November 14, 2018

Dear Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and Members of the House Health Committee:

My name is Dr. Sarah Ann Flaherty and I am a practicing anesthesiologist. I am here today to urge opposition for House Bill 191.

I completed by medical degree at the Ohio University Heritage College of Osteopathic Medicine and I am a board certified anesthesiologist. I completed my residency at Doctors Hospital in Columbus, OH and I have been practicing for over ten years.

As a current member of the Ohio Osteopathic Association, I am writing in opposition of House Bill 191. The OOA represents approximately 4,700 osteopathic physicians (DOs) in the state of Ohio and also advocates for the Ohio University Heritage College of Osteopathic Medicine. DOs represent 16 percent of the total physicians practicing in Ohio and 28 percent of the state's family physicians.

Balanced health care in any surgical setting must be overseen by a trained physician. It is imperative for a physician to serve as the leader of the operative/procedural health care team. The extensive training, experience, and leadership of a physician is paramount in even the most routine days, but the importance is immeasurable when unforeseen emergencies arise. Osteopathic physicians and medical doctors receive a bachelor's degree, a four-year medical degree, and then continue training in residency programs. Anesthesia residencies are comprised of four additional years of training and more if you enter a fellowship. General surgery residents train for a minimum of five additional years in residency programs.

Physicians are the ultimate patient care advocates before, during, and after the administration of anesthesia for surgery and other complex procedures. The practice of anesthesia care itself can be extraordinarily complex. Physicians have the knowledge base which allows us to make informed decisions concerning patient care. Just to reiterate, when a life or death matter arises, and that scenario can occur in *any* surgery or procedure, a physician has a more extensive knowledge base on which to draw. That is the basis of excellent patient care.

A physician training to become an anesthesiologist spends his or her internship year of training rotating through multiple specialties, such as surgery, obstetrics, cardiology, emergency medicine, pulmonology, and critical care,etc. as a practitioner of that specialty, not as an anesthesiologist. This allows for the future anesthesiologist to learn the intricacies of each specialty allowing for a vast knowledge base on which to eventually practice anesthesia. The residents then spend three years in the practice of all aspects of clinical anesthesia which includes critical care, cardiac, nerve blocks, pediatrics, neurology, general anesthesia, and other focused rotations. They are required to take and pass rigorous written examinations every year of residency. Anesthesia residents also participate in research projects. During **one** year of residency, 1022 cases were logged and 3,236 procedures were completed by a single resident in a residency program. Procedures are defined as oral intubations, central venous catheters, peripheral intravenous lines, epidurals, spinals, arterial lines, transesophageal echocardiography, and peripheral nerve blocks, to name a few. That

was 3,236 procedures in one year of four years of training. Anesthesia residents complete between 12,000 and 16,000 clinical hours during residency. At the completion of anesthesia residency, they are required to take a complex written examination. Following the successful passage of that examination, they are then required to take a demanding, painstaking oral examination. After successful completion of these two tests, only then do they achieve Board Certification in Anesthesiology. The complexity of these two examinations, the written and oral, can be appreciated by the plethora of expensive preparatory courses for each single examination.

In stark contrast, midlevel providers, or advanced nursing practitioners, such as certified registered nurse anesthetists, should be allowed to practice at a level that is consistent with a nurse's education and certification. Becoming a nurse anesthetist requires a commitment to an education in nursing. Worth noting, a person is not required to have a Bachelor of Science in Nursing to become a registered nurse. All potential certified registered nurse anesthetists (CRNA) have to complete at least one year of experience as an RN in an acute care setting such as an intensive care unit, cardiac care unit, or emergency room prior to admittance to a training institution. Following training, in which the nurses are exposed to approximately 2500 clinical hours and approximately 850 anesthetics, they are required to pass a National Certification Examination through the National Board of Certification and Recertification for Nurse Anesthetists. Each student must answer between 100 and 170 questions. After successfully answering between 100 and 170 questions, they achieve board certification as a nurse anesthetist. Again, it's important to compare this training to the decade of education and training undergone by anesthesiologists.

I work with and train anesthesia residents, CRNAS, and student nurse anesthetists. It is a rewarding, collaborative effort. I respect the knowledge and skill set that a certified registered nurse anesthetist brings to the operating room and procedural arenas. I say to all the anesthesia residents, the CRNAs, and the SRNAs that I interact with that there is no such thing as a routine surgery. Patient situations can change at any instant and when critical thinking skills are needed most, the physician provides the vast knowledge and experience base on which to make decisions and implement life changing and life saving decisions. That is what I would want for myself and any of my family and friends. That is what the physician anesthesiologist provides for every patient we care for.