Testimony in Support of SB312

My name is Shannon Seifert and I am a Certified Registered Nurse Anesthetist residing in Laurel MD. I served as a Captain in the United Sates Army Nurse Corps before going to Georgetown University for my Masters degree and currently provide anesthesia care for Medstar Health in 9 hospitals and multiple surgicenters throughout Maryland and DC. I am a past president of the Maryland Association of Nurse Anesthetists and today want to endorse HB055 which provides prescriptive authority for CRNAs in the state of Maryland. Nurse Practitioners and Nurse Midwives already have this authority and nurse anesthetists are prepared to join the ranks of 27 other states that already have prescriptive authority for their CRNAs.

In the hospital setting, nurse anesthetists routinely select and administer anesthetic agents and other drugs and this is not considered prescribing. Prescription in our world is when the delegated task of giving the medication or treatment falls to another person such as ordering an anti nausea drug to a preoperative nurse or a breathing treatment order to a respiratory therapist in the recovery area. Common orders include medications for anxiety (midazolam), nausea prevention (scopolamine, ondansetron, dexamethasone), antibiotics (cefazolin, metronidazole, vancomycin) pain (fentanyl, morphine, dilaudid), respiratory treatments (albuterol, ipratropium), anesthetic agents (propofol, ketamine, inhaled vapors) and more. We already write these orders every day in the hospitals across Maryland, this bill will just codify our practice into statute.

In the outpatient setting, prescriptive authority can be even more important as nurse anesthetists often collaborate directly with surgeons or dentists and may be the sole provider of pre and postoperative services. Prescriptive authority assures healthcare workers that our orders are legal and legitimate. Additionally, allowing up to 10 days of postop pain medication provides patients' access to quality postoperative care after their outpatient procedures.

Let me provide a brief clinical scenario. A healthy 21yo is scheduled at an ambulatory surgery center for knee arthroscopy for a meniscal tear caused while playing soccer. The patient has had previous nausea and vomiting with general anesthesia which is the plan for today so the nurse anesthetist orders a scopolamine patch in the preop area as well as IV acetaminophen to begin the plan for pain management. The patient undergoes an uneventful induction of anesthesia with versed, fentanyl and propofol and the surgeon performs an uncomplicated meniscectomy with the patient spontaneous breathing Desflurane gas. Dexamethasone and ondansetron are given for nausea prevention. Ketoralac and ketamine are used for pain management. In the recovery room, the nurses call to report the patient is experiencing hypertension. The anesthetist comes to the bedside to evaluate the patient who reports 1/10 pain and is in no apparent distress. An order for labetolol 5mg is written as necessary and after one dose the patient's hypertension resolves. The patient is discharged to home with oxycodone for pain and vistaril for nausea.

Prescriptive Authority has been successfully implemented in 27 states and I believe it will work well for Maryland patients. CRNAs extensive education, training and experience with selecting and administering medications and treatments will continue with prescriptive authority. Thank you.

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