



**House Bill 177: Opponent Testimony
Presented to the Ohio House Health Committee
May 14, 2019**

Good morning. Chairman Merrin, Vice Chair Manning, Ranking Member Boyd, and Honorable Members of the Health Committee, thank you for hearing my testimony today in opposition to House Bill 177.

My name is Elizabeth Muennich and I am a Board Certified Dermatologist in private practice in Mason, Ohio. I am here today testifying on behalf of the Ohio Dermatological Association and the Ohio State Medical Association. Dermatology is a highly competitive and academic subspecialty that combines internal medicine and surgery of the skin. In order to become a Dermatologist I had to do 2 years of pre-medicine prerequisites including inorganic and organic chemistry, biochemistry, biology, physics, calculus, psychology and sociology. In the first 2 years of Medical School I studied anatomy, physiology, biochemistry, pharmacology, histology, and microbiology. Wright State starts their clinical training in the first year of medical school so by the end of my second year I had 2 years of clinicals in addition to the hard sciences. I was the first MD/PhD student at Wright State and completed a 4-year PhD after my second year of Medical School. I was required to continue my clinical training, one day a week, through my four years of graduate school. My third and fourth years Of Medical School were all clinical, by graduation I had amassed well over 7000 hours of clinical training. I did two years of Internal Medicine Residency and then 3 years of Dermatology Residency. In those five years I had over 10,000 hours of training. All total over 17,000 hours of clinical training. I give that background to highlight the differences specifically in clinical training, which by contrast that of an APRN is about a 10th of what a physician receives.

In my practice, I work with two APRNs on a regular basis. I deeply respect their roles in the care team and their ability to contribute to the process of providing high-quality care to our patients. We work in an efficient, collaborative relationship, by which APRNs perform a variety of essential patient care-related functions under my supervision. My two APRNs, do my specific follow up patients, and assist me with small procedures. They do not want to practice independently and appreciate when a patient says, "Hey can you look at this rash?" that I am no more than 50 feet away.

I am here today, though, because HB 177 would terminate the current method by which physicians and APRNs work together safely and efficiently. This legislation concerns me for several major reasons, but I would particularly like to elaborate on diagnostic evaluations, based on my years of clinical experience as a physician Dermatologist.

Patients may visit my practice for a multitude of skin conditions, many of which can present with symptoms that upon observation, appear extremely similar. Because of the intricacies involved in the process of medical diagnosis, there is a strong possibility of making an error in identification of diseases and atypical skin lesions if the evaluator does not have extensive clinical background and training on the diagnosis of conditions of the skin. Dermatology takes surgical skill. In addition to my role as the local

go to on all things skin rash related and remover of skin tumors I also see Medical Dermatology patients. There are over 2600 rashes that occur on the skin. My APRNs can recognize about 50. They are about equivalent to a 3rd year medical student who has interest in Dermatology and has read the beginning primers on skin. There are rashes and clinical changes to the skin, hair and nails that are indicative of internal cancers and internal disease. One thing that the years of clinical training taught me is to be able to know what I don't know and be able to do the next steps appropriate to find the answer.

This is a powerful example of why the team approach - with a physician leading a team of health care professionals - is so important. Misdiagnosis of serious skin conditions can quickly have deadly consequences.

My most heart wrenching patient whom I met when she was 38 years old and I was the first dermatologist that she has seen. She had a dark mole on her thigh and she was seen by an APRN who did a shave biopsy, which is a superficial biopsy, and missed the melanoma because the cancer had a deeper invasive component that was missed by the type of biopsy performed. It should have been either a punch biopsy or an excisional biopsy which takes surgical skill and training once you have a clinical suspicion for a melanoma. A year went by and now she had several brown spots close to where the initial spot was. Again, a superficial shave was performed and the fact that the cancer was metastatic and had spread was missed. She finally got diagnosed when the cancer had spread internally, she was hospitalized and formally diagnosed with metastatic melanoma and sent to an oncologist. This is tragic. She is on a 70K a year drug for life. Her daughters will only have a mom as long as she is able to maintain insurance to cover the cost of the drug.

Thank you for the opportunity to provide my comments and explain some of the specific and serious concerns my colleagues and I have with House 177. I would be happy to answer any questions from the committee at the conclusion of testimony.