



# CardioVISION™

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SPRING 2011



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ASSOCIATION OF PHYSICIAN ASSISTANTS IN CARDIOVASCULAR SURGERY

**EDITOR-IN CHIEF**  
**Doug Condit, PA-C**

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**MISSION & CONTENT**

The mission of *CardioVISION™* is to provide a means of communicating pertinent information among practitioners of the specialty and among related professionals in the medical field and industry. *CardioVISION™* is a peer-reviewed quarterly journal that includes articles on practice issues, credentialing issues, educational opportunities, and more. *CardioVISION™* also includes classified job ads and industry advertisements.

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## PRESIDENT'S MESSAGE

By Jonathan Sobel, PA-C, FAPACVS



This past January, the Association of Physician Assistants in Cardiovascular Surgery (APACVS) held its Annual Winter meeting in San Diego, CA. This was a special meeting for our organization, as it was our 30th Anniversary. In thinking about who I should invite to be our keynote speaker, I wanted someone who could provide a historical perspective, had a long experience working alongside Cardiovascular PAs, had been a pioneer in the field, and was an advocate for our profession. It did not take long to decide on Dr. Robert Guyton. Dr. Guyton had been working with PAs at Emory for over thirty years, was a national leader amongst CV surgeons having served as the President of the Society of Thoracic Surgeons, and has been a strong advocate for our profession as evidenced by the speed in which he accepted the invitation. Many of you may recall the outstanding testimonial that he provided during interviews for the APACVS promotional video that can be viewed from our website [www.apacvs.org](http://www.apacvs.org).

Our attendees were treated to an entertaining and emotional journey during which Dr. Guyton demonstrated the unique interdependence between CV surgeons and their PA partners.

Utilizing an enchanting vignette of a fictitious patient “Mr. Malone,” Dr. Guyton revealed his understanding of how we share the same passion, dedication and love for our specialty and for our patients. For those who were not able to join us, please take advantage of the webcast of Dr. Guyton’s speech: <http://www.webcastregister.com/apacvs>

This love and dedication to our work and this passion that we feel is what drives us to work the insane hours, to enhance our knowledge and skills base, to share what we have learned with our students, and to strive for continuous improvement. Many of us have been practicing long enough to recall the recurring discussion on an appropriate name for our profession. As illustrated by Dr. Guyton, and felt by so many of us, what we share with our Physician partners goes far beyond the role of an “Assistant.” Some even graduated from “Physician Associate” programs only to see the name of the profession later change to “Physician Assistant” in response to various pressures at the time.

There are many excellent points on both sides of the argument over a name change, as there have been in the past. The discussion was recently started again via an open letter to the profession from over 50 leaders in the field lending their personal support for the term “Physician Associate”. After initially signing on, I was asked if our organization would come out in support of a name change, and thus a survey of the membership was in order. After providing web links to information on the debate, two questions were posed and approximately 38% of the membership responded.

“Do you support changing the name of our profession to ‘Physician Associate?’” had 261 respondents of which 49.8% said Yes, and 50.2% said No. “Should APACVS as a society support changing the name of the profession from Physician Assistant to Physician Associate?” had 261 respondents of which 50.2% said Yes, and 49.8% said No. At first glance, the membership appeared evenly split. However, the survey also allowed free text commentary which provided greater insight. There were 64 members who took the time to write lengthy comments and of these 70% were clearly opposed to a name change and to dedicating organizational resources toward such an endeavor. A few of the comments stood out and caused me to re-evaluate my thinking. One member wrote, “While I do support the name change, I think that this is not the correct time. As NP’s are attempting to become independent, I would not want our physician colleagues to associate our name change with a quest for independent practice.” Another wrote, “We currently have a profession that is well respected and accepted by the medical community as a whole. I have heard grumbings from Physicians time and again, about Nurse Practitioners wanting to be completely independent practitioners...I don’t want our profession to become part of that whole conversation...Come on, lets continue to focus on patient care.”

Indeed there has been a call from advanced practice nurses to broaden their role and scope of practice as the U.S. healthcare delivery model evolves. Fairman et al, in a Perspectives article appearing this past January in the NEJM wrote “Fighting the expansion of nurse practitioners’ scope of practice is no longer a defensible strategy. The challenge will be for all health care professionals to embrace these changes and come together to improve U.S. health care.”<sup>(1)</sup> The authors cite the recommendations from a 2010 report from Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine which as one of its conclusions stated, “The U.S. is transforming its health care system to provide quality care leading to improved health outcomes, and nurses can and should play a significant role. The current conflicts between what APRNs (Advanced Practice Registered Nurses) can do based on their education and training and what they may do according

*Continued on page 4*

to state and federal regulations must be resolved so that they are better able to provide seamless, affordable, and quality care.”<sup>(2)</sup>

The position taken by physician societies lends credence to our APACVS members’ concerns. In their response to the IOM committee’s report, the Council of Medical Specialty Societies (CMSS) representing 34 societies with an aggregate membership of over 650,000 U.S. physicians expressed its concerns over the wisdom of expanding nursing scope of practice. “CMSS is concerned that the IOM report advocates for an expanded scope of nursing practice without specifying the standard minimum amount of supervised clinical experience and documented clinical competency that must be achieved before an APN (Advanced Practice Nurse) would be permitted to treat and prescribe without physician guidance.”<sup>(3)</sup> This formal response from CMSS goes on to discuss several additional concerns with the IOM report, and is clear evidence that the physician response goes far beyond mere grumblings.

I had invited Patrick Killen, President of the American Academy of Physician Assistants (AAPA) to speak to the APACVS Board of Directors. Pat also agreed to address our membership on Friday morning, and he had the opportunity to interact with many of our members during the 30th Anniversary weekend. I asked Pat to talk about the AAPA’s response to the IOM report and the NEJM article calling for enhanced scope of practice for Advanced Practice Nurses. Pat detailed how the AAPA approach has been to work with physician organizations such as the American College of Physicians and the American Academy of Family Physicians to develop joint policy statements endorsing the physician-PA team as a proven model for delivering high quality affordable care.<sup>(4)(5)</sup>

When putting it all together, it becomes obvious through Dr. Guyton’s highlighting of our professional alignment and shared passion, the stated concerns of our members in our survey, and the collaborative approach that the AAPA is taking in working with the physician organizations, that all share a commonality in enhancing the concept of PA and physician partnership. Attempting to change the name of our profession, despite all of the good reasons and intentions, is counter to this line of thinking, and should not be presently undertaken. Rather, we should listen to the advice of our anonymous member and “continue to focus on patient care”.

One area where we can have significant impact is in the arena of patient safety. As liaisons between patients, families, nurses, physicians, and administrators, we are truly in a unique position to affect outcomes. Please read our Board Member, Summer Critical Care CME Chairman, and Facebook Editor, Dave Bunnell’s thoughtful and well written commentary on understanding, treating and preventing hospital complications, in this issue of CardioVISION. Checklists and safety tools have been demonstrated to catch errors before they reach the patient, but ensuring that everyone on the team is consistently following the procedures is the more difficult task.

As PA’s, we can play an instrumental role in helping to develop a culture of safety in our organizations. We must aim to foster a work environment where all members of the team are able to communicate confidently when something, anything, is in need of correction. An environment where the opinions of all on the team are as important as anyone else’s and there are no fears of repercussion. Where individuals are recognized for speaking up, and held accountable if they do not. Communication failures are still found to be at the root cause of the majority of adverse events, and we must be integral and courageous in fixing this shortcoming. Working in critical care units and operating rooms, APACVS members practice in arenas with ever increasing complexity, where each patient is unique, and pitfalls abound. We therefore must dedicate ourselves not only to creating safer systems, but to optimizing the communication between the people who work within our organizations toward our common goal of improving the lives of others.

Professionally,

Jonathan

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<sup>1</sup> Julie A. Fairman, Ph.D., R.N., John W. Rowe, M.D., Susan Hassmiller, Ph.D., R.N., and Donna E. Shalala, Ph.D. Broadening the Scope of Nursing Practice *N Engl J Med* 2011; 364:193-196 January 20, 2011

<sup>2</sup> Institute of Medicine. *The future of nursing: leading change, advancing health*. Washington,DC: National Academies Press, 2010.

<sup>3</sup> [http://www.cmss.org/uploadedFiles/Site/CMSS\\_Policies/IOM%20FON%20Report%20CMSS%20Response.pdf](http://www.cmss.org/uploadedFiles/Site/CMSS_Policies/IOM%20FON%20Report%20CMSS%20Response.pdf). Accessed on 1/20/11

<sup>4</sup> American College of Physicians. *Internists and Physician Assistants: Team-Based Primary Care*. Philadelphia: American College of Physicians; 2009: Policy Monograph. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

<sup>5</sup> [http://www.aapa.org/images/stories/Advocacy-Joint-Policies/AAFP\\_Joint\\_Paper.pdf](http://www.aapa.org/images/stories/Advocacy-Joint-Policies/AAFP_Joint_Paper.pdf) Accessed on 4/10/11

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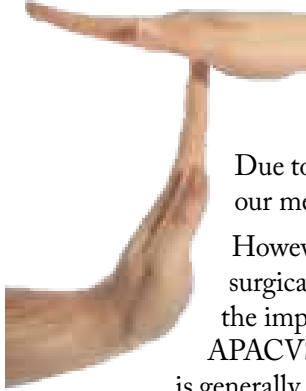
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## “TIME OUT” IN THE OPERATING ROOM



The APACVS annually surveys our membership regarding their salary, benefits and clinical responsibilities. This survey results in an annual publication which is the number one publication requested from the APACVS. It has proven invaluable to numerous CVT PAs in obtaining satisfactory salary reimbursement and benefits. Additionally, data from these surveys have been utilized in the defense of CVT PAs in medical malpractice suits.

Due to the annual distribution of this comprehensive survey, the APACVS has hesitated about surveying our membership outside of the annual event.

However, during the year, numerous hospitals began instituting a “time out” at the beginning of every surgical procedure. Since CVT PAs often begin a surgical procedure prior to the arrival of a surgeon. With the implementation of the “time out,” this practice was abruptly curtailed at numerous institutions. Many APACVS members placed frantic calls to the APACVS National Office and/or sent emails (since the office is generally not available to take PAs calls at 3am) asking: “what are other practices utilizing CVT PAs doing?”

In an attempt to provide a rapid response to this question, the APACVS sent an email to all of our members with two questions:

- 1. In your practice setting, are PA’s permitted to conduct the pre-operative time out and open the chest without the surgeon or CT resident being physically in the operative suite?**
- 2. Does a surgeon or CT resident have to do the time out before the chest can be opened because they are deemed qualified to place the patient on bypass?**

The APACVS was pleasantly surprised that 393 APACVS members responded to this question in a timely manner. The results reveal:

- 1. In your practice setting, are PA’s permitted to conduct the pre-operative time out and open the chest without the surgeon or CT resident being physically in the operative suite?**

Response	Percent	Count
Yes	16.5%	65
<b>No</b>	<b>83.5%</b>	<b>328</b>
Other (please specify)	56	
<b>answered question</b>	<b>393</b>	
<b>skipped question</b>	<b>0</b>	

The 56 ‘other’ responses were interesting: In some cases the surgeon could do the ‘time out’ via a speaker-phone. In others the PA would do a “time out” and begin harvesting the saphenous vein and when the surgeon entered the operating room, another time out would be performed prior to the surgeon performing the sternotomy. One PA noted that the PA could perform the ‘time out’ at one hospital but not another.

- 2. Does a surgeon or CT resident have to do the time out before the chest can be opened because they are deemed qualified to place the patient on bypass?**

Response	Percent	Count
<b>Yes</b>	<b>65.1%</b>	<b>256</b>
No	34.9%	137
Other (please specify)	70	
<b>answered question</b>	<b>393</b>	
<b>skipped question</b>	<b>0</b>	

Many of the ‘other’ responses were that the PA never performed the mediansternotomy at the individual PAs practice.

## APACVS BOARD MEETING



*JoAnn Montecalvo, PA-C & Sid Lavender, PA-C*



*Jonathan Sobel, PA-C & David Lizotte PA-C*



*Jonathan Sobel, PA-C & AAPA President, Patrick Killen, PA-C*

The APACVS Board of Directors held a meeting in San Diego, California, one day prior to the APACVS 30th Annual Educational Meeting.

After introduction of the new Board members, the Board began a full day of work! APACVS members will be pleased to know that, despite the recession, the APACVS remains in good financial shape. However, concern was voiced, that possibly do to the fact that individuals are watching their expenses a bit more closely, membership renewals are a bit slow this year. The Board encouraged all APACVS members to encourage their peers to join the association, which is the sole organization which represents the interests of PAs in Cardiovascular and Thoracic Surgery.

The Board received an update on Title 22 in California from former Board member Edward A. Ranzenbach, PA-C, who is currently working on this issue in conjunction with the California STS. Currently, instead of seeking to change the California Rules & Regulations, which require the first assistant on all cardiac cases which are performed utilizing cardiopulmonary bypass to be a physician, the plan is to try and seek "exemptions" from such rules whenever a qualified PA is available. Such an exemption to similar rules and regulations were successfully obtained in New York State, which the APACVS worked hand-in-glove with the New York State Society of Physician Assistants to obtain. During this past year, Ed has worked tirelessly to perform an evaluation of outcomes of cardiac surgical procedures where the first assistant was a CVT PA, compared with cardiac surgical procedures where the first assistant was a physician. Ed has compiled the data, prepared a paper and is currently in the process of having it published in a medical journal. The Board thanked Ed for his efforts on behalf of CVT PAs practicing in California.

APACVS Leadership Fellows Michael Nowak and David Bunnell (who were both elected to positions on the Board) presented the results of their projects to the Board.

AAPA President Patrick E. Killeen, PA-C met with the APACVS Board in the afternoon. He brought greetings to the APACVS from the AAPA and assured the Board that the AAPA was interested in working in concert with the APACVS on issues affecting the PA community. Killeen stayed at the APACVS meeting to participate in a Town Hall with the APACVS membership and to enjoy the APACVS 30th Anniversary Banquet.

The Board reviewed the agenda for the January Educational Meeting and were indeed pleased. The Board also reviewed the plans forthcoming APACVS summer critical care meeting at the Gaylord National Resort & Convention Center, in National Harbor, MD.

The Board made plans for the upcoming joint meeting with the STS Board.

As a reminder to all APACVS members, your board members are practicing PAs, and take time away from their practices and families to participate in all Board activities. As most PA organizations, we are proud to have an all-volunteer Board.

## CARDIOVISION™ WANTS YOU!



Have you had an ‘interesting case,’ lately, which sent you to the local medical library or the internet? Have you given a recent lecture to PA students, or to nurses taking care of CVT patients? Have you recently written a ‘thesis’ as part of a PA Masters program? If you can answer yes to any of these questions, the APACVS would greatly appreciate it if you would share your expertise with your peers.

The APACVS will be including more clinical articles in *CardioVISION™*, IF and only IF you supply them. During the past two years, we have only published two clinical articles, as, to be perfectly honest, that is all we have received. Of course, we have not previously solicited clinical material from our members.

If you would like to become published in *CardioVISION™*, we’d love to hear from you!

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## MORE CME CREDIT

APACVS members who attended the 30th Annual Educational Meeting, held recently in San Diego, California are encouraged to log ALL of the CME which they attended.

In addition to the *20 hours of Category 1 CME Credit(s)™* for which attendees received a certificate, PA’s who attended luncheon sessions or evening sessions are entitled to log *Category II CME Credit(s)™* for those sessions. Educational sessions, in which the sponsor selects the speaker(s) are not eligible to receive Category 1 certification. However, PAs participating in these educational sessions may log them for Category II credit.

The National Commission on Certification of Physician Assistants requires PAs to log 100 hours of CME every two years; 50 hours of which must be category 1. Therefore, 50 hours of mandated CME may be Category II.

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## PHYSICIAN ASSISTANT VERSUS PHYSICIAN ASSOCIATE

In 2010, there was a surge in discussion of rebranding the PA profession. We covered the pro and con arguments in the Summer 2010 issue of *CardioVISION*. At the request of some of our members, we surveyed our membership to determine their views on this topic and to ask for guidance for the APACVS Board of Directors; specifically “Should APACVS as a society support changing the name of the profession from Physician Assistant to Physician Associate?”

The first interesting result of this survey was that despite the fact that 393 APACVS members responded to our survey regarding the O.R. “Time Out,” only 216 APACVS members responded to this survey. Consequently, a significant number of APACVS members did not think that this topic was important enough to respond to.

The second result of this survey is that of the members responding to the question, 49.8% (130) felt that the name ‘assistant’ should be changed to ‘associate’ while 50.2% felt that the name should not be changed.

The APACVS Board of Directors wants to thank the APACVS membership for providing guidance with this issue. At this point in time, the APACVS Board will not devote Association time or resources to support the change of our professional name from physician assistant to physician associate.

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## WHY UNDERSTANDING, PREVENTING, AND TREATING HOSPITAL COMPLICATIONS MATTERS

*David J. Bunnell, MSHS, PA-C*

The Institute for Healthcare Improvement (IHI) defines medical harm as:

Unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment or hospitalization, or that results in death. Such injury is considered harm whether or not it is considered preventable, resulted from a medical error, or occurred within a hospital.<sup>1</sup>

The IHI estimates that this type of harm currently happens at a rate of 40,000 occurrences per day in US hospitals. <sup>(1)</sup> This independent, non-profit organization collaborates with hospitals to study and improve quality for patients. You may have noticed their efforts related to the Surgical Care Improvement Project. If you are being encouraged to start and stop antibiotics in a timely fashion, clip hair before surgery, and control blood sugar, then you are already feeling the effects of these projects.

When I talk with families in the ICU after an operation, I often say that my job is to protect their loved one until they are strong enough to defend themselves. PAs in Cardiothoracic Surgery and Critical Care are on the front lines of preventing and treating hospital complications. Our job as defenders against the bad things that can happen to good patients come to us as part of a public trust. We have the privilege to be at the bedside during the most difficult time of someone's life. Any event that involves a median sternotomy or thoracotomy will likely be a notable event when their biography is written. I would like to make sure that the story involves a happy ending.

There are tools on a public level to encourage our profession to prevent complications. The Centers for Medicare and Medicaid Services has identified events so detrimental that they should not only be avoided but instead that they should never happen. For many, these "Never Events" carry financial consequences.

There are several registries that publicly report hospital outcomes. The public reporting of Cardiac Surgery data in New York is widely known and discussed in the surgical community. The Department of Veterans Affairs has published hospital system quality data so that they can be accountable to veterans and taxpayers. The Society of Thoracic Surgeons has taken the innovative step in encouraging surgical groups to be evaluated by Consumer Reports so that good quality can be promoted.

However, these efforts are based on an organization being called out and embarrassed in public for having too many Never Events, having poor quality reported on a public database, or having a "one star" cardiac surgery program. These sticks can be effective, and sadly, needed in the effort to protect patients but they do not respond to the higher calling that we all answered when we dedicated ourselves to caring for people. None of us sat in an admissions interview proclaiming our desire to look good and avoid pain. We wanted to help people.

It has crossed my mind that it is one thing to be the person that realizes that keeping the head of an intubated patient's bed elevated to 30 degrees prevents pneumonia. The person that documents and educates the world about this strategy becomes a leader in patient safety. The person who actually ensures that this is accomplished is in for a harder time. Policing the ICU, encouraging staff, and documenting patient safety efforts can be difficult and often thankless work. Knowing the right thing to do is the easy part. Doing the right thing requires effort.

There are tools and information available for providers who want to make a difference. The Agency for Healthcare Research and Quality is dedicated to improving quality, safety, effectiveness, and efficiency of healthcare. <sup>(2)</sup> They fund research and disseminate the information on-line at [AHRQ.gov](http://AHRQ.gov). There is an ongoing effort to reach clinicians, patients, researchers, policy makers, and payers.

Check lists have gained notoriety during the past decade. Peter Pronovost's work on critical care and hospital safety and Atule Gawande's book "The Checklist Manifesto" with discussions about safety in the operative suite are notable examples. A widely adopted intervention described in the New England Journal of Medicine is the use of checklists and standardized procedures for the placement of central venous catheters. <sup>(3)</sup> The Centers for Disease Control and Preven-



*Continued on page 10*

tion recently released data comparing 2001 levels of central line associated blood stream infections to the data from 2009. These efforts had the striking result of decreasing this problem by 58% for an actual number of 25,000 fewer complications.<sup>(4)</sup> This is not useless busy work. This is action that you can take to make a difference for your patients.

Understanding, preventing, and treating hospital complications matters because they are common and can be devastating. It matters because thoughtful study and practice of patient safety literally saves millions of lives. It matters because I may be able to protect your loved ones and you may be able to protect mine. It may be something as dramatic as recognizing a potential wrong site surgery or as subtle as raising the head of the bed to 30 degrees. So educate yourself, pay attention, and speak up.

David is a Physician Assistant at the Washington DC VA Medical Center in Cardiothoracic Surgery. He is an APACVS Board Member, CME Committee Member, and Speaker Chairperson for the Summer 2011 Critical Care Conference.

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### APACVS MEMBER OPERATING IN PERU

APACVS member Isaac Hammond, PA in pediatric Cardiothoracic Surgery at Children's Hospital at Montefiore (CHAM) recently participated in a medical mission to INSTITUTO NACIONAL DE SALUD DEL NIÑO in Lima, Peru. The mission was organized under the auspices of Heart Care International. Surgeons Dr. Robert E. Michler, the Chairman of Cardiovascular and Thoracic Surgery and the Chairman of Surgery at Montefiore Medical Center/Albert Einstein College of Medicine and Dr. Sam Weinstein, Director of Pediatric Cardiothoracic Surgery at CHAM accompanied Hammond on this mission.

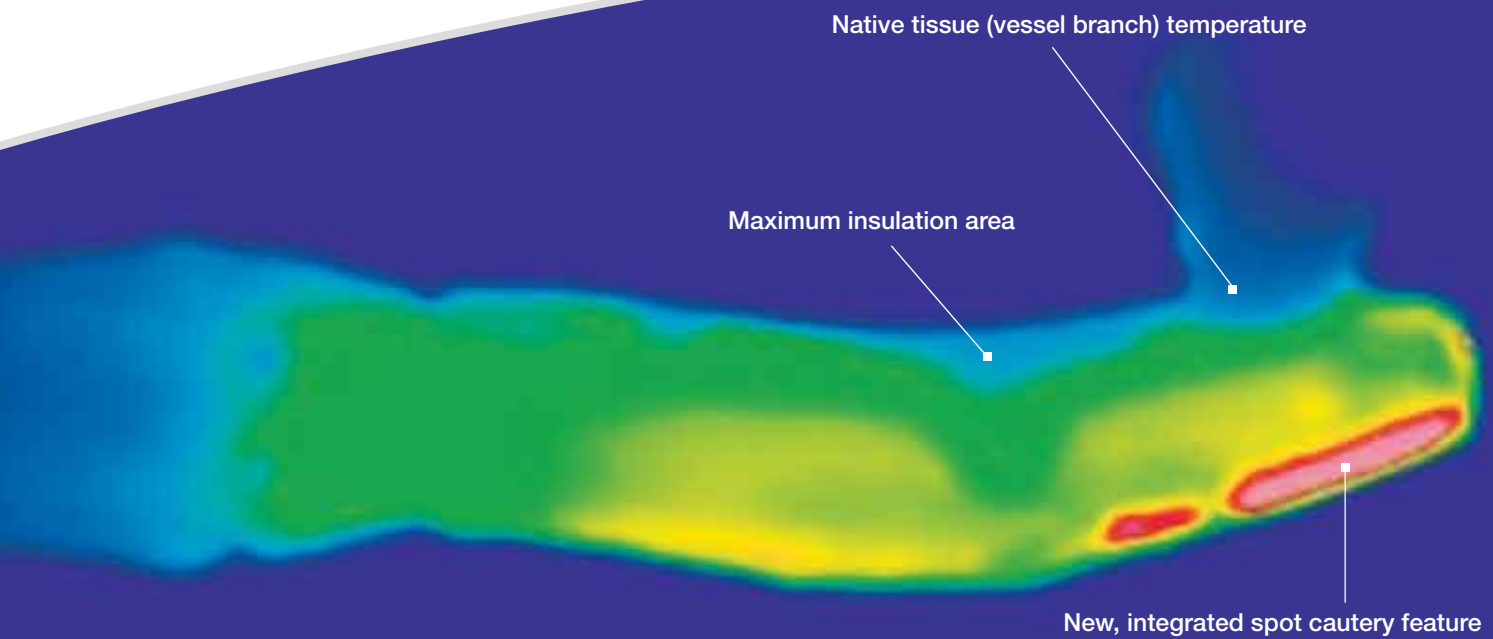
This was the first mission to Peru for Heart Care International. Hammond reports that since there are cardiac surgeons in Peru, this was more of an educational mission than others he has participated in and involved surgery and care of patients with higher acuity than he has encountered in previous missions

Issac noted that due to his participation in previous medical missions to Latin America countries, his use of Spanish in the operating rooms and when dealing with patients and staff in the hospital has greatly improved. He also noted that "The Food was outstanding, Had some amazing Ceviche' (still not as good as Chico's in San Salvador though)." He also said that he was able to bring home "some insane new recipes for Antichichos and Cebiches."

While medical missions are designed to provide sophisticated cardiac care to children with cardiac diseases, it is obvious that these missions also bring true enrichment to the lives of the PAs who participate in them.



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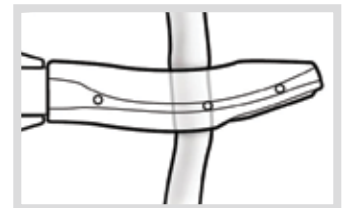
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*Illustration showing vessel branch transection as represented in image above*

## FIRST ANNUAL APACVS ADVOCACY DAY: SPEAK FOR THE PROFESSION ON CAPITOL HILL AND EARN CME



APACVS, in partnership with AAPA, is pleased to offer a powerful new opportunity to PAs in cardiovascular surgery attending the Summer CME meeting in Washington, DC: the 2011 **Advocacy Boot Camp and Capitol Hill Day**.

The APACVS Advocacy Day is an exciting and ambitious collaboration between AAPA and APACVS. Starting in 2010, all PAs and PA organizations meeting in Washington DC are being asked to take part in advocacy activities on Capitol Hill. Facilitated and funded by AAPA, this new initiative seeks to harness the power of PAs delivering a unified message “en mass” to Congress while PAs are in town for meetings with specialty or constituent organizations or as AAPA volunteers.

The 2011 APACVS Capitol Hill Day begins at 1:00 pm on Tuesday June 21. We will meet at the Gaylord National Harbor with a fast-paced interactive “advocacy boot camp” training session designed to increase grassroots lobbying skills, refine the message, and provide training on the elements of a successful meeting with elected officials and congressional staff members. Then, from 3:00 – 5:30 pm, participants will join forces with PAs from across the country in conducting face-to-face meetings with Members of Congress and staff on the key legislative issues that directly affect patients and the future of the profession.

AAPA is providing logistical support, advocacy training, background on the legislative issues, materials, and even get you to and from Capitol Hill. Additionally, up to 5 Category 1 CME credits will be awarded for participation in the Advocacy Boot Camp and hill visits.

Novice and seasoned advocates alike will benefit from the **APACVS Capitol Hill Day**. Make an impact - speak for the profession.

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## NCCPA SPECIALTY CREDENTIAL FOR CVT SURGERY PAS



In the Winter 2011 issue of CardioVISION, Janet J. Lathrop, MBA, President/CEO of the National Commission on Certification of Physician Assistants (NCCPA) was kind enough to provide APACVS members with an overview of the new specialty credential for CVT surgery PAs.

The NCCPA had an exhibit at the 30th APACVS Annual Educational meeting to answer any questions APACVS members might have regarding the specialty credential.

In order to keep expenses at a minimum, the Specialty examination will only be administered once in 2011, on September 12th. In her article, Janet informed us that “the exam will include 120 multiple-choice questions based on what CVT surgery PAs told us when they completed our recent PA Practice Analysis survey.”

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## APACVS SCHOLARSHIP AWARDED

The PAs in Cardiovascular Education is proud to announce the 2011 scholarship recipient Jasmine Kettley, PA. Congratulations to Jasmine Kettley, PA from the PAs in Cardiovascular Education and the APACVS.

The PAs in Cardiovascular Education is a nonprofit association for the betterment of PAs in cardiovascular surgery. All contributions are tax deductible. Contributions can be sent to the APACVS office.



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## APACVS BOARD MEETS WITH STS BOARD



*Doug Mathisen, MD  
& Jonathan Sobel, PA-C*



*Damon Marquis  
& Carol Goddard*

During the 30th Annual APACVS Meeting, held recently in San Diego, California, the APACVS Board of Directors met with representatives of the STS Board of Directors and staff of the STS.

Joining the APACVS Board at the meeting was Ann Davis, PA-C, AAPA Senior Director of State Advocacy and Outreach.

During the meeting, the APACVS updated the STS Board on our activities relative to Title 22 in California. Our Board noted the research which Ed Ranzenbach, PA-C had performed. Ann Davis articulated the AAPA's support of our endeavor's to obtain waivers for CVT PAs to perform as first assistants, when requested to do so by a CVT surgeon.

APACVS Leadership Fellow/Board Member Michael Nowak gave an overview of the curriculum the APACVS has developed for PA students participating in cardiothoracic clinical clerkships. The STS Board was so impressed with this, that they enquired if they could obtain copies to provide guidance for medical students performing cardiothoracic clerkships.

It was a very congenial meeting.



*Sid Lavender, PA-C  
& Cynthia Sherwan*

## APACVS LEADERSHIP FELLOWS HONORED

During the 30th Annual APACVS Educational Meeting, the APACVS/Maquet Leadership Fellows were honored for the completion of their Fellowship.

The presentations of their activities on behalf of the APACVS, with the financial support of an educational grant from Maquet Cardiovascular can be found at

<http://www.webcastregister.com/apacvs>

**David J. Bunnell, PA-C** had three separate projects which he pursued:

- Being a CVT PA in the Veterans Administration Hospital, he found it amazing that the VA had no idea how many PA's currently practice within the VA system or at what facilities. Consequently, David contacted all of the VA Hospitals with cardiac surgery programs, identified PAs working in CVT surgery & was able to communicate with all of them. The formation of this group has proved very beneficial for several individual PA's, as each facility had different rules & regulations in place governing the performance of their PA's. With the formation of this cadre of CVT PA's, beneficial improvements have been made in the lives of many CVT PA's throughout the VA system.
- Since David has a profound interest in the internet, he has established and continues to actively support a new, improved APACVS site on FACEBOOK. You can check it out here:

<http://www.facebook.com/pages/Association-of-Physician-Assistants-in-Cardiovascular-Surgery/269283986306?ref=ts>

- Since David currently practices in our nation's capital, he has been working tirelessly in spearheading the APACVS Annual Summer Educational Meeting, to be held June 22-25 at the Gaylord National Resort & Convention Center in National Harbor, Maryland.

**Michael J. Nowak, PA-C** spent much of his time contacting you, our members. With the help of many of you, he developed a syllabus for PA students participating in a Cardiothoracic surgery rotation. He has put together a loose-leaf syllabus to be utilized in conjunction with an online PowerPoint series covering numerous topics. The APACVS expects to have this activity available in the near future to all practices which host PA students.

David and Michael were congratulated by APACVS President Jonathan Sobel, PA-C & APACVS Past President Michael Doll, PA-C, on behalf of Maquet Cardiovascular and the APACVS membership.



*David Bunnell, PA-C; Michael Nowak, PA-C;  
Jonathan Sobel, PA-C & Michael Doll, PA-C*

## INNOVATION

During the APACVS 30th Annual Educational Meeting held recently at the Westin Gaslamp Quarter in San Diego, California, 22 pharmaceutical, medical device companies and medical publications had representatives present to introduce APACVS members to their products and reveal new innovations.

Representatives of the companies which participated in the meeting were very pleased with their interactions with APACVS members.

APACVS members, who were not present at the Annual Educational Meeting, can contact the representatives of the companies who exhibited in San Diego for an update on their new innovations. Companies at the meeting were:

- Baxter Healthcare
- Biomet Microfixation
- CompHealth
- Covidien VNUS
- Cryolife
- Ethicon, Inc
- I-Flow a Kimberly-Clark Healthcare Company
- JAAPA
- Karl Storz- Endoscopy-America, Inc.
- KCI, Inc.
- KLS Martin Goup
- Lexion Medical
- Maquet Cardiovascular
- Medtronic
- NCCPA
- Sorin
- Spiration, Inc
- Starion Instruments
- Terumo
- Thoratech
- Toshiba
- Zymogenetics



## APACVS 30TH ANNUAL EDUCATIONAL MEETING



Hemant Thatte, PhD

CVT PA's from throughout the country left their winter wonderlands for the 30th Annual APACVS Educational Meeting (referred to by some APACVS members as 'the winter meeting'), held at the Westin Gaslamp Quarter in San Diego, California. The meeting was held January 27-30, immediately preceding the

47th Annual Meeting of the Society of Thoracic Surgeons. This allowed some PA's to extend their visit in San Diego and attend STS sessions with the surgeons with whom they work.

While the meeting officially began on the morning of the 27th, the APACVS Ambassador Reception was held on the evening of January 26th at Ultimate Skybox Restaurant overlooking Petco Field. The reception was sponsored by Terumo Cardiovascular. Immediately following the reception, Terumo presented an educational dinner meeting featuring innovator Hemant Thatte, PhD, Director, Cardiac Surgery Research at VA Boston Healthcare System and Associate Professor of Cardiothoracic Surgery at Harvard Medical School. Dr. Thatte had the audience mesmerized with a dynamic educational presentation.

During the meeting, the PA's were able to obtain up to 22 hours of *Category 1 CME* by participating in lecture-learner sessions, which covered cutting-edge topics in Cardiovascular and thoracic surgery. In addition, PA attendees were able to earn *Category II CME* for attending industry-sponsored luncheon and evening educational sessions. PA's also were able to renew past friendships and make new friends during the three day conference.

If you were not fortunate enough to personally participate in this meeting, in keeping with the APACVS mission of service and education, you may obtain virtual registration to this meeting: <http://www.webcastregister.com/apacvs> for registration and payment information.

Webcast lectures will be available for all to view for free. CME will be available to those who wish at a nominal fee. However, members who participated in the conference are not eligible to receive additional CME credits for participating in the on-line presentations.

After viewing all of the material presented and completing an on-line program evaluation, PA's who did not attend the conference are eligible to earn up to *16.25 hours of Category 1 CME Credit(s)*<sup>TM</sup>.

APACVS members who participate in this on-line program should contact the APACVS national office to receive a member's discount for their participation.

## APACVS NIGHT OUT



On Saturday, January 29th, APACVS members attending the 30th Anniversary Annual Educational Meeting were treated to a night at the House of Blues in San Diego, California.

During the evening, PA's were entertained by a live band, while they dined on real Southern food.

PA's were able to renew old friendships and make new ones in a relaxed atmosphere.



## APACVS 30TH ANNIVERSARY BANQUET



The APACVS 30th Anniversary Banquet was held during the APACVS 30th Annual Educational Meeting, in San Diego, California on Friday evening, January 28th in The Westin Gaslamp Quarter in San Diego, California.

The evening's activities began with a reception on a roof over the hotel's entrance lobby. From the roof, attendees could see the APACVS logo, with the notation "30th Anniversary 1981-2011," which was projected onto the wall of an adjoining building.

Inside the banquet facilities, individuals attending included APACVS founding-President John Byrnes and APACVS Past-Presidents Gregg Munson, Dana Gray and Michael Doll, in addition to current President Jonathan Sobel. Also attending were AAPA President Patrick E. Killeen and Ann Davis, PA-C, AAPA Senior Director of State Advocacy and Outreach.

The keynote address was given by CVT PA's longtime friend and mentor, Robert Guyton, M.D. Dr. Guyton, a Past-President of the Society of Thoracic Surgery and the Chief of Cardiothoracic Surgery at Emory University, most recently assisted the APACVS in the development of a CD which provides an overview of CVT PA's. APACVS members interesting in viewing the CD may download it from the APACVS website.

Dr. Guyton gave a very inspiring address, during which he noted that "I am unapologetically passionate about Cardiothoracic Surgery." You may view his entire presentation at: <http://www.webcastregister.com/apacvs>

The banquet was supported by an educational grant from Terumo Cardiovascular.



*APACVS Past & Present Presidents:*

*Gregg Munson, PA-C; Dana Gray, PA-C; Jonathan Sobel, PA-C; Michael Doll, PA-C & John Byrnes, PA-C*



*Janeen Quatman, PA-C; JoAnn Montecalvo, PA-C  
Michael Nowak, PA-C & Steven Gottesfeld, PA-C*



*David Lizotte, PA-C; Robert Guyton, MD  
& Jonathan Sobel, PA-C*



*Robert Guyton, MD; Jonathan Sobel, PA-C; David Lizotte, PA-C;  
JoAnn Montecalvo, PA-C; Steven Gottesfeld, PA-C;  
Michael Nowak, PA-C; David Bunnell, PA-C*



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**FOOTNOTES**

- 1 A study has shown that use of the VirtuoSaph® EVH System results in limited thermal spread during ligation of branches. Data on file and awaiting publication by the University of Michigan, Ann Arbor, Michigan.
- 2 Burris et al. Incidence of residual clot strands in saphenous vein grafts after endoscopic harvest. *Innovations: Technology & Techniques in Cardiothorac & Vasc Surg* 2006;1(8):323-327.
- 3 Brown et al. Strategies to reduce intraluminal clot formation in endoscopically harvested saphenous veins. *J Thorac Cardiovasc Surg* 2007;134:1259-1265.
- 4 Burris et al. Catheter-based infrared light scanner as a tool to assess conduit quality in coronary artery bypass surgery. *J Thorac Cardiovasc Surg* 2007;133:419-427.
- 5 Chiu et al. Reduction of carbon dioxide embolism for endoscopic saphenous vein harvesting. *Ann Thorac Surg* 2006;81:1697-1699.
- 6 Lin et al. Carbon dioxide embolism during endoscopic saphenous vein harvesting in coronary artery bypass surgery. *J Thorac Cardiovasc Surg* 2003;126:2011-2015.



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