March 16, 2026

House Health Committee
6 Bladen Street
House Office Building
Annapolis, Maryland 21401

Dear Chair Bagnall, Vice Chair Cullison, and members of the House Health Committee,

My name is Dr. Dwain Skinner and I am a physician anesthesiologist who lives in Maryland and practices anesthesiology in both Maryland and Washington, DC. I am writing in support of HB 1558 from the perspective of a practicing anesthesiologist who works every day in the Anesthesia Care Team model with both CAAs and CRNAs.

In my Washington, DC practice, I work exclusively in the physician-led Anesthesia Care Team model. That is the model I know best, the model I trust, and the model I believe provides safe, high-quality, efficient anesthesia care for patients. In that setting, physician anesthesiologists remain involved in the medical direction, judgment, and management of the anesthetic, while working collaboratively with non-physician anesthesia professionals – Certified Anesthesiologist Assistants and Certified Registered Nurse Anesthetists - as part of one connected team. The Anesthesia Care Team is a physician-led and built around the fact that physician anesthesiologists are responsible for leading anesthesia care administered by qualified members of the team.

That description matches what I see in actual practice. This is not theory. It is what anesthesia care looks like on a daily basis in modern operating rooms and procedural areas. In the ACT model, anesthesiologists, CRNAs, and CAAs work together in coordinated fashion. The anesthesiologist is not removed from care. To the contrary, the physician remains actively engaged in the patient's anesthesia care, including evaluation, planning, key intraoperative decisions, and management of complex or changing clinical conditions. CAAs and CRNAs practice collaboratively within that physician-led structure. It is a practical, efficient, and safety-focused model.

I have also worked in high-acuity settings, including a Level I trauma hospital caring for some of the most challenging surgical patients in the region. In that environment, I worked with both CRNAs and CAAs in the same physician-led care model. From the standpoint of daily practice, patient care, team function, and outcomes, both practitioners contributed effectively within the ACT structure. What mattered was the strength of the physician-led model, clear roles, strong communication, and the ability to respond quickly to patient needs.

I also staff multiple surgery centers in Maryland, and the coverage reality is straightforward: we are continually short-staffed. We do not have enough anesthesiologists nor CRNAs to cover the growing demand for care within the ambulatory setting. That shortage is not isolated to one site. It is a recurring issue

across multiple Maryland locations and as surgical volumes increase and case complexity evolves, the gap between available providers and patient care needs continues to widen. Within that context, adding another qualified anesthesia professional who works exclusively within the physician-led ACT model is a pragmatic response to a genuine workforce shortage.

HB 1558 would not change the physician-led nature of anesthesia care. It would simply allow Maryland to add Certified Anesthesiologist Assistants to the same care model already used successfully in Washington, DC and many other jurisdictions. In practical terms, that means more staffing flexibility, improved coverage, and better ability to maintain timely access to anesthesia services while keeping physicians involved in all anesthesia care.

From where I sit as a practicing anesthesiologist, this is not an abstract policy debate. It is about whether Maryland will allow hospitals and surgery centers to use a proven, team-based model to care for patients safely and reliably. I respectfully urge you to support HB 1558.

Sincerely,

Dr. Dwain Skinner