Opposing House Bill 4359—Preserving Safe Anesthesia Care

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Good afternoon Chairwoman Kahle, Vice-Chairman Meerman, Vice-Chairwoman Witwer, and Members of the Committee.

My name is Bobby Mukkamala. I am a board-certified otolaryngologist from Flint and current President of the Michigan State Medical Society. Thank you for the opportunity to testify and to share why MSMS opposes House Bill 4359.

Let me create an image of what the OR is like for me. Thursday mornings I perform surgery and most of the patients are kids. Being an ENT, the cases include some sort of work in their airway. While my procedures are challenging, they are no more so than the art and science of putting these kids to sleep and waking them up safely. Sometimes the color of the kid goes from pink to purple, and the tone of the oxygen monitor starts to get lower and lower as the numbers go from 98% to 60%. These moments make my heart stop, and my hair gray and I am ALWAYS grateful to have an anesthesiologist available to make these kids pink again. The thought of not having one around in that moment scares me.

All of the facilities at which I operate utilize CRNAs as well as board-certified physician anesthesiologists. CRNAs are members of the anesthesia team and are valued by anesthesiologists and me. Unfortunately, HB 4359 would dismantle this team by allowing CRNAs to practice medicine independently, with no additional education or training beyond initial certification, and with no physician available when things go wrong.

While this may seem to be a simple change in care delivery, the adverse ramifications to patient safety are far-reaching. To make light of the knowledge and work required to safely anesthetize, monitor, deal with any surprises and ultimately wake up my patients is a very dangerous disservice to them. While nurse anesthetists have two years of training after their bachelors degree, physician anesthesiologists complete 4 years of medical school, 4 years of residency, and 12,000-16,000 hours of clinical patient care. This training is critical to prepare them for the unexpected.

During my cases, whether it's a breathing tube that can't be inserted, or an IV that can't be placed, or a patient whose vocal cords slam shut after surgery, the first call that is made is for the supervising anesthesiologist to come to the room. If the proposed language in HB4359 is adopted, we will find ourselves in the dangerous situation of having the most qualified person in these emergencies, the anesthesiologist, nowhere to be found.

There is much more to the delivery of care that anesthesiologists provide than simply turning the gas on and off. Questions of a patient's overall health, and particularly cardiac and pulmonary health, come into play every day.

Given the critical care aspect of the services delivered, there is a reason anesthesiologists spend much of their training caring for the sickest of patients in the ICU. By training with the most critically ill, anesthesiologists are as prepared as possible for all that could happen in a seemingly routine procedure. Anesthesia in and of itself is a dangerous procedure and is provided on a daily basis across the state in emergency and trauma cases. Whether it's the decision of how to put a patient safely to sleep, how to manage the passage of an endotracheal tube through a large laryngeal cancer, or how to balance the fragile cardiac condition of a patient that has had a pacemaker and a 3 vessel bypass, all of these situations need to have the most qualified person, an anesthesiologist, available to manage them.

When reviewing legislation that expands scope of practice, there is a crucial question that must be asked: can the profession in question handle the complications that might arise as a result of their expanded scope? As I and many other surgeons have attempted to illustrate by describing our work, the answer is NO.

As a healthcare organization, we are always open to conversations about improving patient care and access. House Bill 4359, however, does nothing to improve quality, and data shows it will not improve access. We find it deeply concerning that patients in rural Michigan should settle for care from a health care provider with a fraction of the education and training of physicians. Rather than go down a path that has proven to be detrimental, we ask the committee to consider solutions to increase access to care, telehealth expansion, expanding Graduate Medical Education (GME), loan forgiveness programs for physicians practicing in rural areas, and programs that encourage students from underserved areas to become doctors.

This bill would lower the standards in Michigan by removing doctors from patient care. Given the choice, would you feel safer having your loved one's anesthesia provided by an individual with less training and education, without the participation of a highly trained physician? Unfortunately, House Bill 4359 makes this choice for you.

Granting independence to CRNAs and HOPING that access improves, and more importantly, HOPING that patient safety is NOT negatively impacted, is not a path Michigan should follow. While MSMS supports many of the bills in the House of Representatives bipartisan health care package released last week, House Bill 4359 is not one of them. Instead of moving toward a healthier Michigan, this bill in particular will HURT my patients and others like them.

Therefore, the Michigan State Medical Society opposes House Bill 4359 and urges you to do the same.

Thank you for allowing me to share our concerns with you on behalf of our patients.