To Whom It May Concern:

My name is Dr. Robert Wilson, I am a Medical Doctor and have been since 1995. I have somewhat of a unique background in that I was a critical care nurse and a Certified Registered Nurse Anesthetist before going to Medical School. I earned my Associate Degree in Nursing and my Bachelor of Science Degree in nurse anesthesia in 1981. I worked for 8 years as a certified registered nurse anesthetist full time from 1981-1989. In 1989, I returned to college to complete my pre-medical requirements and take the medical college admissions test. I then began medical school at the University of Oklahoma College of Medicine in 1991 and graduated in 1995.

My current practice as a physician is in a pain management practice that is concentrated on interventional therapies. While I have not actively practiced in the role of an operating room anesthesiologist since 2006, that does not disqualify me from knowing the training and discipline differences of an anesthesiologist and a nurse anesthetist. My board certifications are current in both anesthesiology and pain medicine by the American Board of Anesthesiologists.

There is no question that I was well trained as a nurse anesthetist. The nurse anesthetists who are trained today are well trained for the administration of an anesthetic and monitoring of the patient. What I didn't realize until I spent nine years in medical school, internship, residency and fellowship training is how important it is to have the education, training and knowledge of medicine to differentially diagnose and treat problems that arise before, during and after the anesthetic is administered. That is where the difference in the two disciplines is significant and critical. In my nursing-based education, that curriculum was never taught, nor could it have been in the time allowed for a nursing education. Medical school applicants generally have a four-year science based undergraduate degree. This is followed by four years of medical school where the core of the medicine discipline begins. Anesthesia residency is a minimum of four years following medical school. Physicians who pursue subspecialties, such as me, must do an additional 1-3 years of fellowship training.

My nurse anesthesia curriculum consisted of a two-year nursing degree (associate degree) and two years of nurse anesthesia school. Less than a third of the time spent to becoming a physician. I should state that since I went through nurse anesthesia training, the nurse anesthesia association now requires a four-year nursing degree as an entrance into nurse anesthesia school.

The best way for me to explain to you the difference between a nurse anesthetist and physician practicing anesthesiology is to relay to you of an event that occurred in my practice several years ago. I was supervising a nurse anesthetist when I encountered an elderly Medicare patient in the post anesthesia recovery room who was not as alert as she was when I had checked on her upon emergence from anesthesia in the operating room. Both the nurse anesthetist and the recovery room nurse stated that they thought the patient was doing well despite the change in the level of alertness. Both thought that she must have been doing well as "her saturation was fine". They were referring to the oxygen saturation level in her blood stream, which was a normal level. What both had failed to do was to examine the patient. It sounds simple, but until you had this taught to you for four years of medical school and four years of internship and residency, you may not be aware of its importance. In this patient's case, she had a very shallow breathing pattern and was responding only minimally to painful stimuli. Considering all the possibilities in the differential diagnosis, I performed a neurological exam to rule out an adverse central neurological event. When I examined the pupils, one was larger than the other. The nurses immediately thought that was the reason for the patient's downturn. As the physician, I knew better, as she did not lateralize any physical symptoms during her motor exam to one

side or the other. As well, her vital signs remained normal throughout this process. I explained to the nurse anesthetists that a neurological consult was not needed at that time based on my exam. To explain the irregularity of her pupils, I had been exposed during my months of intensive care training and neurology to people who have irregular pupils for other reasons and you must look again at the entire patient and assimilate all the information. Another important point that the nurses had missed was that although the oxygen level was remaining normal, she was retaining carbon dioxide secondary to shallow breathing. If this trend continued, she would become more somnolent and eventually stop breathing because of carbon dioxide buildup. The cause of this in the post anesthesia setting is most likely due to either too much residual sedating medicine or too much residual muscle relaxant post anesthesia. Either way, the treatment is to reestablish a normal breathing pattern, which I did by re-intubating the patient and ordering ventilator settings appropriate for her age and size. After thirty minutes of this therapy, she was successfully extubated and went to her room some time thereafter. Had the nursing staff been in charge and the pattern I witnessed continued, I shudder to think of the results, or the expense incurred in her postoperative care. The difference in thought processes relates back to the difference in education between a nursing discipline and a physician discipline. There are many times in this past year that similar events have occurred in which my direction was guided by a difference in education. I am not stating that CRNA's are poorly trained or ignorant. I am simply saying that because of the many years of medical school, internship, residency, and fellowship training that I have, I am equipped to make those medical decisions, while a nurse is not. Since I first trained as a nurse anesthetist, I am uniquely qualified to speak on this issue.

Anesthesia Outcome Studies:

Silber study in 2000:

2.5 more deaths per 1,000 cases when an anesthesiologist was not involved in the anesthesia care of the patient.

6.9 more (failure to rescue) deaths per 1,000 cases with complications when an anesthesiologist was not involved in the anesthesia care of the patient.

When extrapolated over 20 million Medicare surgical procedures of all types annually, the study suggests hundreds of excess deaths per year predicted when an anesthesiologist is not involved in the anesthesia care of the patient.

Pine Study in 2003 (AANA Journal): this is the nurse anesthetists' journal

38 deaths per 10,000 cases in hospitals were anesthesia was administered by an anesthesiologist or anesthesiologist/CRNA care team.

45 deaths per 10,000 cases when anesthesia was administered by CRNA's who where supervised by non-anesthesiologist physicians.

Conclusion: Seven more patients died for every 10,000 cases when an anesthesiologist was not involved in the anesthesia care.

In conclusion, there is overwhelming evidence that anesthesia outcomes are better when an anesthesiologist is involved in the care of the patient. CRNA's are very well trained for the role they were trained to do. They are great providers of nurse anesthesia care. But you must understand that simply administering an anesthetic is not all that is involved in anesthesia care. A nursing-based education does not educate a person to practice medicine. That is derived by going to medical school.