March 3, 2021

The Honorable Bronna Kahle
Chair, House Health Policy
Anderson House Office Bldg
124 North Capitol Avenue
Lansing, MI 48909

Dear Chairman Kahle:

I am writing in strong opposition to House Bill 4359 (HB 4359). This is alarming legislation that among other things would authorize nurse anesthetists to administer anesthesia without supervision as the sole and independent anesthesia provider. Eliminating the state's long standing anesthesia laws[1] would directly impact the safety of every patient receiving surgical and procedural anesthesia in Michigan.

As a physician anesthesiologist, recently retired Professor and Department Chair, and Past President of the American Society of Anesthesiologists, I have worked daily to ensure patients' medical needs are being met safely and effectively. In my hospital as well as in much of the United States, we practice in the model known as the Anesthesia Care Team,[2] which includes the delegation of appropriate medical tasks to non-physicians. In each of those circumstances, the responsibility for those tasks remains with the supervising physician. Since the advent of modern anesthesia in the 19th century, the Anesthesia Care Team has safely and effectively delivered anesthesia care with either an anesthesiologist assistant or nurse anesthetist as the non-physician anesthetist member of the team.

Removing physician supervision of anesthesia care makes no more sense than removing it from any other critical care location. **Prior to becoming a physician anesthesiologist, I was a nurse anesthetist. As one who has completed education and training in *both* medicine and nursing, I can tell you true differences exist between a nurse anesthetist and a physician.** Those differences warrant clear guidance concerning anesthesia as the practice of medicine because the education and training differences directly impact one's ability to comprehensively manage the medical care and emergent needs of patients.

In my experience, there are two main differences in the education and training of a physician anesthesiologist and a nurse anesthetist:

1. *Length of Training*: Nurse anesthesia education and training ranges from 4-6 years after high school. Nurse anesthetists trained in the past two decades have obtained a baccalaureate degree in nursing (four years), worked a minimum of one year in an intensive care setting, and then participated in an approximately 30-month anesthesia training program, graduating with a master's degree. Nurse anesthetists average about 2,000 hours of patient care training

[1] Mich. Comp. Laws Ann. § 333.16215(1).
[2] Standards, Guidelines and Statements: Statement on the Anesthesia Care Team available at https://www.asahq.org/standards-and-guidelines/statement-on-the-anesthesia-care-team

in their curriculum.[3]

Conversely, a physician's education and training is at least 12-14 years after high school. For example, to become a physician anesthesiologist, one must complete a bachelor's degree with a pre-medicine curriculum (four years), medical school (four additional years), as well as another year of hospital-based training in general medicine, pediatrics, surgery, or combination (internship year). Only then does a physician begin their specialty residency training in anesthesiology (three years). After residency, many physician anesthesiologists also complete subspecialty training (1-2 additional years after residency) in areas including pain medicine, cardiac anesthesia, pediatric anesthesia, neuroanesthesia, obstetric anesthesia, or critical care medicine. Altogether, physicians have anywhere from 12,000 – 16,000 hours of patient care training in their curriculum.

2. *Depth of Medical and Surgical Knowledge*: Equally important as the difference in education and training is the difference in depth of knowledge. Physicians complete all courses relevant to the practice of medicine, including associated laboratory courses. The breadth of courses plus the duration and hours of coursework allow for detailed, comprehensive medical knowledge of all the systems of the human body. Nurse anesthetists take selected courses related to anesthesia. The limited number of courses plus the shorter duration and fewer hours do not allow for detailed, comprehensive medical knowledge.

The administration of anesthesia is a complex and technically demanding and potentially dangerous medical procedure that requires physician supervision. An independent outcomes study published in the peer-reviewed journal *Anesthesiology* found that the presence of a physician anesthesiologist prevented 6.9 excess deaths per 1,000 cases in which an anesthesia or surgical complication occurred.[4] Nurse anesthetists often advocate that substituting nurses for physicians cuts costs without increasing patient deaths or complications. However, there are no definitive, independent studies that confirm nurse anesthetists can ensure the same quality of care, patient safety, and outcomes at less cost when working without physician supervision. Surveys also repeatedly show patients *want* physicians in charge. In a recent American Medical Association survey, eighty-four percent said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care.[5]

Based on the differences in education and training between physicians and nurse anesthetists, I feel strongly that – for the sake of patients – in the absence of a physician anesthesiologist, a physician should retain responsibility for the patient when a non-physician anesthesia provider is delegated the authority to administer anesthesia.

Based on my completion of nurse anesthesia training and medical school and anesthesiology residency, I know nurse anesthetists are not educated or trained in medical decision making,

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[3] Council on Accreditation of Nurse Anesthesia Educational Programs. Standards for Accreditation of Nurse Anesthesia Educational Programs – Revised January 2019. Available at https://www.coacrna.org/wp-content/uploads/2020/01/2004-Standards-for-Accreditation-of-Nurse-Anesthesia-Educational-Programs-revised-October-2019.pdf

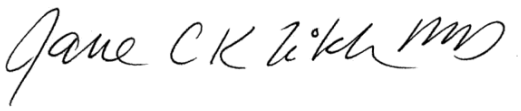
[4] Silber JH, Kennedy SK, Even-Shoshan O, Chen W, Koziol LFL, Showan AM, Longnecker DE: Anesthesiologist direction and patient outcomes. Anesthesiology 2000; 93: 152-a63.

[5] Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf

differential diagnoses, medical diagnostic interpretations, or medical interventions. Anesthesia administration requires physician supervision, whether by a physician anesthesiologist or surgeon, as most of the patient related problems encountered in the perioperative period relate to underlying medical illnesses or to the surgical procedure rather than to a specific anesthesia-related problem.

Because of the aging population and increasingly complex medical and surgical procedures, the need for physician supervision has never been greater. Nurse anesthetists are valuable members of the healthcare team; however, the surgically-based medical practice of anesthesiology is far too critical to not have physician supervision. I can attest from personal experience; the medical education and training process best serves the interests of our patients. As one who relied on her training as a physician each day in the operating room for decades, I respectfully request that the House Health Policy maintain the safety that our patients deserve and that the public demands for their anesthesia care by continuing physician supervision of nurse anesthetists.

Respectfully yours,



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