PROPONENT TESTIMONY – HB 191

Ohio House Health Committee, Wednesday, December 13th
Dr. Thomas Zaciewski, MD

Good morning, Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and members of the House Health Committee. My name is Dr. Thomas Zaciewski. I am a surgeon, board certified in Urology. I appreciate the opportunity to appear before you today in support of HB 191 which eliminates outdated supervision requirements of CRNAs and defines their scope of practice.

I provide urological services, including a multitude of surgical procedures, in four different communities and four different hospitals ranging in size. In three of these hospitals, CRNAs are the only providers of anesthesia care. The fourth hospital utilizes both CRNAs and anesthesiologists. My patients receive the same standard of anesthesia care regardless of who is providing the anesthesia services.

I feel strongly that the Ohio General Assembly should modernize the current statute to reflect the modern-day practice of CRNAs. Currently, the definition of supervision requires that a CRNA work "under the direction of a physician, dentist, or podiatrist." As a surgeon I do not develop, administer, maintain, or direct any part of the anesthesia care plan for my patients. CRNAs are educated, trained, and certified to do that independently and I expect them to provide anesthesia care to our patients to the highest possible standard.

I obtained a Bachelor's of Neuroscience Degree from Vanderbilt University. I attended medical school and completed residency at The University of Toledo. I received board certification from the American Board of Urology. I have no formal training in anesthesia. There were no required anesthesia rotations during medical school, only electives. There are no stipulations to credentialing concerning anesthesia for surgeons at my facilities. I am not credentialed to perform any aspect of anesthesia except basic life support (BLS). My education and training qualifies me to practice urology and surgery, not anesthesia.

The current definition of supervision also requires the "immediate presence" of a physician during the administration of anesthesia by a CRNA. Given the training that I have described to you, my immediate presence has absolutely no bearing on my patients' anesthesia care. During surgery, I am completely focused on providing the best surgical services I can to my patients. Before and after a procedure, I also ensure my patients receive the best care that I can provide. During the course of a day, I see about 40 patients, operate on up to 12 patients, meet with family members to discuss care, prepare for surgeries, perform administrative functions from previous surgeries, and perform any number of other additional tasks that ensure my patients have the best possible outcomes. I wish I could spend more time directly with patients, we all do, and the utilization of Advanced Practice Nurses to their fullest education and training, like CRNAs, is most valuable to my surgical team and my patients' care. The requirement of "immediate presence" simply does not reflect current practice and is completely unnecessary.

Furthermore, regarding supervision, it should be clear in state law where my liability lies, but it currently is not. The notion that CRNA's are supervised as it currently states, would appear to impute liability for a CRNA's actions to the supervising physician. My first several years in practice, I was warned by many anesthesiologists that I was responsible for the actions of CRNAs. This was a scare tactic that turned out to be false, but it's a misconception that pervades throughout the practice of surgeons. I have been advised by legal counsel that my liability lies only where I exert control over CRNAs, and the same applies when I work with an anesthesiologist. For this reason, surgeons are very cautious not to exert control over CRNAs or anesthesiologists. We do not direct either of them in their practice. They are the trained expert in their field and CRNAs do not require superfluous supervision, especially in the model of anesthesia care where they are the sole provider that I work in on a daily basis.

Because a CRNAs scope of practice is described in general terms in the statute, interpretations of the code have limited our ability to utilize CRNAs to their full capability, especially where it is most necessary in anesthesia care models that do not employ anesthesiologists. For example, CRNAs cannot order diagnostic testing and/or medications that relate to anesthesia for our patients in the pre-anesthesia and post-anesthesia settings, despite

being trained to do so. My patients have to wait for the CRNA to either personally administer the necessary medication or IV fluid, or the staff members have to call me to receive an order for the needed treatments or medications. It does not serve patients well that the anesthetist who selected and administered the anesthesia, does not have the ability to order the medications related to their anesthetic. This is a routine practice, an intrinsic function of anesthesia care, and well within a CRNA's education and training. HB 191 clearly outlines the scope of practice a CRNA may perform, including explicitly reinstating their ability to place anesthesia orders.

When surgeons are the only ordering providers on the team, patients are subject to one of the following; surgeon availability or unavailability to write or give needed orders; CRNA availability or unavailability to personally administer a necessary medication or treatment; or a generic anesthesia order set placed by surgeons containing any and all possible clinical decisions that might relate to anesthesia. Order sets are useful when placed by an expert in their related field. I want to be clear, I am not the anesthesia expert on the surgical team. When I work with CRNAs, the CRNA is the expert, and when I work with anesthesiologists, they are the expert. I am less qualified than a CRNA to place anesthesia order sets. Period.

To understand the need for this scope of practice clarification it is important to note that I refuse to place routine anesthesia order sets, as do many of my colleagues, for the aforementioned reasons. Instead, I manage individual patient situations as they present with phone calls from staff and recovery room nurses before and after surgery. These calls range from the need for pain medicine in recovery room, to the need for additional IV fluid to treat blood pressure problems, to the need for an EKG. The clinician administering the anesthetic is keenly aware how the patient individually responded to pain medications, what their heart rhythm has been, and how their body responded to the stress of surgery. These are the basics for anesthesia providers, whether they are CRNAs or anesthesiologists, and why these questions are best directed to those providers. However, where CRNAs are concerned, staff nurses are forced to bypass the anesthesia expert and instead contact me. I, in turn, must then contact the anesthesia expert, the CRNA, regarding what anesthesia orders are best for any given patient. In other

words, surgery team members ask me to provide direction for anesthesia functions that then requires me to consult with the anesthesia expert, and then respond back to the team member. This is very inefficient and HB 191 will allow hospitals the flexibility to decide the best practice and process for anesthesia care.

Finally, I would also like to address the assertion that HB 191 will dismantle or have deleterious effects on what is referred to as the "care team" model of anesthesia care; a CRNA being supervised by an anesthesiologist. That model does not exist in three of the four facilities where I operate on patients. Furthermore, any facility currently using a care team will not be forced to change their model if this bill passes, so that assertion couldn't be further from the truth. As the admitting physician of my patients, regardless of whether my anesthesia provider is a nurse anesthetist or physician anesthetist, I am always in charge of the patient's overall care, but all teams work best when each member of the team contributes their best and distinct functions.

I am a surgeon board certified in urology. CRNAs are the providers board certified in anesthesia. Each of us must attend to the needs of patients to the best of our ability to provide the best patient outcome. Communication and coordination of care are vital and basic obligations of all health care providers and House Bill 191 will have no impact on these operational functions of surgery teams. The legislation will, however, introduce more efficiency and patient-focused care into anesthesia care models utilized in most of the facilities where I work. For that reason, I ask for your support of HB 191.

Thank you for your time and allowing me to testify. I would be happy to answer any of your questions.