing, especially since they keep advancing. As of now, I have not had any real-world experiences in surg tech since I will only be starting my clinical rotation in January of 2026. I can't wait to be in real surgeries and test my knowledge. I can say I am eager to learn more about surgical technology. As of right now what I think will be the best part of my job is getting to see the real art of surgery.

DEBORAH ZELLEKE-YEARWOOD, CST

LAUREL RIDGE COMMUNITY COLLEGE/
LORD FAIRFAX COMMUNITY COLLEGE
WOODBRIDGE, VA

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

Choosing surgical technology as my career was not just a decision, it was a calling shaped by personal experience, deep compassion, and a vision for the future. When my third child was born prematurely, I was overwhelmed by fear and uncertainty. But I also witnessed firsthand the power of skillful, compassionate care. The surgical and obstetric teams who cared for us not only ensured our safety but left an imprint on my heart. Their dedication inspired me to pursue a path where I could one day provide the same support and expertise to others, particularly women during some of the most vulnerable and life-changing moments of their lives.

As a Certified Surgical Technologist, I recently secured my dream job working in Labor and Delivery, where I'm honored to be part of the operating room team during cesarean sections and obstetric procedures. Women's health has always been at the center of my aspirations, and now I'm living that dream, supporting mothers through childbirth, assisting surgeons, and helping bring new life safely into the world. It's incredibly rewarding to be in a role that demands both technical precision and emotional strength.

What I enjoy most about working in surgery is the sense of purpose and the teamwork it requires. Every day, I enter a fast-paced environment where lives are changed. I love the preparation, the focus on sterile technique, the trust placed in me by the surgical team, and the unspoken communication that happens in a well-coordinated OR. It's a privilege to contribute to something greater than myself.

Looking ahead, I plan to further my education and become a surgical first assistant. I want to expand my scope, take on more responsibility in the operating room, and continue focusing on women's health. I am determined to be a steady, skilled presence in the OR—just like the team that was there for me and my son. This scholarship will help support that vision and allow me to continue growing in the field that has truly become my passion.

SARAH CARLSON
RASMUSSEN UNIVERSITY
LAND O'LAKES, FL

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

During high school, I was involved in a program that introduced me to the operating room and every other part of the hospital. During those years, I was fortunate enough to shadow hospital staff and observe firsthand the incredible work behind the scenes. When I shadowed the surgical team, something inside me clicked. I was drawn to the fast-paced environment, the level of focus and precision, and the teamwork that held everything together. Watching the surgical team work with such skill, communication, and organization was absolutely inspiring.

While shadowing, I also had the chance to speak with patients who were preparing for or recovering from surgery. Hearing them express how surgery had changed or even saved their lives was incredibly moving. It made me see the operating room not just as a place of sterile instruments and procedures, but as a space where lives are transformed. Thats the kind of environment I want to be part of every single day.

I am especially drawn to general surgery, but I'm also fascinated by the idea of working in cardiac procedures. The heart is such a powerful and delicate organ and assisting in surgeries that involve it would be a true honor. I am excited to begin clinicals and explore different specialties, knowing that one of them will resonate deeply with me. I plan to continue my education after becoming a surgical technologist and eventually become a surgical first assistant.

Being part of a surgical team is a meaningful and rewarding path. I'm drawn to the structure, responsibility, and sense of purpose that comes with the role. It's important to me to contribute to patient care in a hands-on and focused way. I find the process of surgery and the complexity of the human body both challenging and fascinating. As I continue in this field, I look forward to growing professionally and playing a supportive role in improving patients' lives.

MARIAH JOSSELL, CST
MALCOLM X COLLEGE
CHICAGO, IL

$1,500

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

My journey into surgical technology was not linear, it was led by loss, strengthened by motherhood, and anchored in an unshakable faith. As a child, I witnessed two of my beloved aunts battle cancer. The hospital, though full of pain, became a place of purpose in my eyes. I didn't know the names of the roles or the titles of the professionals who worked there, but I knew I belonged in that world.

Years later, after weathering life's storms, financial setbacks, raising three daughters, and adjusting to a virtual academic life during the pandemic, I found myself reimagining my career path. I've always held a deep admiration for surgeons, but when I discovered the role of the surgical technologist, something clicked. This profession aligned with my reality and my ambition. I saw a path where I could work alongside those I admired most and still be present in the lives of my children. It wasn't just a career move; it was a calling confirmed.

I've immersed myself in this field before even stepping foot into a program, consuming educational YouTube videos, purchasing extra anatomy resources, and preparing my life for success with organized childcare, adjusted work schedules, and financial planning. I co-founded my college's Surgical Technology Club, served as a teacher's assistant for Sterile Processing, and was named to the Honors List, and a Cook County Health scholarship recipient all while giving birth and continuing to show up fully in my academic pursuits.

I've lived through what most would consider barriers, but I've transformed each one into a bridge. I am persistent. I am prepared. And I am positioned to thrive. The best part of surgery for me is witnessing and participating in the incredible innovations that are constantly shaping the future of healthcare. From minimally invasive techniques to robotic-assisted procedures, being part of a field that is always advancing, excites and motivates me. One of my absolute favorite parts of the role is setting up the sterile field and arranging the back table. There is a calming rhythm to the precision and intentionality required. It's like preparing for a performance, every instrument in its place, every detail considered. That level of preparation is a love language in the operating room, and it reflects the pride I take in my craft. Setting up a back table isn't just routine, it's ritual. It sets the tone for the entire case, and I take that responsibility seriously.

I find deep satisfaction in knowing that my readiness contributes directly to patient safety, surgical efficiency, and overall outcomes. There is no task too small when lives are on the line. And that's what makes this profession so powerful, we show up every day knowing that our work matters.

My long-term goal is to become a Surgical First Assistant, but more than that, I want to serve as a living example that God's grace and grit can take you further than circumstances ever could. Surgical technology is my path, my purpose, and the legacy I am building, not only for myself, but for the daughters who watch me every single day. Thank you for investing in that future.

KAYLIE ANDREWS, CST
GREAT BAY COMMUNITY COLLEGE
KITTERY, ME

$2,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

I have chosen surgical technology as my career based entirely off my passion to assist patients in receiving the quality of care they deserve and the quality of life they deserve. From a young age, I have always had a passion to serve my community, especially those who are most vulnerable. I have been in the healthcare field for 13 years and continue to educate myself in the ever-changing advancements, techniques, and concepts. I have a bachelor's degree in science – Health Science from the University of Southern Maine, and now an associate's degree in science – Surgical Technology from Great Bay Community College.

Surgery has always intrigued me. The way the surgical team works together to save a patient's life, or give them a new hip, or heart, etc., almost seems poetic. I have been a part of a team, whether it be for sports, school, or work, I thrive within that teamwork mentality and environment, and that's what surgery is all about.

During my nine months of clinicals, where I assisted in over 120 cases before successfully graduating from my program, I quickly knew I had found my passion. A surgical technologist is very crucial to any surgical case. Being able to critically think, anticipate, and stay organized are the top assets that I bring to the field. My ultimate goal is to become my best self within this field and to work towards becoming a surgical first assistant to the surgeon. I want to be the person that every patient hopes to have in the OR, to trust that I will uphold my duty of being a surgical technologist to the highest degree.

As I stated above, being part of a surgical team is poetic to me, in the sense that everyone has such a critical role to play during surgery, if one is missing, the case can not be successful. The surgical technologist's motto 'Aeger Primo' - the patient first, reflects total commitment to patient safety and advocacy, which is what I am committed to. The skills of a surgical technologist are admirable. There is no one else like the ST in the OR.

BRIAN KRIEVER, CST
SOUTHEAST COMMUNITY COLLEGE
THAXTON, VA

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

First, I want to thank the Foundation for Surgical Technology for honoring me by accepting me into the scholarship program. Thanks to the Foundation's generosity, I am free of some of the financial burden of education and able to continue to advance my education in surgical technology. Regarding my background and how I got into this field, it was a bit of a roundabout method. My career in healthcare started as an environmental services worker in New York at UHS Wilson Hospital. From there, I moved on to become an EMT, then a critical care emergency medical technician, working out of Syracuse. When I moved to Virginia, my New York state certifications wouldn't transfer, and I needed to find a new career path. After finding out about the surgical technology program offered by Radford University, I enrolled and finished with a degree in surgical technology and started working at Carilion Roanoke Memorial Hospital. Moving from pre-hospital medicine to the surgical setting was a rewarding experience to be able to see the end goal of patient care. The best part of this job is being able to see the patients receive a procedure that will either completely cure their ails or provide long-term relief from their conditions.

During my time at Carilion, I became certified on the DaVinci Si and Xi robotic surgical systems

through Intuitive Surgical, became very comfortable in surgical oncology cases, as well as OBGYN, orthopedics, pediatrics, and emergency general surgery. Additionally, the hospital increased my experience in bariatrics, plastics, neurology, trauma, total joint, ENT, and podiatry. I was lucky to have amazing coworkers and work with great surgeons that have allowed me to learn more and look towards the next step in my career. Eventually I took a few travel CST positions in North Carolina, Maryland, New York, New Hampshire, and Massachusetts, where I was able to continue learning, find new ways to approach problems, and anticipate on the fly with teams who could be new every shift.

During this time, I decided I wanted to do more for my patients and the teams I worked with, which is why I enrolled in a certified surgical first assist program. I am excited looking to the future and know that my time working as a certified surgical technologist will be the foundation on which I am building my future. I hope to continue working with surgeons in surgical oncology, pediatrics, or EGS once I finish my education and continue to provide the highest quality of care available to the patients who I serve.

JOSE MONTANO
TRITON COLLEGE
MELROSE PARK, IL

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

As a first-generation Latino college student, choosing surgical technology was a decision influenced by purpose, ambition, and a desire to serve others. I've always wanted to work in the medical field, and when I learned about the critical role surgical technologists play in the operating room, I immediately felt connected to the profession. The precision, teamwork, and the responsibility of supporting patients during some of their most vulnerable moments inspired me to begin this journey.

Currently, I am a student in the surgical technology program at Triton College, and I will begin my clinical rotations this upcoming fall. Though I have not yet stepped into the operating room, I've spent the past year building a strong foundation through lectures, lab practice, and skills development. I'm eager to take the next step and gain real-world experience in surgery, where I can apply what I've learned and continue growing.

Looking ahead, my goal is to graduate in summer 2026, work as a certified surgical technologist, and later pursue a bachelor's in health science to become an assistant physician. I hope to work in communities where access to care is limited and be a source of comfort and reliability for every patient I encounter. Receiving this scholarship from the Foundation for Surgical Technology means more than financial support; it's a token of confidence in my potential. I'm incredibly grateful for this opportunity and excited to represent the next generation of surgical technologists with pride, compassion, and excellence.

ISSAC EBERLE
BISMARCK STATE COLLAGE
BISMARCK, ND

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

From a young age, I have always felt a deep and genuine calling to help others through their pain and suffering. This passion was only strengthened by my time in the United States Army, where I learned discipline, resilience, and the importance of service.

My experience in the medical field has granted me the extraordinary honor of standing beside patients from all walks of life-holding their hands, offering comfort, and supporting them through some of the most vulnerable moments of their lives. Those moments continue to remind me that even the smallest act of kindness or care can leave a lasting impact on someone's life.

What began as a desire to serve evolved into a lifelong mission when I first witnessed an open-heart procedure. That experience changed me. It was unlike anything I had ever encountered-both surreal and spiritual. In that moment, I knew without hesitation that I wanted to become a part of the surgical world. The precision, teamwork, and intensity of surgery awakened something in me that I couldn't ignore.

Surgical technology appealed to me not only for its medical and technical aspects but also for its deep ties to the military—a connection that resonates with my own roots. As I continue my journey,

I am fully committed to advancing toward the role of Surgical First Assistant. This next step is driven by a desire to elevate my skills, expand my impact in the operating room, and serve patients at an even higher level of care.

I am truly humbled and honored to have received this award. It is a meaningful recognition of the path I have taken and the purpose I continue to follow— serving others with compassion, integrity, and unwavering dedication.

VICTORIA HARMS
LINCOLN LAND COMMUNITY COLLEGE
SHERMAN, IL

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

I have always found an interest in surgery since the first surgery I watched in high school. I did not know surgical technologist was a career opportunity until about a year and a half ago. I was originally convinced I wanted to go to school to become a veterinarian until I realized there would be no work-life balance. My path towards becoming a surgical technologist started when I unexpectedly found out I was pregnant with my now 16-month-old son. At the time I found out, I knew I did not want to attend veterinary school but was not sure where I wanted to go from there. After doing lots of research I came across LLCC's surgical technology program and started doing more research on the career field. Once I learned what the job entailed, I was hooked. I have always loved medicine and have always wanted to be in some career field to help either people or animals. In high school I received my CNA license and loved doing that. I also have worked in home health care. I knew helping people was my calling. After starting my clinical this semester at Memorial Hospital, it has made me even more confident in my decision to pursue this career field. My goals going through this program are to expand my knowledge on as many different specialties as I can and absorb as much information as possible. After working as a surgical technologist for a couple years, I would like to further my education and become a first assist. I think the best part of this job is knowing the number of lives I can and will affect throughout my career. Knowing that I have performed my best and can better the lives of others, fills my heart with joy. I'm excited to see where this career field takes me within the next five years.

ESTEFANIA MARTINEZ
COLLEGE OF DUPAGE
WEST CHICAGO, IL

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

I've always known that I wanted a career with purpose, something that allowed me to make a real impact rather than just exist. I was drawn to healthcare, but I wasn't sure which path was right for me. Surgery had always lingered in the back of my mind, but I assumed only surgeons worked in the OR. There was a moment I felt lost and every program I looked into never quite felt like the right fit. But one day, after more research, I discovered surgical technology as a career option. I decided to shadow in the operating room, and the moment I stepped inside, everything changed. I watched an orthopedic procedure, and something just clicked. I could actually picture myself standing beside the surgeon, being part of that environment. That was the moment I knew I had found where I truly belong. After that experience, I made the decision to return to school and pursue surgical technology. It was a mix of emotions, fear, excitement, and a bit of intimidation but most of all, it felt right. I had finally found a challenging and meaningful career that connects my love for human anatomy with the ability to directly impact lives. I just graduated from the program and now I am focusing on passing the national exam. My goal is to work at a Level One trauma hospital in Chicago. I'm drawn to the fast-paced environment and the opportunity to be part of a team that handles a wide range of complex and unique cases. I'm excited to challenge myself, refine my skills, and become well-rounded across various surgical specialties. A personal aspiration of mine is to participate in mission trips. Ever since I discovered that surgical technolo-

gists can travel and provide surgical care in underserved countries, I have been excited by the idea of using my skills to help those who lack access to proper surgical care. For my long-term goals, I've always had a strong interest in cardiology, and my goal is to one day work in cardiothoracic surgery. Ultimately, I plan to continue advancing my education, with a direct path of staying in the surgical field. What I love most about surgery is how every day is never the same. It's a fast-paced, exciting, and sometimes intimidating career, but that's exactly what I love about it. Surgery is constantly evolving, and with every case I learn something new and each time I learn more about myself. For instance, I never thought I would develop an interest in robotic surgery, and that quickly became one of my favorite surgical approaches. This career has pushed me out of my comfort zone and helped me grow in ways I never anticipated. I also appreciate the discipline it requires and the sense of purpose it brings. Throughout my program, I've had the pleasure of meeting some truly amazing people. I'm especially grateful to my professors for their constant support and encouragement. I've also had the privilege of working with incredible preceptors and surgeons who not only inspired me but also taught me so much. Lastly, I am honored and grateful to the Foundation for awarding me this scholarship and the financial support it has provided.

MAKENZIE MARRA
NEW ENGLAND INSTITUTE OF TECHNOLOGY
BERKLEY, MA

$3,000

DALTON GAY MEMORIAL SCHOLARSHIP, SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

A common question that comes to mind for a lot of adults when thinking about the future is "What defines success?" This question can be answered in many ways for all different types of people, as success in life looks different to everyone, and has no specific time frame. My personal time frame of success is something that I have struggled with for quite some time. Many high school students attend college immediately after graduating, but life had a different plan for me. I needed to pull away from my future to focus on the present, and while this is something that I may not have realized at the time, it was not only necessary for my survival but also necessary for my current successes. During this time, not a day went by where I didn't ask myself, "What do I really want to be when I grow up?" Having a respectable and fulfilling job is something that I believe a lot of people long for, me included. I always wanted to work in the medical field, but I was never quite sure what route I wanted to take. Last year, I felt ready to begin and made it a personal goal to start an education program that fall. While researching healthcare programs, schools, and career paths, I decided that I was less interested in being on the front lines of action and more interested in being right in the throes of it – the OR. So, I continued with further research and came to find out, not every person in an operating room is a nurse, doctor, or surgeon and the team includes someone else who is vital to the success of the team in the OR. This is when I discovered the surgical technological career, and I had never felt so sure of my future.

Success, to me, is not defined by time, but rather by readiness, spirit, and motivation. Having spent many years working to be where I am today, I am proud of where I am and eager to see where life continues to take me. I wouldn't be who or where I am today if not for my struggles and I wouldn't have it any other way. These first three terms of the surgical technologist program have been eye-opening, motivating, and incredibly interesting. I have been able to jump right back into school like I never took any time off. Studying for and learning this career already have me feeling fulfilled. I can see myself becoming a future mentor for others like me some day, and I am eager to continue this rewarding path. Along with this, I am incredibly grateful for my current mentors and teachers, and I look forward to heading off to my clinical experience in just a few short weeks. I feel honored and incredibly grateful to accept this scholarship and I am proud to represent the Foundation in all my future endeavors.

BRENDA HERNANDEZ, CST
MOORE NORMAN TECHNOLOGY CENTER
MOORE, OK

$2,500

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

My name is Brenda Hernandez, I graduated with a surgical technology certification from Moore Norman Technology Center, and I am honored and proud to have received this award.

I have always been drawn to the medical field, and being in the operating room has always been the end goal. Before I decided to pursue being a surgical technologist, I earned two different certifications and worked at a local hospital in Oklahoma City in the emergency room. I have chosen this career because I am fascinated by surgery and the precision and detail it requires. I enjoy being a part of a team that thrives in a fast-paced environment to deliver the best care to patients. It is a great career full of opportunities for growth and the ability to specialize in different areas. It has shown me a lot about myself and what I am capable of. It gives me a sense of purpose, pride, and contribution to something bigger than myself.

In the near future, I aspire to become a first assist surgical technologist and perhaps also go to nursing school.

I would like to take a moment to thank everyone who has been on this journey with me. I could not have gotten this far in my career path without the support of my instructors, Julie Pennington and Fallan Hammond. I have a lot of respect for both, and I will forever be grateful that they pushed me to become the best version of myself and a great scrub.

I would also like to thank my friends, the ones that stood by me while going through school.

But most importantly I would like to thank my family, without them I wouldn't be where I am today. Thank you to my mom and dad for your support, love, and sacrifices during this journey. Your constant encouragement, guidance, and belief in me have been the foundation of everything I have achieved.

Lastly, I would like to thank the Foundation for Surgical Technology for this award.

National Academy Of Medicine Publishes A Code Of Conduct For Artificial Intelligence

FOREWORD

The history of artificial intelligence (AI) dates to 1935 when Alan Turing, a British mathematician and logician, described an abstract computing machine capable of limitless memory that could modify or improve its own program.[1] The concept is now simply called the Turing machine. During World War II he was a leading cryptanalyst, but that didn't stop him from continuing to think about machine intelligence. After the war, in London, 1947, he is credited with giving one of the earliest public lectures to mention computer intelligence by saying, "What we want is a machine that can learn from experience," and the "possibility of letting the machine alter its own instructions provides the mechanism for this."[2]

Going forward, 2020 to the present, the recent AI surge has mostly occurred because of the developments in generative AI – the ability for AI to generate images, text, and videos in response to text prompts. Past systems are required to be coded to respond to a set of inquiries, whereas generative AI continues to learn from documents, photos, and search words from across the Internet.

This has led to many questions as to how these AI breakthroughs will affect and transform the approaches to diagnostic techniques, disease prevention, management of health systems, medical research, and most importantly, patient treatments. However, the development and use of AI has also introduced a myriad of issues related to accountability, ethics, and safety. It brings to the forefront that it must be closely monitored and held to standards that promote its ultimate goals of contributing to the advancement of the health of all people, as well as ensuring the well-being of health care providers (HCPs) that has been an ongoing discussion for several years but particularly emphasized during the COVID-19 pandemic.

Based upon these advancements and the potential for AI to significantly transform the many facets of health care, the National Academy of Medicine (NAM) initiated a project in 2023 to develop an AI Code of Conduct (AICC) to be used as a guide in the effective and ethical use of AI applications in healthcare with a focus on improving health outcomes. The result of the project is the publication, *An Artificial Intelligence Code of Conduct for Health and Medicine: Essential Guidance for Aligned Action*. NAM, by establishing the AICC, has the goal of aligning stakeholders around the ethical, responsible, and safe use of AI that includes promoting equitable health outcomes.[3]

The following is a summary of the publication. The document itself is 186 pages; therefore, this article will focus on key factors and provide a summary of the health and health care workforce perspective as an example of the application of the AICC. The reader is encouraged to review the report to understand the full scope of the NAM project and publication. The report is free online: https://nam.edu/our-work/programs/leadership-consortium/health-care-artificial-intelligence-code-of-conduct/

AICC CODE COMMITMENTS AND PRINCIPLES

AI has already been incorporated into many aspects of health care, including dermatology, internal medicine, pathology, and radiology. However, its use has generated multiple concerns in the health care community. A leading issue is equity to ensure AI can be accessed by all HCPs and patients no matter the healthcare setting, for example, rural healthcare facilities.[3] Other concerns involve security of patient information to ensure patient confidentiality and privacy, accuracy of results such as diagnostic results, and accountability in the use of AI.[3] Therefore, NAM developed the AICC with a set of rules referred to as Code Commitments and Code Principles. It is intentionally designed for healthcare organizations and groups to consider including when developing their own approaches and policies regarding AI.[3] Table 3-2 provides the updated AIC code principles as follows – engaged, safe, effective, equitable, efficient, accessible, transparent, accountable, secure, and adaptive.[3] The reader is encouraged to review the description of each

item in the document. All tables are available in the report referenced above.

Table 3-3 is the Updated AICC Code Commitments:[3]

- Advance humanity: Protect and advance human health and connection as the primary aim.
- Ensure equity: Ensure equitable distribution of benefit and risk for all.
- Engage impacted individuals: Engage people as partners with agency in every stage of the lifestyle.
- Improve workforce well-being: Renew the moral and well-being and sense of shared purpose in the health care workforce.
- Monitor performance: Monitor and openly and comprehensibly share methods and evidence of AI's performance and impact on health and safety.
- Innovate and learn: Innovate with scalable design, adopt, collaboratively learn, continuously improve, and advance the standard of practice.

Chapter 5 provides real-world applications and activities from the perspective of the stakeholder working groups. As stated in the report, "to realize the goal of improved health of the U.S. population using AI, it is essential to translate the AICC commitments into actionable, real-world practice."[3] The AICC steering committee formed the stakeholder working groups to gather their insights on AI real-world activities as well as their perspectives, responsibilities, and needs as related to the AI Code of Commitments. Table ES-1 provides a list of the stakeholders and a description of their contribution to the application of the AICC. The stakeholders are developers, researchers, health systems and payors, patients and advocates, federal agencies, health care workforce, quality and patient safety experts, and ethicists and equity experts.[3] The rest of this discussion will focus on the health care workforce because that is what is most pertinent to CSTs. The following is the description of contribution by the health care workforce from Table ES-1.[3]

> As end-users of some types of health AI, the health care workforce is situated to identify workflow needs and priorities, and as purchasers or influencers of purchasing decisions, clinicians in particular may have contracting opportunities to require disclosure of AI models' alignment with the Code principles and commitments and to address liability concerns should model outputs cause harm.

HEALTH CARE WORKFORCE PERSPECTIVE ON AI

In addition to the ongoing issue of burnout, the well-being of HCPs and healthcare delivery continues to be affected by the shortage of health care personnel. The World Health Organization estimates that by 2030 there will be a shortage of 14 million HCPs around the globe.[3] AI has the potential to either negatively or positively contribute to addressing these challenges. The following information summarizes the insights the AICC steering committee gathered from the health care workforce working group according to each AICC Code of Commitment. The working group provided their views as to the "key opportunities and challenges in the use of AI in health care" through the perspective of Commitment 4: Improve Workforce Well-Being.[3]

Commitment 1: Advance Humanity

A contradiction could exist with the use of AI applications in health care. On one part, AI applications could contribute to breaking down the personal communications HCPs rely upon to form a professional connection with patients that helps to gather patient information and build the confidence of the patient in the health care team.[3] However, using AI to automate some uncomplicated tasks could provide HCPs with additional time to be able to communicate among themselves as well as with patients. A balance must be achieved to ensure that AI contributes to allowing HCPs to give patient care in the way they feel it needs to be accomplished, while advancing the use of AI applications in a way that positively contributes to patient care.[3]

Commitment 2: Ensure Equity

It is important for HCPs to continue their vital role in supporting workforce diversity and equitable care. This includes understanding the use of AI for under-represented populations, for example rural healthcare facilities, and to ensure it contributes to improving equitable care and workforce well-being rather than worsening the concerns.[3]

Commitment 3: Engage Impacted Individuals

This commitment addresses the possibility of the displacement or loss of jobs by HCPs because of AI automation, for example, AI performing pathological diagnostic tasks. It will be a high priority to maintain the current level of the HCP workforce, as well as address the shortage. This includes identifying training and employment needs in fields that are least likely to be affected by AI automation, as well as retraining HCPs in the use of AI.

Commitment 5: Monitor Performance

Commitment 5 addresses two aspects of the health care workforce – well-being and a legal perspective. As mentioned

in other AI commitment statements, AI tools should be monitored for performance to prevent harm to patients and workforce. AI presents the opportunity to better identify, assess, and measure the actions, interventions, policies, and environments that negatively affect the ability to improve the workforce wellbeing.[3] However, as with other instances in the use of AI, if the tools are not appropriately implemented, they could have the opposite effect of directly lowering the well-being of HCPs.

Additionally, the use of AI tools must be considered from a legal perspective. An HCP who uses AI tools may be responsible for personal liability for an AI-associated error that causes patient harm, even though the HCP is following employer policy in the use of AI. Tort doctrine will need to develop as AI continues to advance, as well as HCPs informed by the employer of the risk for personal liability and the facility policies that are in place to monitor its use.[3] The facility purchasing agents may have the ability to protect HCPs and patients by placing the liability on AI developers when the AI tool causes errors leading to patient harm, while still maintaining HCPs remain liable for AI tool misuse.[3] Further, healthcare facilities, as the purchasers of AI tools, could insist there are mechanisms in place that communicate the tools have been demonstrated to be effective and safe for use in the care of patients.[3]

Commitment 6: Innovate and Learn

The effects of AI on the health care workforce and patients will include factors that cannot be predicted. The recommendation in commitment 6 is not to focus on prediction, but to identify the areas of the AI tool(s) that are susceptible to error to be able to address and strengthen.[3] This also contributes to the ongoing goal of ensuring AI contributes to the well-being of HCPs and patients.

COMMON THEMES IDENTIFIED AMONG THE STAKEHOLDER WORKING GROUPS AND THE ROLE OF HCPS

Table 5-2 provides a list of 10 repeated common themes or needed actions given by the stakeholder working groups, while table 5-3 provides a summary description of the role that each stakeholder working group could fulfill when applying the AICC Principles and Commitments. As examples, four of the ten actions are listed here and the role of the health care workforce.

Common Themes for Action Among Expert Working Groups[3]

- Ensure that patients, end users, and ethicists are represented throughout the entire AI lifestyle.
- Promote a continuous learning environment in the context of use of health AI applications, with elements of education, iterative improvements, and establishing a culture of systems-based learning and quality improvement.
- Promote user-centered design of health AI tools and applications to optimize satisfaction, ease of understanding, and appropriate use in health AI applications.
- Create a safety culture, including non-retaliatory reporting for adverse outcomes and includes the training necessary to adapt to an AI-enabled health environment.

Distinct Contributions of Various Stakeholders to the Application of the Use of AI Code of Conduct Framework[3]

Health Care Workforce

As end users of some types of health AI, the health care workforce is situated to identify workflow needs and priorities, and as purchasers or influencers of purchasing decisions, clinicians in particular, have contracting opportunities to require disclosure of AI models' alignment with the Code of Principles and Commitments and address liability concerns should model outputs cause harm.

Conclusion

To exact the benefits of AI and mitigate the potential harms and risks to HCPs and patients will require participation by all the stakeholders identified in the NAM report. This also requires the participants to take under consideration the AICC as well as Principles and Commitments when working on healthcare facilities AI policies to achieve a common vision, goals, and objectives to advance the use of AI in the care of patients and the well-being of the workforce.

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Dorothy Lavinia Brown, MD: Medical Pioneer, Leader, Role Model

AST Staff

MEDICAL MARVELS

When asked what enabled Dr. Brown to persevere through so many hardships she replied, "I tried to be not hard, but durable." What also inspired her was the knowledge that she could serve as a role model "not because I have done so much, but to say to young people that it can be done. Dreams can be made to come true."[1]

Dr. Dorothy Lavinia Brown (January 7, 1919 – June 13, 2004) used her personal motivation to overcome multiple obstacles to become one of the most famous African American female surgeons in history. Born in Philadelphia, her mother, Edna Brown, moved soon afterwards to upstate New York. Her mother placed her in the predominantly white Troy Orphanage, later renamed Vanderheyden Hall, and that was her home from the age of five months to 13 years of age when her mother reclaimed her.[1,2] However, Dr. Brown made it apparent she preferred life at the orphanage by running away from home five times returning to the orphanage, but with her mother reclaiming her each time.[3]

Unwavering in her determination to obtain an education, as well as inspired by a woman who employed her as a mother's helper who encouraged her to return to school and pursue a career in medicine, she ran away for a final time at the age of 15 and enrolled in Troy High school.[1,3] With the principal becoming aware that she was homeless, the twist of fortunate fate occurred when he arranged for her to stay in the foster home of Samual and Lola Redmon.[2] They immediately became a major influence in Dr. Brown's life, providing long-term security that she had been missing in her life and a source of support providing encouragement and motivation to achieve her dreams.

In 1937, when Dr. Brown graduated valedictorian from Troy High School, the Troy Conference Methodist Women awarded a four-year scholarship to attend Bennett College, a private historically black liberal arts col-

"Dreams can be made to come true."

lege for women, located in Greensboro, North Carolina.[1,2] She completed a Bachelor of Arts degree in 1941, graduating second in her class.[3] To support the World War II effort, she took a job as an inspector in the Rochester Army Ordinance Department.[3]

Ever since Dr. Brown had her tonsils removed at the age of five and remembering the soothing care she received while recovering at the orphanage, she desired to be a physician.[1] In 1944, she enrolled at Meharry Medical College in Nashville, TN, a private medical school founded in 1876, it was the first medical school for African Americans in the South.[1-3] She graduated in 1948. After completing a one-year internship at Harlem Hospital, she set sights on the next goal of obtaining a residency in surgery. Again, Dr. Brown was faced with overcoming another obstacle – a female wishing to be a surgeon in the male world of surgery at that time. However, Dr. Matthew Walker, Sr., one of the most prominent African American surgeons in the 20th century in the U.S., saw it differently. In 1948, Dr. Walker was the Chairman and Professor of the Department of Surgery at the George W. Hubbard Hospital that was affiliated with Meharry Medical College.[4] A five-to-seven-year residency program had been created by Dr. Walker, and against the advice of peers who said a woman couldn't withstand the demands of surgery, he accepted her into the residency.[2] Dr. Brown completed the residency in five years becoming the first African American female surgeon in the South. Her next accomplishment was being appointed as an Assistant Professor of Surgery in 1955.

From 1957 to 1983, Dr. Brown was the Chief of Surgery at Nashville Riverside Hospital (closed in 1983), clinical professor of surgery at Meharry Medical College, and educational director for the Riverside-Meharry Clinical Rotation Program. In 1982, she served as a consultant on education, health, and welfare on the National Advisory Council Heart, Lung, and Blood, National Institutes of Health.[2]

Dr. Brown's beliefs, generosity, and values led her to accomplish additional "firsts" in the state of Tennessee. When a young, unmarried women pleaded with Dr. Brown to adopt her newborn daughter, she became the first single adoptive mother in Tennessee in 1956, naming her Lola Denise Brown in honor of her foster mother.[1-3] In 1966, Dr. Brown became a candidate for a seat in the Tennessee General Assembly (Tennessee state legislature) and won, becoming the first African American woman representative in Tennessee. During her two-year term, she was successful in passage of the Negro History Act, requiring Tennessee public schools to conduct special programs to recognize African American achievements during Negro History Week that is now nationally known as Black History Month.[1,3] She introduced a controversial bill to reform the Tennessee state abortion law to allow legalized abortions in cases of incest and rape as well as when the mother's life was in danger.[3,5] The bill was narrowly defeated.

Dr. Brown received many honors and recognitions including, in 1955, being the first African American woman general surgeon to be inducted as a Fellow of the American College of Surgeons.[5] In 1970, she was honored by the naming of the Dorothy L. Brown Women's Residence Hall at Meharry Medical College.[5] She received the Humanitarian Award from the Carnegie Foundation in 1993 and the Horatio Alger award in 1994, given to individuals recognized for their exceptional leadership who overcame adversity to achieve their goals.[3]

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Gastric Bypass Superior to Sleeve Gastrectomy

JAMA Surgery

OF INTEREST IN THE MEDICAL ARENA

Topline: Patients who underwent a Roux-en-Y gastric bypass (RYGB) had a higher excess body mass index (BMI) loss as compared to patients that underwent laparoscopic sleeve gastrectomy (SG) with severe obesity over 10 years. Additionally, patients who underwent SG had a higher number of conversion rates to different bariatric procedures and a higher rate of de novo* gastroesophageal reflux (GERD).

Why Trial is Important: A comprehensive randomized clinical trial comparing laparoscopic SG to RYGB was needed because there are very few trials reporting on long-term outcomes.

Objective of the Trial: The researchers from the Swiss Multicenter Bypass or Sleeve Study (SM-BOSS) set out to compare long-term weight and metabolic outcomes in patients with severe obesity undergoing laparoscopic SG or RYGB at 10 years and beyond. The primary outcome was percentage excess BMI loss at 10 years and beyond. Secondary outcomes included changes in weight, obesity-related diseases, reoperation rates, and quality of life.

Methodology: The randomized clinical trial was held from January 2007 to November 2011 that involved four bariatric centers in Switzerland. The trial was led by Marko Kraljevic, MD, Clarunis University Abdominal Center Basel, Department of Visceral Surgery, University Digestive Health Care Center, St. Clara Hospital and University Hospital, Basel, Switzerland.

Patient Population: 217 patients with severe obesity were enrolled in the trial and randomized to undergo either laparoscopic SG or RYGB. The mean baseline BMI** was 43.9, mean age 42.5, and 71.9% (156 patients) of the participants were female. 107 patients underwent laparoscopic SG and 110 underwent RYGB. 10-year follow-up was available for 65.4% of patients.

Results of the Trial: Patients who underwent SG as compared to RYGB had a significantly higher conversion rate to different bariatric procedures (29.9% vs 5.5%), mainly because of insufficient weight reduction or reflux. Of approximately 142 patients who were assessed 10 years after surgery and did not undergo additional treatments prior to the follow-up, RYGB patients experienced a greater excess BMI loss than SG (65.9% vs. 56.1%). De novo GERD occurred significantly more in SG patients versus RYGB (32.3% vs 7.9%). However, both procedures showed similar improvements in obesity-related comorbidities including type 2 diabetes remission as well as similar complication rates and quality of life.

Study Conclusions: "In the SM-BOSS randomized clinical trial, RYGB led to significantly higher [percentage excess body mass index loss] in the [protocol] population compared with SG beyond 10 years of follow-up, with better results for GERD," the authors wrote.

Study Limitations: The trial was initially going to be based on a five-year follow-up. However, because of the change to a 10-year follow-up, it potentially resulted in participant loss. The high number of conversion from SG to RYGB possibly influenced the interpretation of long-term outcomes.

Funding/Support: The clinical trial was supported by grants from Ethicon Endo Surgery USA and the Swiss National Science Foundation. Some authors reported receiving grants, lecture fees, and personal fees from Ethicon Endo Surgery USA and Swiss National Science Foundation, as well as other pharmaceutical companies.

Conflict of Interest Disclosure: None reported.

***De novo:** New or spontaneous occurrence; condition that previously never existed.

****Scale for BMI**

- Underweight: Less than 18.5
- Healthy weight: 18.5 – 24.9
- Overweight: 25 – 29.9
- Obesity: 30 or higher
  - Class 1: 30 – 34.9
  - Class 2: 35 – 39.9
  - Class 3 (severe obesity): 40 or higher

Reference
Kraljević M, Süsstrunk J, Wölnerhanssen BK, et al. Long-term outcomes of laparoscopic Roux-en-Y gastric bypass vs laparoscopic sleeve gastrectomy for obesity: the SM-BOSS randomized clinical trial. *JAMA Surg*. 2025; 160(4): 369-377. doi: 10.1001/jamasurg.2024.7052

Metabolic and Bariatric Surgery Associated with Improvement in Psoriasis

Journal of the American Academy of Dermatology

Topline: A systematic review showed most patients with psoriasis exhibited clinical improvement or remission after undergoing metabolic and bariatric surgery (MBS).

Why Study is Important: Obesity is a well-known risk factor for psoriasis and the higher the body mass index (BMI) the frequency and severity of the disease increases. The combination of obesity and metabolic syndrome and psoriasis, and the social stigma caused by the comorbidities, the individual can experience a poor quality of life. The systematic review provides information that can be used by clinicians as a guide in determining the clinical and surgical treatment of a patient.

Objective of the Study: The systematic review was completed to examine the association between MBS and psoriasis severity.

Methodology: The research team utilized Embase, MEDLINE, and Scopus indexing and literature databases using keywords related to bariatric surgery and psoriasis.

Patient Population: The search of the databases identified 14 studies with 169 patients, mean age of 46.8 years and 74% women (n = 125/169), with psoriasis who underwent MBS. The patients underwent various types of MBS; gastric bypass was the most common (75.1%, n = 127/169), followed by sleeve gastrectomy (17.8%, n = 30/169), gastric banding (5.3%, n = 9/169), and jejunoileal bypass (0.6%, n = 1/169). Pre-MBS treatments included topical (46.2%, n = 78/169), non-biologic (35.5%, n = 60/169), and biologics (16.6%, n = 28/169). The average baseline BMI was 43.7. (See previous article for BMI scale). The baseline psoriasis was principally moderate (76.3%) with 15.6% being mild cases and 8.2% severe cases.

Results of the Study: The psoriasis severity was either mild or completely resolved in 97.2% of patients post-MBS. Four patients (2.4%) experienced worsening condition. Most patients continued psoriasis treatment (78.1%, n = 132/169), with many downgrading to a lower medication category, for example, systemic to topical treatment or no treatment.

Study Conclusions: "MBS may improve psoriasis outcomes following surgery," the research team wrote. They continued, "While initial findings are promising, further controlled trials are necessary to validate the long-term effects of MBS on psoriasis and explore its potential role as an adjunctive therapy."

Study Limitations: Limitations acknowledged by the research team included inclusion of case reports, reporting bias, and variability in the outcome measures.

Funding/Support: No funding was provided.

Conflict of Interest Disclosure: Ronald Vender, MD, reported receiving grants, honoraria, research support, and speaker fees from multiple companies including AbbVie, Alumis, Amgen, Arcutis, Bausch Health/Valeant, Boehringer Ingelheim, Bristol Myers Squibb, Eli Lilly and Company, Janssen, Novartis, and Pfizer. Miranda Branyiczky and Megan Lowe declared no conflicts of interest.

Reference
Branyiczky MK, Lowe M, Vender R. The association between bariatric surgery and improvement in psoriasis: a systematic review. J Am Acad Dermatol. May 24, 2025. Accessed July 30, 2025. doi: 10.1016/j.jaad.2025.05.1412

Increase in Minimally Invasive Surgery Procedures for Colorectal Cancer Prompted by Robotic-Assisted Surgery

Diseases of the Colon & Rectum

Correspondence: To contact corresponding author George J. Chang, MD, MS, MHCM, Department of Colon and Rectal Surgery, Department of Health Services Research, The University of Texas MD Anderson Cancer Center, 1515 Holcombe Blvd., Unit 1401, Houston, TX 77030-4008, gchang@mdanderson.org

Topline: A U.S. study shows that robotic-assisted surgery to treat colorectal cancer (CRC) has significantly increased from 2010 to 2020, accounting for 48.8% of all rectal cancer procedures. The increase in robotic-assisted surgery has been a significant factor towards the increased use of MIS in treating patients with CRC.

Why Study is Important: Minimally invasive surgery (MIS) has been linked to improving short-term outcomes, patient recovering with less pain, and similar long-term oncologic outcomes for patients with CRC when compared with open surgery. As an MIS option, robotic-assisted surgery is known for its technical benefits, but how it has influenced MIS overall, including laparoscopic surgery, has not been well-studied.

Objective of the Study: Compare trends in open and MIS procedures for CRC resections and analyze factors that

influence MIS. The primary outcome measures are surgical approach rates for open, laparoscopic, and robotic-assisted procedures in patients diagnosed with nonmetastatic colon or rectal adenocarcinoma. Secondary outcomes included conversion rates to open surgery, 30-day readmission and mortality rate, and postoperative patient length of stay (LOS).

Methodology: Retrospective cohort study using data from the National Cancer Database (NCDB) from 2010 to 2020. The NCDB is a facility-based database joint effort of the American Cancer Society and American College of Surgeons Commission on Cancer (CoC). It contains comprehensive patient-level data for approximately 70% of new cancer diagnoses from more than 1,500 CoC-accredited facilities.

Patient Population: Researchers analyzed 475,001 patients 18 to 90 years of age with nonmetastatic CRC adenocarcinoma. The patient population consisted of 389,903 patients (82.1%) with colon cancer and 85,098 patients (17.9%) with rectal cancer. The analysis revealed that 217,819 patients (45.9%) had laparoscopic surgery, 192,237 (40.5%) underwent open surgery, and 64,945 (13.7%) underwent robotic-assisted surgery. MIS increased across all facility types during the study period, with robotic-assisted surgery being at the forefront of pushing this trend. Older people 75 to 90 years were less likely to undergo robotic-assisted or laparoscopic surgery as compared to those underwent open surgery (20.4%, 28.8%, and 32.3% respectively).

Results of the Study: Facilities with robotic capability had larger increases in MIS as compared to facilities without robotic capability that plateaued at a 58% utilization rate. Specifically, laparoscopic surgery for treating colon cancer peaked in 2016 at 54% of total procedures and then rapidly declined. In comparison, the rates of robotic surgery increased from 1.7% in 2010 to 9.2$ in 2015 and significantly increases to 27% in 2020.

Regarding rectal cancer, laparoscopic surgery peaked in 2014 at 37.2% and again, significantly decreased, while rates of robotic surgery increased. In 2010, the rate of robotic-assisted surgery was 5.5% of total procedures to 24.7% in 2015 and 48.8% in 2020.

Open surgeries for both colon and rectal cancer had a significant decline across all facility types during the period of time of the study.

Patients who underwent MIS had shorter inpatient LOS as compared to patients that underwent open surgery. For patients with rectal cancer who underwent MIS the median LOS was five days as compared to six days for open surgery. Postoperatively, the inpatient LOS for patients that underwent open surgery for colon cancer was highest at six days versus four days for MIS.

Robotic-assisted surgery was shown to have a lower conversion rate to open surgery for both colon and rectal surgery as compared to the higher rate for laparoscopic surgery (6.3% robotic vs 12.6% laparoscopic). Additionally, MIS exhibited a lower 30-day mortality rate compared to open surgery, with robotic at 0.8% vs 1.5% for laparoscopic and 3.5% for open surgery. Overall, the number of lymph nodes harvested by MIS was much higher as opposed to open surgery.

Factors such as facilities with a high volume of MIS cases and patient income level were linked to an increase in the probability of those patients' undergoing MIS. However, African Americans, patients with lower income, and facilities located in rural areas were linked to a lower utilization of MIS for both colon and rectal cancer resections. "Additional qualitative studies may be necessary to further elucidate surgeon and facility-level causes for these disparities," the authors wrote.

Study Conclusions: "Rates of MIS for colorectal cancer steadily increased across all facility types from 2010 through 2020. For patients with colon cancer and rectal cancer, rates of open resections declined, and laparoscopic resections plateaued, but robotic surgery continues to increase. Robot-assisted surgery is now the most common approach for rectal cancer surgery. Increased rates of MIS are likely driven by continued increases in the use of robot-assisted surgery," the authors concluded.

Study Limitations: The authors reported multiple limitations. Because the NCDB information is CoC-accredited facility-based data, not population-based data, the findings could be limited. Based upon the research, even though it was revealed that the adoption of robotic-assisted surgery was linked to higher rates of MIS, the causality could not be confirmed. Additionally, the information provided by the NCDB does not provide the possibility of knowing the number of surgeons that transitioned to the robotic-assisted surgical approach. Lastly, another driving factor for increased rates of MIS was facility robotic-assisted surgery capability, but the researchers could not inform as to a facility's decision to adopt or not adopt robotic-assisted surgery capability.

Funding/Support: The study was supported by the Sue and Radcliffe Killam Chair and the National Institutes of

Health, National Cancer Institute.

Conflict of Interest Disclosure: None reported.

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First-of-Its-Kind Surgery Rare Spinal Tumor Removed Through Eye Socket

A surgical team removed a rare spinal tumor through the patient's eye socket (transorbital) at the University of Maryland Medical Center (UMMC) on May 1, 2024. The transorbital approach is routinely used to access tumors in the brain and sinuses, this is the first time it has been used to remove a spinal tumor. The rare bone tumor called a chordoma was "wrapped around the patient's spine and spinal cord and had invaded the vertebrae in her neck, just below the base of the skull," according to neurosurgeon Dr. Mohamed A. M. Labib, an Assistant Professor of Neurosurgery at the University of Maryland School of Medicine (UMSOM). Only about 300 chordomas are diagnosed in the U.S. annually. The cause of the tumor is not known, but it is known that they arise from the remnants of the notochord, the cartilaginous structure that leads to spinal development in the fetus.

This approach avoided the possibility of damaging key anatomical structures including the eustachian tube, the internal carotid artery and jugular vein, and the nerves that control speech and swallowing.

"By going through the bottom of the eye socket, we were able to remove a tumor that otherwise would have been very difficult and risky to address," Dr. Labib said. Additionally, he said that trying to reach the tumor through a back incision would have risked damaging the spinal cord. "We created a huge surgical corridor that enabled us to get in front of the spinal cord. It was a straight shot," he added.

In addition to the spine tumor, the patient also had a second chordoma wrapped around the brain stem. During two separate procedures, UMMC surgeons performed an open craniotomy to remove a portion of the tumor and Dr. Andrea M. Hebert, a head and neck surgeon and an Associate Professor of Otorhinolaryngology – Head and Neck Surgery at UMSOM, excised the rest endoscopic endonasal.

The 19-year old female patient, Karla Flores, was treated with proton radiation therapy to destroy any remaining cancer cells and underwent a fourth procedure to fuse the C1 and C2 vertebrae to stabilize the spine. She said she started experiencing double vision at age 18 and after several months of the cause being investigated, she visited an ophthalmologist who referred her to Dr. Labib, who diagnosed her with the chordoma.

Dr. Labib developed the novel surgical approach using cadavers in the UMMC Department of Neurosurgery's Skull Base 360˚ Laboratory. He referred to the eye socket as "the third nostril." Dr. Kalpesh T. Vakharia, Chief of Facial Plastic and Reconstructive Surgery in the Department of Otorhinolarygology – Head and Neck Surgery and Director of the Facial Nerve Center at UMMC, and an Associate Professor of Otorhinolaryngology – Head and Neck Surgery at UMSOM, created the entryway through the eye socket. He incised the conjunctiva inside the lower eyelid that included making an incision inside the patient's mouth. He excised the inferior portion of the eye socket, as well as some cheek bone to create an entrance for the neurosurgeons to insert the endoscope and endoscopic instruments to access the cervical spine.

With the assistance of Dr. Andrea M. Hebert, Dr. Labib drilled through the vertebral bone to access the tumor and excise it. After the tumor was excised, Dr. Vakharia repaired the inferior portion of the eye socket using a titanium plate and reformed the check using bone graft taken from the patient's hip.

"Karla is doing very well. I am happy that through a very coordinated multidisciplinary team effort she had such a successful outcome," Dr. Labib said, adding that she has postoperative issues with moving her left eye because of nerve damage from the chordoma pushing against the brain stem.

Reference

University of Maryland School of Medicine. In first-of-its-kind surgery, rare spinal tumor removed through patient's eye socket at University of Maryland Medical Center. UMMC Media Relations. May 6, 2025. Accessed July 19, 2025. https://www.umms.org/umgccc/news/2025/university-of-maryland-medical-center-neurosurgeons-perform-pioneering-surgery

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ARIZONA STATE ASSEMBLY

Program Type: Workshop
Date: November 15, 2025
Title: Tucson Time!
Registration: azsaofast.org
Location: Pima Medical Institute – Tucson, 2121 N Craycroft Road, Building 1, Tucson, AZ 85712
Contact: Teresa Sochacki, azsa.assembly@gmail.com
CE Credits: 4 Live approved by AST

ARKANSAS STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 4, 2025
Title: Harvesting Credits: Reap Knowledge and Refine Skills
Registration: ar.ast.org
Location: Center for Economic Development-University of Arkansas Fort Smith (Bakery District), 70 S 7th St, Suite D, Fort Smith, AR 72901
Contact: Tamara Morgan, 479-414-6720, tamara.morgan@uafs.edu
CE Credits: 6 Live Planned

CALIFORNIA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 18, 2025
Title: Beyond The Basics CST's Adapt, Innovate, Thrive
Registration: https://ca-saofast.wixsite.com/casa/events/warriors-behind-the-mask
Location: Keck Medicine of USC, 1450 Biggy Street, Los Angeles, CA 90033
Contact: David Reyes, 1317 Eagle Vista Dr, Los Angeles, CA 90041, 323-206-0031, ca.sastateassembly@gmail.com
CE Credits: 8 Live Planned

COLORADO/WYOMING STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 11, 2025
Title: Annual Business Meeting, Elections and Workshop
Location: Intermountain Health Platte Valley Hospital, 1600 Prairie Center Pkwy, Brighton, CO 80601
Contact: Julie Beard, 720-256-5863, jbeard2650@gmail.com
CE Credits: 5 Live Planned

CONNECTICUT STATE ASSEMBLY

Program Type: Workshop
Date: November 1, 2025
Title: My Neck My Back
Location: Norwalk Hospital, 34 Maple St, Norwalk, CT 06856
Contact: Sharkia Bookert, PO Box 581, Monroe, CT 06468, 203-503-7900, bookertsharkia@yahoo.com
CE Credits: 6 Live Planned

FLORIDA STATE ASSEMBLY

Program Type: Workshop
Date: February 28, 2026
Title: Spring into 2026!
Location: St. Joseph's Hospital, 3001 W Dr Martin Luther King Jr Blvd, Tampa, FL 33607
Contact: Stephanie Hurst, flsastateassembly@gmail.com
CE Credits: 8 Live Planned

GEORGIA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: March 14, 2026
Title: Spring Forward: Advancing Surgical Technology Education
Registration: ast-gasa.com/spring-2026-meeting
Location: Chattahoochee Technical College - North Metro Campus, 5198 Ross Road SE, Acworth, GA 30102
Contact: Erin Baggett, PO Box 109, Auburn, GA 30011, 678-226-6943, gasawebmaster@gmail.com
CE Credits: 7 Live Planned

ILLINOIS STATE ASSEMBLY

Program Type: Workshop
Date: October 11, 2025
Registration: https://www.illinoisstateassembly.com/events.html
Title: Honoring the Legacy, Transforming Tomorrow
Location: Malcolm X College, 1900 W Jackson Blvd, Chicago, IL 60612
Contact: Sonya Conton, 5407 North University Cedar Hall C105J, Peoria, IL 61653, 309-690-7568, sonya.conton@icc.edu
CE Credits: 6 Live Planned

IOWA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 18, 2025
Title: IASA Fall Business Meeting and Workshop
Registration: ia.ast.org
Location: Mary Greeley Medical Center, 1111 Duff Ave, Ames, IA 50010
Contact: Tim Danico, 319-540-6008, timothy-danico@uiowa.edu
CE Credits: 7 Live Planned

KANSAS STATE ASSEMBLY

Program Type: Workshop & Webinar (webinar approved only for Kansas State Assembly members)
Date: October 4, 2025
Title: Annual Fall Workshop
Location: WSU Tech, 3821 E Harry St, Wichita, KS 67218
Contact: Melanie Meyer, 785-550-4101, ks.st.assembly@gmail.com
CE Credits: 4 Live Planned

MAINE STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 18, 2025
Title: ME-SA Fall Conference and Business Meeting
Location: Northern Light Mercy Hospital, 175 Fore River Parkway, Portland, ME 04102
Contact: Brittany Babb, 1298 Cape Rd, Limington, ME 04049, 910-477-1559, bnvbabb@gmail.com
CE Credits: 6 Live Planned

MARYLAND/DELAWARE STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 11, 2025
Title: Maryland and Delaware Fall Workshop, Business Meeting, and Elections
Location: University of Maryland Medical Center-Midtown Campus, 827 Linden Ave, Baltimore, MD 21201
Contact: Charmaine Miller, 410-818-8208, mddestateassembly@gmail.com
CE Credits: 5 Live approved by AST

MASSACHUSETTS STATE ASSEMBLY

Program Type: Webinar (approved only for Massachusetts State Assembly members)
Date: October 25, 2025
Title: F.A.L.L. 2025
Contact: Kristen Urbanek, 617-257-5384, mastateassembly@gmail.com
CE Credits: 4 Live Planned

MONTANA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 4, 2025
Title: Montana State Assembly of AST Fall Conference and Workshop
Registration: mt.ast.org
Location: Intermountain Health St. Vincent Regional Hospital, 1233 N 30th St, Billings, MT 59101
Contact: Megan Ellman, PO Box 1513, Columbia Falls, MT 59912, 406-471-1363, meganrellman@gmail.com
CE Credits: 6 Live Planned

NEW HAMPSHIRE/VERMONT STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 4, 2025
Title: NH/VT AST Fall Conference
Location: Elliot Hospital, 1 Elliot Way, Manchester, NH 03103
Contact: Lynn Jones, 603-370-1489, lmwhitney76@gmail.com
CE Credits: 6 Live Planned

NEW YORK STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 3-5, 2025
Title: 2025 NYAST Conference, Business Meeting, and Elections
Location: Renaissance Albany Hotel, 144 State St, Albany, NY 12207
Contact: Alisia Pooley, 315-575-0403, boardnyast@gmail.com
CE Credits: 12 Live Planned

NORTH CAROLINA STATE ASSEMBLY

Program Type: Workshop
Date: October 4, 2025
Title: Elevating Excellence
Location: Arthrex Tricoast Facility, 703 Slater Road, Morrisville, NC 27560
Contact: Christine Anderson, 919-798-8755, ncsaast@gmail.com
CE Credits: 7 Live Planned

NORTH DAKOTA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 18, 2025
Title: NDSA 2025 Workshop & Elections
Location: Dakota Medical Foundation, 4321 20th Ave S, Fargo, ND 58103
Contact: Emily White, 701-202-5779, esmallbeck27@gmail.com
CE Credits: 6 Live Planned

OHIO STATE ASSEMBLY

Program Type: Webinar (approved only for Ohio State Assembly members)
Date: October 11, 2025
Title: Ohio Fall Webinar
Registration: oh.ast.org
Contact: Heather Buchan, 614-551-6276, ohioast@gmail.com
CE Credits: 4 Live Planned

OKLAHOMA STATE ASSEMBLY

Program Type: Workshop
Date: October 4, 2025
Title: Spring Conference
Location: Tulsa Technology Center, 3420 S Memorial Dr, Tulsa, OK 74145
Contact: Rochelle Lewis, 918-772-8002, rochelle-lewis@cherokee.org
CE Credits: 5 Live Planned

OREGON STATE ASSEMBLY

Program Type: Workshop
Date: October 18, 2025
Title: 2025 OAST Fall Conference
Registration: or.ast.org
Location: Doernbecher Children's Hospital, 700 SW Campus Dr, Portland, OR 97239
Contact: Jeffrey Rebo, 406-291-7220, jeffreyrebo.oast@gmail.com
CE Credits: 6 Live Planned

RHODE ISLAND STATE ASSEMBLY

Program Type: Reformation Meeting/Elections
Date: October 4, 2025
Title: Advancing Technology in Surgery
Location: New England Institute of Technology, 1 New England Tech Blvd, East Greenwich, RI 02818
Contact: Christine Madeira, 401-474-7892, rhodeislandast@gmail.com
CE Credits: 4 Live approved by AST

SOUTH CAROLINA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: November 1-2, 2025
Title: SCSA Fall Business Meeting and Workshop
Registration: scsaast.org
Location: Southeastern Institute of Manufacturing Technology (SIMT Building), 1951 Pisgah Road, Florence, SC 29501
Contact: Katrina Williams, 843-615-7454, katrinawilliams89@yahoo.com
CE Credits: 12 Live Planned

SOUTH DAKOTA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 17-18, 2025
Title: SDSA Fall 2025 Conference & Elections
Location: Western Dakota Technical College, 800 Mickelson Dr, Rapid City, SD 57703
Contact: Krista Hagemann, 605-718-2917, krista.hagemann@wdt.edu
CE Credits: 9 Live Planned

TENNESSEE STATE ASSEMBLY

Program Type: Workshop
Date: October 4, 2025
Title: Wild Wild West Regional
Location: West Tennessee Healthcare Jackson-Madison, 620 Skyline Dr, Jackson, TN 38301
Contact: Ellen Wood, 1344 Copperstone Lane, Knoxville, TN 37922, 865-283-5901, ellenwoodtnast@gmail.com
CE Credits: 6 Live Planned

Program Type: Workshop Cruise
Date: October 2-5, 2026
Title: CE's at SEA
Location: Carnival Glory, 1492 Charles M. Rowland Dr, Cape Canaveral, FL 32920
Contact: Ellen Wood, 1344 Copperstone Lane, Knoxville, TN 37922, 865-283-5901, ellenwoodtnast@gmail.com
CE Credits: 6 Live Planned

TEXAS STATE ASSEMBLY

Program Type: Workshop
Date: October 4, 2025
Title: Odessa Workshop
Registration: texasstateassembly.org
Location: Odessa College Simulation Hospital, 201 University Blvd, Odessa, TX 79764
Contact: Jaime Lopez, 432-638-2269, djj-aimelopez@yahoo.com
CE Credits: 8 Live approved by AST

UTAH STATE ASSEMBLY

Program Type: Workshop
Date: October 18, 2025
Title: Back to the Bone: Strengthening our Surgical Core
Location: Intermountain Health: Foremaster Building, 1424 Foremaster Dr, St George, UT 84770
Contact: Heather Osness, 435-215-1060, heather.osness@utahtech.edu
CE Credits: 4 Live Planned

VIRGINIA STATE ASSEMBLY

Program Type: Workshop
Date: October 25, 2025
Title: VCSA Fall CE Workshop - All About Pediatrics
Location: Children's Hospital of the King Daughters- Children's Pavilion, 401 Gresham Dr, Norfolk, VA 23507
Contact: Rebecca Schultheis, 757-202-9962, virginiastateassemblyofast@gmail.com
CE Credits: 7 Live Planned

WASHINGTON STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 11-12, 2025
Title: Fall Workshop and Annual Business Meeting
Location: Spokane Community College, 1810 N Greene St, Spokane, WA 99217
Contact: Eugene LeRoy, PO Box 55153, Seattle, WA 98155, 903-453-4738, gene.leroy.wsa@lebbrin.com
CE Credits: 8 Live Planned

WEST VIRGINIA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 18, 2025
Title: 2025 West Virginia AST Fall Workshop and Business Meeting
Location: WVU Reynolds Memorial Hospital, 800 Wheeling Ave, Glen Dale, WV 26038
Contact: Erin Carr, 304-214-8930, ecarr@wvncc.edu
CE Credits: 6 Live Planned

STATE ASSEMBLY ANNUAL BUSINESS MEETINGS

Members interested in the election of officers & the business issues of their state assembly should ensure their attendance at the following meetings.

ARKANSAS
Fort Smith
October 4, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

CALIFORNIA
Los Angeles
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

COLORADO/WYOMING
Brighton
October 11, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

GEORGIA
Acworth
March 14, 2026
Annual Meeting
2026 BOD Elections
& 2026 Delegate
Elections

IOWA
Ames
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

MAINE
Portland
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

MARYLAND/DELAWARE
Baltimore
October 11, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

MONTANA
Billings
October 4, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

NEW HAMPSHIRE/VERMONT
Manchester
October 4, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

NEW YORK
Albany
October 3-5, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

NORTH DAKOTA
Fargo
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

RHODE ISLAND
East Greenwich
October 4, 2025
Reformation
Meeting & Elections
2025 BOD Elections
& 2026 Delegate
Elections

SOUTH CAROLINA
Florence
November 1-2, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

SOUTH DAKOTA
Rapid City
October 17-18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

WASHINGTON
Spokane
October 11-12, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

WEST VIRGINIA
Glen Dale
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

Program Approvals: Submit the *State Assembly Program Date Request Form A1* no less than 120 days prior to the date(s) of the program for AST approval. The form must be received prior to first (1st) of the current month for program publication in the next month of the AST monthly journal *The Surgical Technologist*. The *Application for State Assembly CE Program Approval A2* must be received at least thirty (30) days prior to the date(s) of the program for continuing education credit approval. An application submitted post-program will not be accepted; no program is granted approval retroactively.

Contact stateassembly@ast.org or 800.637.7433, ext. 2547.

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- The Workforce Shortage: A Message from AST
- Turning the Workforce Chute into a Ladder
- CSTs Many Lifesaving Roles
- Education and Certification as an Appropriate Minimum
- Standard for Surgical Technology and Patient Safety
- AST Position Statement on Minimum Education for Surgical Technologists
- AST Position Statement on Accreditation, Certification, Official Title of the Profession, and OJT Training
- ACS Statement Supporting Surgical Technology Accredited Education and the CST
- AORN Job Description Supporting Surgical Technology Accredited Education and the CST
- AST Encourages Healthcare Facility Leaders to Support Local, Accredited Surgical Technology Educational Programs
- AST Recommendations for CSTs, Program Directors, and State Assemblies when Addressing OTH Training with a Healthcare Facility
- Message to Surgical Technology Program Directors Regarding Alternative Certification Credentials from the AST, ARC/STSA, and NBSTSA
- Should Healthcare Facilities Require CST Certification for Surgical Technologists? Yes...Here's Why

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