

**WRITTEN TESTIMONY TO THE
LEGISLATIVE COMMITTEE ON HEALTH CARE**

Monday, March 24, 2008

5:30 p.m.

Chair: Assemblywoman Sheila Leslie
Vice Chair: Senator Maurice E. Washington

**PUBLIC COMMENT AND DISCUSSION CONCERNING
HEPATITIS C EXPOSURE AND RELATED PUBLIC HEALTH MATTERS**

PLEASE SUBMIT YOUR TESTIMONY BY APRIL 7, 2008

(See instructions below for mailing or faxing this document)

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**This document will be included as part of the public record of the March 24, 2008, minutes of the Legislative Committee on Health Care.*

Chair Leslie, Vice Chair Washington, and Members of the Committee:

**EXHIBIT BB - HEALTH CARE
MEETING DATE: 03-24-08
DOCUMENT CONSISTS OF 3 PGS**

Nevada Legislature's Legislative Committee on Health Care (NRS439B.200)

Assemblywoman Sheila Leslie, Chair

Dear Madam Chairwoman and members of the Committee:

I come before you today as a representative of the Nevada Association of Nurse Anesthetists (NVANA).

On behalf of this professional organization I wish to express our deepest concern for the patients who have contracted hepatitis C allegedly after undergoing procedures at the Endoscopy Center of Southern Nevada and for the other patients of that center who must be subjected to testing for this and other potentially life-threatening viruses as well.

No one, here today, who did not receive a letter informing them to be tested for the hepatitis C, hepatitis B, and HIV viruses, can begin to understand the fear, frustration, anger, and panic that these patients and their loved ones experienced after opening that letter.

I am here today representing the NVANA and the nurse anesthesia profession as a whole, because infection control and proper use of needles, syringes, and medication vials are serious public health issues and of the utmost importance to the nurse anesthesia profession.

The patients of Nevada and in the United States of America can be assured that MOST healthcare professionals have their patients' best interests at heart, and adhere to accepted infection control standards and guidelines when injecting anesthetic drugs or other medications.

However, for reasons yet to be determined, there allegedly appears to be some nurse anesthetists, physician anesthesiologists, and other healthcare professionals who may still be using questionable infection control and injection practices.

As a leading advocate for anesthesia patient safety, the American Association of Nurse Anesthetists (AANA) believes that safe anesthesia care by nurses anesthetists based on adherence to AANA's practice standards, guidelines, and code of ethics is critical to the public's well-being.

The AANA's position on the reuse of needles and syringes is clearly stated in the AANA *Infection Control Guide* as follows: "Properly dispose of all needles and syringes after

use. Do not reuse needles and syringes. Once used, all needles and syringes are contaminated. They are single-use items."

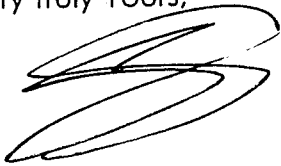
Simply stated, it is never acceptable practice to reuse needles, syringes, and single use medication vials between multiple patients. This practice is inappropriate, unsafe, inexcusable and cannot be tolerated.

The AANA is committed to working with the CDC, the FDA, and other groups to put an end to the infection control disasters that have occurred in Nevada, New York, and Indiana in recent months.

This issue extends well beyond provider specialty, title, and credentials. It includes nurses, doctors, and other healthcare professionals. We must put aside any professional differences and all work together for the health and safety of our patients.

If there are any gray areas with regard to proper usage of needles, syringes, and medication vials, then those gray areas must be identified and changed to black and white.

Very Truly Yours,

A handwritten signature in black ink, appearing to be 'S. Sertich', written in a cursive style.

Steven M. Sertich, CRNA, MAE, JD

President-Elect, Nevada Association of Nurse Anesthetists