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

Chairman Merrin, Vice Chair Manning, Ranking Member Boyd, and Honorable Members of the Health Committee, good morning and thank you for giving me the opportunity to speak before you today in opposition to House Bill 177. I am Dr. Brenda Prince, an emergency medicine physician. I have practiced for 25 years in an independent physician group in northeastern Ohio. During my years of practice, I have had the opportunity to supervise and work with APRNs.

I would like to first echo my colleagues in stating that APRNs serve an important role in the health care team and that physicians value the work of APRNs. However, the role of the physician and the role of the APRN in that team are not interchangeable positions. By virtue of the more extensive medical education and hours of clinical experience, the physician is the natural leader of the care team, and members of the team work together in a way that allows the skills of each team member to combine and complement the skills of others involved. That is how we best ensure safe and efficient care delivery to our patients.

To remove the supervision of the APRN by the physician and allow the APRN to act, in essence, as the leader of the care team, no different than a physician, is incongruent with the knowledge and experience base possessed by an APRN. At this time, I would like to elaborate my concerns on the differences in knowledge and experience of an APRN.

I would like to begin by stating that I was a nurse for 8 years in neonatology and adult hematology/oncology. My education began with a BSN degree. Upon graduation, I began nursing practice in the NICU. This was a very specialized practice that required additional classes and training beyond my BSN degree. After 2 years, I was offered a position as nurse in the oncology practice of a physician with whom I had worked as a medical assistant while in nursing school. With additional education classes and training by this oncologist, I was expanding my role beyond traditional nursing. I began to realize that my education was limited in nursing and to practice more independently, I needed to go to medical school. To accomplish this goal, I had to take an advanced organic chemistry, physics, and calculus class as well as pass the MCAT. All in addition to my BSN education.

The curriculum of medical school was more in-depth than any of my BSN classes, even with the additional education I received from my prior nursing practices. The detail of my Anatomy and Physiology class included a cadaver lab with hands-on education of the human body. I also took classes in histology, neuroanatomy, and biochemistry which are also important sources of knowledge to understanding the disease process and are not part of nursing education. Microbiology, Pharmacology, and Pathology went into more detail in the disease process so that the appropriate diagnosis could be made. There was also the testing and passage of Part 1 United States Medical Licensing Exam (USMLE) at the completion of year 2.

The last two years of nursing and medical school was clinical based. The clinical training of nursing was based on the nursing process, focusing on care plans. Medical rotations consisted of focus on disease diagnosis and management by observing and teaching from the physician teacher. Part 2 USMLE required passage at the end of year 4. Residency, which was 3 years of additional clinical and lecture education before independent practice. It was at this time that I not only observed the clinical instructor, I was supervised as an active participant in making a differential diagnosis, evaluation, and treatment of the disease. During the third year, I also trained with other residents learning to be a leader by acting as a senior resident. After the first year, commonly referred to as internship, I was required to pass the Part 3 USMLE. After completing the residency and passing my boards, I was then allowed to practice independently.

Putting the most experienced and knowledgeable member of the care team in the supervisory role is what is best for patients and all parties involved. APRNs are already practicing to the top of their skills and abilities in the approach we currently use. It is just not sensible to put a professional with such a vast difference in education and experience in the position of leading on patient care with absolutely no oversight.

The only way to practice medicine independently is to get a medical education. Without a complete knowledge base, you don't know what you don't know. I do not think this is the kind of health care we want for our state or our country.

Thank you for your time and for the opportunity to provide my comments on HB 177. I would be happy to answer any questions you may have at the conclusion of the testimonies today.