Opponent Testimony
Before the
Ohio House of Representatives
Health Committee

HB 224
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By

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Good morning, Chair Merrin; Vice Chair Manning, ranking member Boyd and members of the Health Committee, my name is Dr. John Bastulli. I present today on behalf of the Academy of Medicine of Cleveland and Northern Ohio (AMNCO) and the Ohio State Medical Association (OSMA). Currently I serve as Vice President of Legislative Affairs of the AMCNO and I am also a member of the OSMA Council and its Focused Task Force on State Legislation. In addition, I am a member of the Ohio Society of Anesthesiologists. I am an anesthesiologist practicing at St. Vincent Charity Medical Center in Cleveland, Ohio. At St. Vincent's I serve as the Medical Director of Surgical Services and the Director of the Division of Anesthesia. I would like to thank the Committee for providing me with the opportunity to testify here today in opposition to HB 224 - legislation that would expand the scope of practice of certified registered nurse anesthetists or CRNAs.

The bill before you today greatly expands the scope of practice for CRNAs and attempts to dismantle existing patient safety standards that ensure patients access to physician-led, team based models of anesthesia care. As drafted HB 224 will result in confusion, duplicative and unnecessary orders, increased health care costs and, most importantly, it will compromise patient care.

I graduated from Case Western Reserve University with a Bachelor of Science in Health Science. A degree in health science allowed me to function as a non-physician anesthesia provider commonly referred to as an

anesthesia assistant (AA). I was a member of the anesthesia care team consisting of an anesthesia assistant and anesthesiologist. My job descriptions, duties and responsibilities were exactly the same as a nurse anesthetist.

I worked as an anesthesia assistant for one year prior to attending medical school and during my medical school education. I realized that while anesthesia assistants were well trained there were significant gaps in their education. Therefore, in order to function as a consultant in anesthesia, managing the continuum of care, it was imperative that I become a physician. I soon came to realize the difference in education between an anesthetist and an anesthesiologist, how much I learned and how much I didn't know. That view has been reinforced down through the years as I have been involved in the education of student nurse anesthetists, student anesthesiologist assistants and physicians in training.

I understand that proponents believe that their scope needs to be expanded so that patients can receive medications in a more timely fashion in the preoperative and postoperative period, especially in rural areas. However, this bill does not address any surgical period and extends well beyond the preoperative and postoperative period. HB 224 does not even require the CRNA to be on site with the patient when giving orders for drugs, tests, treatments and fluids. How is this safe for the patient? I am also unaware of any patient advocacy groups that believe Ohio's team-based model of anesthesia care is unsafe for patients.

If there are ordering issues, they can easily be resolved with the use of standardized protocol order sets. At the healthcare facilities where I provide anesthesia services, these order sets exist electronically or on paper. They can be completed at any point prior to the surgical procedure and can address pre and postoperative orders on one form. This process is safe, efficient and user friendly.

Patient safety mandates that the implementation of policies and procedures are based upon evidence and consensus based data that is accurate, verifiable and reproducible. The bill's provisions are problematic in that so many areas are vague and open to interpretation. The CRNAs seek to order drugs, diagnostic tests, treatments and fluids for patients without a time frame or specificity as to the drugs or tests the CRNA wants to order. Further, what are the clinical functions the CRNAs seek to perform in the facility where they want to order drugs, tests, treatments and fluids while they perform them? When performing a clinical function, why can the CRNA order drugs, tests and treatments for conditions that have nothing to do with the administration of anesthesia? The legislation is so ambiguous one could argue that a CRNA would have the authority to manage medical care of any patient in a hospital irrespective of their diagnosis. I am at a loss to see how this legislation improves the quality of care and/or reduces healthcare costs.

I recognize that the bill maintains physician supervision but the supervision lacks specificity. Is the physician required to be in the facility to supervise the CRNA under the expanded scope? How many supervising physicians can the CRNA have at any one time? The bill only requires the immediate presence of the physician when the CRNA is administering anesthesia or performing anesthesia induction, maintenance and emergence. I am concerned that the bill will be interpreted broadly by some facilities to allow physician supervision to occur remotely. That issue alone raises significant patient concerns as to why supervision of CRNAs can even be considered from afar. This bill is not about primary care-it is about surgical and anesthesia care and all of the complications that surround it. If the supervising physician is not even required to be on site and CRNAs are given broad authority to order drugs and diagnostic tests for patients remotely, this may result in an unnecessary increase in healthcare costs and most importantly, may adversely affect the quality of care and patient safety.

I also noted there are no additional educational requirements in the bill to address the expanded authority to order drugs, diagnostic tests, treatments and fluids for patients. There are many significant issues that need to be resolved with this legislation.

Other states, including the Veterans Administration, considered very similar initiatives and legislation. After policymakers understood the vast difference in education, skills and training between an Anesthesiologist and Nurse Anesthetist, they all decided to preserve physician delivered and physician-led anesthesia care. In addition, team based anesthesia care is a World Health Organization standard. Proponents of HB 224 have used the term “nurse anesthesiologist” in an attempt to create confusion. There is no public or private entity that recognizes the term “nurse anesthesiologist.” The term Anesthesiologist is reserved for physicians specializing in the medical specialty of anesthesia.

I appreciate the opportunity to testify before you today. While my colleagues and I value the role of CRNAs and respect their important contributions to the surgical team, this legislation adds an unnecessary layer of complexity to the surgical process and tries to address a problem that is not proven to exist. I am happy to answer any questions you may have either now or after others have had the opportunity to testify.

Thank you.

ANESTHESIA PRE-OP and PACU ORDERS

Allergies: ☐ NKDA _____

Date	Time	PRE-OPERATIVE ORDERS
		☐ Blood Sugar (ALL diabetic patients)
		☐ Precision Pregnancy Test (females childbearing age) ☐ N/A
		☐ INITIATE IV THERAPY (check order): ☐ N/A
		☐ a. Lactated Ringers _____ 500ml _____ 1000ml at KVO
		☐ b. D5% Water _____ ml at KVO
		☐ c. D5% Lactated Ringers _____ ml at KVO
		☐ d. D5% ½ Normal Saline
		☐ e. Other
		☐ REGLAN (Metoclopramide) 10mg IVPB after admission to Pre-op
		☐ VERSED (Midazolam) _____ mg IV Pre-op
		☐ FENTANYL _____ mcg IV Pre-op
		☐ OTHER:
		☐ OTHER:
		☐ FOLLOW SURGEON'S ORDERS

Date	Time	POST OPERATIVE ORDERS FOR PACU
		☐ Admit patient to Post Anesthesia Care Unit: • Phase I • Phase II
		☐ Notify Anesthesiologist immediately for: Respiratory rate <10/min, or with distress; systolic BP<90 or >180; HR<50 or >120, rhythm changes or signs of ischemia; Temp. above 38.5°C.
		☐ If Physician not immediately available: Pulse less than 40 beats per minute give ATROPINE 0.5mg IVP; SaO2 < 90% for more than 30 seconds, start O2 therapy
		☐ Diabetic insulin Dependent Patient (obtain a blood sugar on admission to PACU) ☐ N/A
		☐ Other:
		A. Nausea
		☐ REGLAN 10mg IVPB for vomiting
		☐ ANZEMET 12.5 mg IV push every four hours PRN for nausea
		☐ ZOFRAN 4 mg IV push every four hours PRN for nausea
		☐ PHENERGAN 12.5 mg IV push may repeat after 15 min x 1
		☐ OTHER:
		B. Pain
		☐ MORPHINE SULFATE 2-4mg IV every 5 min PRN up to a total of 12 mg/hour
		☐ MORPHINE SULFATE _____ mg IM every 4 hours PRN
		☐ DILAUDID 1 mg IV every hour PRN
		☐ DILAUDID 2 mg IM every 4 hours PRN
		☐ DEMEROL 25 mg IV every 5 min PRN up to a total of 200 mg/hour
		☐ DEMEROL _____ mg IM every 4 hours PRN
		☐ TORADOL (Ketorolac) 30 mg IV PRN
		☐ TORADOL (Ketorolac) 30 mg IM PRN
		☐ EXTRA STRENGTH TYLENOL 500 mg one or two tablets PO every 4 hours PRN
		☐ PERCOCET 5mg/325mg one or two tablets PO every 4 hours PRN
		☐ VICODIN 5mg/500mg one or two tablets PO every 4 hours PRN
		☐ Other:
		☐ FOLLOW SURGEON'S ORDERS FOR MEDICATIONS

_____
Physician Signature

_____
Date

PATIENT LABEL