Dear Senator

**I am writing you to voice my concerns and opposition to SB 563 and I respectfully request that you VOTE NO on this bill.** SB 563 was introduced on behalf of the SC Association of Nurse Anesthetists by Senator Tom Davis (R-Beaufort) on February 26, 2019. As currently written, SB 563 seeks to remove the requirement for any physician to be involved in the care of patients receiving anesthesia. Because the development and implementation of an anesthetic plan includes the medical management of the patient as well as the performance of medical acts, it is imperative for patient safety that physicians, more specifically anesthesiologists, remain the leaders and facilitators of the anesthesia care team. As written, SB 563 grossly expands the scope of nursing practice by granting to the nursing profession through legislation the practice of medicine. Despite what the nursing profession reports, this action would be misguided and based upon misinformation.

The misinformation surrounding this issue is precisely what I'd like to address and clarify.
First, with respect to education and training, the two disciplines are hardly comparable and they shouldn't be. The professions are designed to complement each other, not replace each other. Our roles are synergistic and not interchangeable. Why do I feel this way? Well, it's because I have personal experience with both professions. Prior to becoming a physician, I was a registered nurse and also received some advanced practice training. Despite my advanced training in nursing it was not equivalent to the extraordinary level of education and training I received in medical school and residency. To review, anesthesiologists are physicians who have successfully completed 12 -14 years of education and training (4 years of pre medical college education, 4 years medical school education, obtaining a Doctorate of Medicine and 4-6 years of residency/fellowship which includes 16,000 hours of clinical medical work). This is then followed by anesthesia specialty board certification, maintained by the American Board of Anesthesiology that sets rigorous standards that must be achieved annually per every ten year time period. Many physicians also obtain dual degrees in research, public health and business as well. In contrast, nurse anesthetists complete 6-7 years of education and training (4 years of nursing college education and 2-3 years of post-graduate study in a nurse anesthetist (CRNA) program. In my experience with teaching and training countless medical students, resident physicians, and even student nurse anesthetists, I believe that while nurse anesthetists are an important part of the care team (as is any nurse within a team-based medical care unit), their knowledge of anesthesia cannot compete with that of physician anesthesiologists.

Second, regarding the so-called "research" that is reported by the SCANA, much of it is grossly misrepresented and demonstrates questionable validity. Nursing organizations here in SC and elsewhere around the country intentionally manipulate the reporting of data so as to obscure the true facts surrounding the safety, efficiency and quality of anesthesia care. Additionally, much of this data comes from reports that are not produced from independent studies but rather from work in lesser known journals in non-peer-reviewed formats and funded by the AANA (America Association of Nurse Anesthetists) itself. While several examples of this practice exist, one particularly egregious example is the frequently cited study conducted by the Research Triangle Institute and published in *Health Affairs* in 2010. In this study, a flawed approach was used to group anesthesia providers which resulted in

highly questionable data and research validity. Nevertheless, the nursing profession uses this study to justify their claim that there is no difference in patient outcomes when anesthesia is delivered by anesthesiologists, nurse anesthetists or the two together. Of course, this is not true. In looking at this data more closely, it has been noted that instead of having a third group of combined nurse anesthetist and Anesthesiologist cases in the study, the authors assigned these combo-cases to the Anesthesiologist only group. By assigning all these combo-cases (which were a significant percentage of cases, approximately 40%) to the Anesthesiologist only group, the authors were able to reassign mortality/adverse events away from association with CRNA care, to being reported as Anesthesiologist only care. This essentially skewed the data and true nature of the results by removing any adverse events from CRNA outcome analysis and erroneously inflating their claims. This clearly represents a significant statistical analysis inaccuracy and a critical bias that would not pass editorial review if submitted to a more scientifically rigorous peer-reviewed journal. Additionally, the authors of the study acknowledge that if one were to compare individual practice between an Anesthesiologist and a CRNA, the Anesthesiologist would consistently perform higher acuity cases as these patients are far more ill. The results of this study indicate that it is the clinical knowledge and expertise of the anesthesiologist involved that ensures the positive outcomes for patients, and especially with more acutely ill patients.

Moreover, regarding patient safety, the SCANA states that anesthesia care is "50X safer than it was in the 1980s" and therefore our expertise is unwarranted. While anesthesia care is safer than it's ever been, it is because of the presence and medical direction of anesthesiologists. This safety record is the result of advances in medicine and technology facilitated and advanced primarily by physicians. It is precisely these types of advances that have allowed the medical profession to safely delegate appropriate care to other disciplines in a team based model. To advocate for the complete removal of the medical expertise provided by anesthesiologists would be a step backward in patient safety and suggests a lack of sound judgment on the part of the nursing profession and also calls into question the true motives behind their efforts.

A third point to address is the issue of medical supervision. From a federal standpoint, since 1966, Medicare has supported a team approach to anesthesia care, requiring that it be performed by a physician or a physician-supervised nurse anesthetist or physician anesthesiologist-supervised anesthesiologist assistant. The role of the physician anesthesiologist is to medically evaluate the patient's fitness for surgery and anesthesia, determine potential risk, manage the patient's medical condition during surgery, treat any medical complications and supervise post-operative care. In the absence of a physician anesthesiologist, there is only one other medical professional in the operating room with the education and training to perform these services - the surgeon

-And finally - to the issue of access to anesthesia care. The SC Association of Nurse Anesthetists asserts that there is some overwhelming public need for anesthesia care that is not being met. They also assert that this need can only be addressed by granting independent practice to nurses by replacing physicians. The fact is that current state laws and regulations do not prohibit any medical or dental facility or physician practice in SC from employing nurse anesthetists. This bill is essentially – a proposed solution

in search of a problem. It is, instead, an effort that seeks to remove highly trained physicians from the care of their patients for no clear benefit, and to the detriment of the patient's safety.

In closing, I have been a board-certified anesthesiologist for greater than ten years, and practicing in South Carolina for nine years. Prior to my move to South Carolina, I served in the US Navy and was stationed at the Naval Medical Center in Bethesda, MD. I supervised the anesthesia care for our nation's wounded and civilian Veterans in a team-model approach with other personnel – nurses, therapists, etc. This model of care was and continues to provide the greatest efficiency and quality care for this population of complex patients. This practice model was reaffirmed by the Veterans Health Administration in 2016. Similarly, the patients I encounter today are just as complex – older and with chronic conditions not common in the younger military population. Our patients here in SC are no exception and typically, the provision of anesthesia care involves the perioperative medical management of the patient –an intervention that is beyond the scope of independent nursing practice. Additionally, to "go under anesthesia" is often a frightening and intimidating step for many patients and their families. This stress and fear are often alleviated in their trust in us, the physicians, to provide them with safe, high quality care. This is best achieved by a physician-led team-based approach.

The effort undertaken by the SCANA is not in the best interest of our patients as it would remove the most highly-skilled member from the anesthesia care team and eliminate the contribution of medical expertise that patients expect and deserve. This is clearly a patient safety and health care quality issue. Please consider how you would want your loved ones cared for at times of extreme duress when faced with a diagnosis that requires surgery or other invasive intervention. Personally, I would not want my family members or even myself to undergo anesthesia without the direction and involvement by a physician anesthesiologist. Also, I am willing to assert that the nurse anesthetists who suggest our medical expertise is not needed for patients in SC would likely be the first to request our care and direction for themselves and their families. So, for the preservation of safe, high quality anesthesia care in SC, I urge you to **VOTE NO for SB 563.**

Please feel free to contact me for any additional information or questions.

Sincerely,


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