ORAL TESTIMONY BEFORE HEALTH AND HUMAN SERVICES COMMITTEE

IN SUPPORT OF THE

HOUSE BILL 2295

FEBRUARY 18, 2019

MATTHEW PINEGAR, MD

OVERLAND PARK, KANSAS

Dear Chairwoman Landwehr and members of the Health and Human Services Committee:

Thank you for your time and attention. I stand before you in support of HB 2295, which would provide for the licensure of Certified Anesthesiologist Assistants in Kansas. I am a physician anesthesiologist living in Overland Park, Kansas. I currently practice in the Saint Luke's health system with licenses and privileges permitting practice in our facility in Overland Park, KS, and at my primary practice site in Kansas City, MO. Prior to my moving to the Kansas City area one year ago, I practiced for 8 ½ years at the Medstar Washington Hospital Center in Washington, DC – where I practiced in an anesthesia care team model with both Nurse Anesthetists and Anesthesiologist Assistants, and where I participated in the clinical training of anesthesia residents, student nurse anesthetists and Anesthesiologist Assistant students. Similarly, in my current position at Saint Luke's Hospital of Kansas City, I participate in the training of UMKC residents, UMKC AA students, and nurse anesthetist students from the Truman Medical Center program.

From October 2014 through the end of 2018 I participated as the medical director for Case Western Reserve University's Washington DC Anesthesiologist Assistant program, and the 18-20 students in each graduating class. Based on my experience in this capacity I would like to speak to the quality of the training of AA students.

AA students begin their postgraduate training having completed science oriented undergraduate courses very similar to those taken by students preparing for acceptance to medical school. Early in their postgraduate training didactic/classroom training is the primary focus, with comprehensive courses covering anatomy, pharmacology, physiology, pathophysiology, and standards and practices of anesthesia – with additional time being spent in simulation lab to prepare for the clinical arena.

Having achieved the requisite knowledge base in the first few months, AA students spend the bulk of their training time in clinical locations where they learn to provide the full spectrum of anesthesia care by participating in cases with general, orthopedic, ENT, endocrine, bariatric, colorectal, vascular, cardiac, thoracic, and neurosurgeons. They learn to place invasive lines and monitors. They learn how to perform and manage epidurals and spinals, and when necessary, general anesthetics in the Labor & Delivery arena – not just for healthy expectant mothers, but also for those patients at higher risk due to pre-existing heart, lung, kidney, neurologic or immunologic disease, and for those patients with complications specific to pregnancy. They learn to care for patients who emergently come to the OR with traumatic injuries sustained from bullets, knives, vehicular collisions and industrial accidents. They will spend time in the interventional radiology suite – managing

anesthetics for diverse procedures such as treating brain aneurysms and cirrhotic livers. They participate in organ retrievals and transplants. They learn to manage anesthetics for colonoscopies – and if any of you are over 50 you should already have an appreciation for the skillful application of anesthesia to that scenario. If not, please see your doctor and get that scheduled! I could go on – but I hope you get my point.

At MWHC and SLH all these same clinical opportunities are provided to both NA and AA students. In the clinical setting, the expectations that I have for the clinical performance of both are identical. I expect them to show up on time, having adequately read and studied so they are prepared for the particular cases they are scheduled to support. I expect them to know their patients and craft an anesthetic plan appropriate for their medical conditions and the procedure they are scheduled to have. I expect them to come with procedure skills appropriate to their level of training and I expect those skills to improve over time. I expect them to anticipate intraoperative challenges and problems and deal with them in a timely fashion. I expect them to learn to communicate appropriately and effectively with the rest of the OR team. At graduation, the difference between a cohort of SNA's and a cohort of AAS's is indistinguishable.

In my almost 10 years of independent practice experience, an individual's aptitude, study effort, and work ethic determine their level of clinical skill and competence. High performing students from both types of programs perform similarly. Struggling students from both types of programs also perform similarly. No two training programs, whether they be for SRNA's, AA's or resident physicians are going to be absolutely identical. Nonetheless, all the programs have safe and reasonable standards for required clinical knowledge and performance, and graduates will need to meet or exceed those standards.

While I cannot identify any clinical difference between AA's and CRNA's there is one area where they may differ – and it is a philosophical difference. In 1982 the American Society of Anesthesiologists (the oldest and largest of the anesthesia related professional organizations) produced a statement on the anesthesia care team model. Its most updated version reads, "In the interests of patient safety and quality of care, the American Society of Anesthesiologists (ASA) believes that all patients deserve the involvement of a physician anesthesiologist in their perioperative care." AA's universally support this statement – but not all CRNA's do. Now, I am not so naïve as to ignore the complexities in healthcare systems today – and I understand the desire for different professional groups to protect and expand their influence. My hope today is that you will be able to see beyond this territorial dispute. I wish I could show you the talent and skill of the CRNA's and AA's that I work with on a daily basis. I have recommended loved ones to the care of trusted AA's and CRNA's in the past. I believe that AA's provide safe and excellent anesthesia care – just like CRNA's. Kansas already has many who provide high quality anesthesia care – but more are needed. Please support HB 2295 so Kansas can begin to tap into this resource of skilled and talented anesthetists.

Sincerely,

Matthew Pinegar, MD