Testimony of the Hawaii Medical Board

Before the
Senate Committee on Health and Human Services
and
Senate Committee on Commerce and Consumer Protection

Friday, February 6, 2026
9:00 a.m.
Conference Room 229 and Via Videoconference

On the following measure:
S.B.2276, RELATING TO Surgical Assistants

Chair San Buenaventura, Chair Keohokalole, and Members of the Committees:

My name is Young-Im Wilson, and I am the Executive Officer of the Hawaii Medical Board (Board). The Hawai‘i Medical Board has concerns with SB 2276 and, at this time, cannot support the measure. The Board believes the bill raises significant policy and implementation issues related to patient safety, administrative impact on the Board and hospitals, and the practical benefits of the proposal.

SB 2276 would establish a new state licensure scheme for “surgical assistants” under the Hawai‘i Medical Board, including qualifications and supervision requirements, and would define the way surgical assistants may practice in operating rooms. The bill would also create an advisory committee to assist the Board in regulating surgical assistants in the State.

First, the bill's disciplinary verification requirement in Section 1, § -2(f)(2) is fundamentally unworkable. It would require the Board to determine that no disciplinary action has been taken by any medical licensing authority and that the applicant has not been the subject of adverse judgments or settlements reflecting a pattern of negligence or incompetence. While this standard may be workable for physicians and podiatrists through nationwide systems such as the Federation of State Medical Board’s (FSMB) credentials verification service and the National Practitioner Data Bank (NPDB), no comparable system exists for surgical assistants. As a result, the Board would lack reliable tools to screen applicants, creating patient safety gaps and exposing the Board to legal risks.

Second, the bill does not align with how surgical assistants function in practice. Surgical assistants commonly work with different surgeons and teams as needed, with assignments changing based on daily schedules, staffing levels, and emergencies.

Under Section 1, § -2, (e) which addresses supervision and temporary licensure, a temporary license would be required to identify and report all supervising physicians in advance. This requirement is impractical in a dynamic operating room environment and could interfere with efficient scheduling and care delivery.

Third, the bill exempts most personnel currently working in operating rooms in roles that function as surgical assistants, under Section 1, § -2, (n) (1) – (7). As a result, only a limited number of individuals would be subject to new licensure requirements. Given the substantial administrative burden on hospitals and on the Board to create, administer, and oversee a new licensing framework for such a small group, it is unclear that the benefits would justify the associated costs.

Fourth, the requirement in Section 1, § -8 to establish an advisory committee raises significant implementation concerns. Recruiting and retaining qualified volunteers for boards and commissions is already challenging, and vacancies often persist for extended periods. The Hawai‘i Medical Board itself has not had a full complement of members for years. Creating a new, specialized advisory body with very specific statutory requirements could render the implementation timeline in Section 1, § -2(j) overly ambitious for both the Board and the Department.

Fifth, the bill would impose additional administrative burdens on hospitals. The provisions in Section 1, § -2(h), (m), and (n) would require hospitals and their staff to navigate a new licensing category, track exemptions, verify credentials, and modify internal credentialing and privileging processes. These requirements would significantly increase administrative workload for hospital human resources, medical staff offices, and operating room leadership without clear evidence of corresponding improvements in patient safety. Moreover, by creating a narrow, and highly specific license with rigid supervision and reporting requirements, the bill would reduce hospitals’ flexibility to respond to staffing changes and emergencies, at a time when such flexibility is essential for maintaining timely access to surgical care.

Finally, there is currently no in-state surgical assistant education or training program that clearly corresponds to the role defined in the bill. While related perioperative training programs exist, there is no direct educational pipeline to produce the licensees contemplated by this measure. Implementing a new licensure program

without an accompanying in-state training pathway would likely limit the pool of eligible applicants and complicate enforcement and workforce planning.

In addition, only a relatively small number of jurisdictions have created a separate state license for surgical assistants. Most states address operating room staffing and safety through hospital credentialing and existing professional licensure rather than a standalone surgical assistant license. In the context of Hawai‘i’s existing health care workforce shortages and the need to preserve staffing flexibility, SB 2276 would adopt a comparatively uncommon and administratively intensive model for a very narrow segment of the workforce.

Mahalo for the opportunity to provide comments on this measure.

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SB-2276
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Submitted By	Organization	Testifier Position	Testify
Thien Nguyen	Individual	Support	Written Testimony Only

Comments:

I recently became a Certified Surgical First Assistant. I have over 10 years of experience as a Surgical Technologist. My extensive background includes frequent service in 'second scrub' roles, which provided a strong foundation for my transition into advanced surgical assisting. As a First Assistant, I manage a significantly broader scope of clinical responsibilities, including:

- **Pre-Operative Preparation:** Review of patient charts, medical histories, and records; expert execution of surgical site positioning, prepping, and sterile draping.
- **Intraoperative Assistance:** Providing critical surgical exposure, severing or dissecting tissue under the supervision of the attending surgeon, and facilitating efficient procedural flow
- **Clinical Skills:** Administering medications (such as local anesthetics) and performing advanced hemostasis through clamping, tying, and cauterization.
- **Tissue Manipulation:** Expertise in manipulating delicate tissue, including the preparation of tissue grafts under the direct supervision of the surgeon.
- **Wound Management & Closure:** Performing layered closures of the fascia, subcutaneous tissue, and skin, as well as applying specialized dressings such as Wound VACs, tourniquets, and casts.

The CSA/CSFA is a highly specialized member of the surgical team who operates under the direct supervision of the attending surgeon. While other staff members—such as Nurses or Surgical Technologists—may function in a 'second scrub' capacity, their scope is strictly limited by facility and state guidelines. Notably, although the intraoperative scope of practice for a Surgical First Assistant (CSA/CSFA) is clinically equivalent to that of a Physician Assistant (PA) or Registered Nurse First Assistant (RNFA), Hawai‘i has yet to establish a formal licensure requirement for the CSA/CSFA. Establishing licensure would not only recognize their advanced clinical role but also ensure standardized, high-level oversight for patient safety across the islands.