GEORGETOWN UNIVERSITY
Berkley School of Nursing

March 1, 2026

Chair Pam Beidle
Maryland Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401

Dear Chair Beidle,

My name is Carrie Bowman Dalley, PhD, CRNA, and I am an Associate Professor and the Director of Georgetown University's Doctor of Nurse Anesthesia Practice (DNAP) Program in the District of Columbia. I am writing in strong opposition to Senate Bill (SB951). My testimony is grounded in 20 years of Georgetown faculty experience and my roles as Assistant Program Director (2018–2021) and Program Director (2022–present). I have witnessed firsthand what happens when anesthesiology assistants (AAs) enter a market: they do not create new clinical training capacity. They consume the capacity that already exists for nurse anesthesia students. I am deeply concerned that Maryland will experience the same consequences.

The Central Problem: AAs Redistribute Clinical Spots, They Do Not Create New Ones

This is the critical point the legislature must understand. There are a finite number of clinical training slots in any hospital system. When AAs occupy those slots, Student Registered Nurse Anesthetists (SRNAs) are displaced. Maryland is not gaining anesthesia providers by introducing AAs. It is simply redirecting existing training opportunities away from CRNAs, who practice independently and collaboratively, toward AAs, who cannot practice without physician supervision. The net effect on provider availability is, at best, neutral. The net effect on workforce development is demonstrably harmful.

1. Clinical Opportunity Reduction: The Georgetown Experience

Our clinical placement data over the past decade provide a stark illustration of this dynamic. Since the introduction of AAs into the DC market, SRNA placements at flagship hospitals, including MedStar Georgetown University Hospital and MedStar Washington Hospital Center, have decreased by up to 50%. These were not slots that disappeared because of reduced surgical volume or institutional downsizing. They disappeared because AAs filled them.

As a direct consequence, students who chose Georgetown specifically to train and ultimately work in the DC region are now being sent as far as Richmond, Baltimore, and Charlottesville to obtain the clinical experiences required for graduation and CRNA certification. This is not an expansion of opportunity. It is a displacement of it, and it carries serious long-term workforce consequences addressed below.

2. AAs Do Not Address Provider Shortages, They Deepen Them

AAs operate exclusively under medical direction, meaning every AA requires a supervising physician anesthesiologist. Introducing AAs does not add independent anesthesia providers to the Maryland workforce. It creates additional demand on the same physician anesthesiologists who are already stretched thin. Maryland would not be solving its anesthesia provider shortage. It would be adding a category of provider that structurally depends on the very resource that is already scarce.

CRNAs, by contrast, are educated and licensed to practice independently. Every clinical training slot that produces a CRNA yields a provider who can deliver anesthesia services without requiring physician oversight. When those slots are reappropriated for AA training, Maryland loses the opportunity to develop self-sufficient anesthesia providers and gains providers who perpetuate dependence on physician supervision.

3. The Unmet Demand for CRNA Training Is Enormous

The argument for AAs is particularly difficult to justify given the extraordinary unmet demand that already exists for CRNA training in this region. In our most recent admissions cycle (Fall 2025), Georgetown received over 340 qualified applications from experienced ICU nurses with the academic credentials and clinical backgrounds to succeed, for only 35 available clinical training slots. We turned away more than 300 qualified candidates, not because of any shortage of academic faculty, classroom space, or didactic resources, but solely because we do not have enough clinical training slots to accommodate them.

This is the opportunity cost the Maryland legislature must not overlook. Every AA placed in a clinical training slot that could have been filled by a nurse anesthesia student represents a qualified CRNA who was never trained. Maryland does not have a shortage of candidates who want to become independent anesthesia providers. It has a shortage of clinical training capacity, and AAs make that shortage worse, not better.

4. Displacement Has Compounding Long-Term Workforce Consequences

The harm extends beyond training. Students displaced from their preferred DC clinical sites and sent to Baltimore, Inova Fairfax, Richmond, or Charlottesville frequently accept employment at those sites upon graduation rather than returning to DC to practice. This accelerates the erosion of the CRNA workforce in the very region experiencing the shortage, which in turn reduces the availability of experienced CRNA preceptors at DC sites, which further limits our ability to train future CRNAs there – this same experience will happen in Maryland as Maryland programs send

students out of Maryland training sites – these students will most likely not return to the Maryland workforce. The introduction of AAs sets this cycle in motion and sustains it.

Additionally, hospitals that overhire AAs tend to reduce CRNA staffing ratios over time. Fewer CRNAs on staff means fewer preceptors available for SRNA students, compounding the clinical placement crisis further.

5. The Solution Is to Expand CRNA Training Capacity, Not Redirect It

The qualified candidates exist. The faculty exists. The classroom infrastructure exists. What is lacking is sufficient clinical training slots, a solvable problem that does not require introducing a provider category that would make it worse.

I urge the Maryland legislature to reject SB951 and instead explore meaningful solutions to the anesthesia provider shortage, including incentives for CRNA programs to expand clinical training partnerships with Maryland hospitals, loan forgiveness or stipend programs to encourage Maryland residents to pursue CRNA careers and return to practice in the state, and support for CRNA independent practice models that maximize the workforce impact of every provider trained. Invest in the current and proven anesthesia provider pathway in Maryland – the CRNA workforce.

The data from the District of Columbia are clear. AAs do not expand anesthesia provider capacity. They reappropriate the limited clinical training infrastructure available to providers who can practice independently, leaving the healthcare system with fewer self-sufficient anesthesia providers. Maryland deserves a workforce strategy that genuinely increases provider availability. SB951 does not accomplish that goal.

Please feel free to contact me if you require any additional information.

Sincerely,

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