PROPONENT TESTIMONY – Sub. SB 301
Ohio Senate Health, Human Services & Medicaid Committee
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Good afternoon, Chairman Burke, Vice Chair Beagle, Ranking Member Tavares and members of the Senate Health, Human Services & Medicaid 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 Substitute SB 301 which clarifies CRNAs' 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. At each of these facilities, my patients receive the same standard of anesthesia care regardless of who is providing the anesthesia services.

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.

I feel strongly that the Ohio General Assembly should modernize the current statute to clarify the 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 untrained in anesthesia 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 and I expect them to provide anesthesia care to our patients to the highest possible standard.

Given the training that I have described to you I am sure you can appreciate that I do not provide anesthesia care. I consult with an anesthetist, whether it is a CRNA or an anesthesiologist, to provide anesthesia care to my patients. From my perspective as a surgeon, we need CRNAs to be able to prepare patients for anesthesia, to administer it and address complications that may arise from anesthesia throughout the entire perianesthesia period without the barrier of not being able to place orders for that care. That is what is best for my patients.

Because CRNAs' scope of practice is described in general terms in the statute, interpretations of the law 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 staff members have to call me to receive a verbal order for the needed treatments or medications. It does not serve patients well that the anesthetist who selects and administers the anesthesia, does not have the ability to order the medications related to their anesthetic. This is an intrinsic function of anesthesia care, and well within a CRNA's education and training. Sub. SB 301 clearly outlines the scope of practice a CRNA may perform, including their ability to place anesthesia orders.

It is important to note that I do not place routine anesthesia order sets, I place surgical order sets. Many of my colleagues do the same. Instead, I manage individual patient situations in consultation with the anesthetist 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 anesthetist 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 basic for anesthesia providers, whether they are CRNAs or anesthesiologists, and the reason these orders are best placed by the anesthetist. 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. I must then respond back to the team member. This is very inefficient and Sub. SB 301 will allow physicians and hospitals the flexibility to decide the best practice and process for anesthesia care.

We heard in opponent testimony in the House Health Committee that the bill would lead to professional liability for surgeons and other non-anesthesiologist CRNA supervisors. In 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 anesthesia care, 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. They are the trained expert in their field and CRNAs should be placing orders related to their anesthesia care in the same manner that anesthesiologists do, especially in care models where they are the sole provider of anesthesia.

Finally, I would like to tell the Committee what happened to me after I provided similar testimony in support of H.B 191 – the House companion bill - in the House Health Committee. Following my testimony an "anonymous" complaint was filed against me with the Ohio Medical Board on the basis of my testimony and I was subjected to an interview by OMB, and the Ohio Pharmacy Board. Additionally, the Ohio Nursing Board, which has no jurisdiction over my practice, questioned me. This interview was a diversion from my busy urology practice, and had financial and personal consequences. The OMB complaint against me was dropped in record time but I feel strongly that this should not happen to a Committee witness. I come before the Committee today to provide honest and insightful testimony about how I provide surgical care to my patients and the relationship I have with physician and nurse anesthetists. I am providing this testimony so, as policymakers, you can make informed decisions about legislation that impacts my practice and your constituents.

Every member of a surgical care team must work to the best of their ability to provide the best patient outcome. Communication and coordination of care are vital and basic obligations of

all health care providers and Sub. SB 301 will have no impact on these operational functions of surgery teams. The legislation will, however, introduce more efficiency and patient-focus into anesthesia care models utilized in most of the facilities where I work. For that reason, I ask for your support of Sub. SB 301.

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