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My name is Jacqueline C. Mitchell, and I have served as a nurse for forty years, including eighteen years as a Certified Registered Nurse Anesthetist. I respectfully submit this testimony in strong opposition to House Bill 1558. My position is grounded in extensive professional experience as a retired Army Colonel, military CRNA, Clinical Director, educator, and frontline clinician who has cared for some of Maryland's most critically ill patients.

I served 30 years with active and reserve military service and deployed to Afghanistan (2002 and 2008), Kuwait, Honduras, the Dominican Republic, and South Africa. In those environments, I provided critical care and anesthesia services in high-acuity and resource-limited combat settings.

In the combat zone, there is no one to medically direct you. The model must work autonomously, and it does.

Anesthesiologist Assistants are not utilized as anesthesia providers in the U.S. military because a provider model requiring medical direction does not align with operational realities. If a model does not work in war, it should not be adopted in rural Maryland.

As an Army Nurse Corps officer, I trained at the University of Maryland Baltimore Nurse Anesthesia Program through military funding. After 28 months of rigorous preparation, I graduated in December 2007 and deployed to a combat zone five months later, practicing independently in one of the most demanding clinical environments imaginable.

Licensing AAs in Maryland would directly impact nurse anesthesia education. Because AAs cannot train Student Registered Nurse Anesthetists (SRNAs), expanding AA positions in clinical training sites reduces case availability and hands-on learning directly impacting Maryland's long-term anesthesia workforce, including those preparing for military service and rural practice.

CRNAs are highly academically and clinically prepared autonomous anesthesia providers who are a critical part of healthcare access for the most underserved populations in this country. CRNAs must obtain a doctoral degree, either a Doctor of Nursing Practice (DNP) or a Doctor of Nurse Anesthesia Practice (DNAP), which are three-year intensive full-time programs. After securing their degree, Student Registered Nurse Anesthetists (SRNAs) must pass the National Certification Examination (NCE) administered by the National Board of Certification and Recertification for Nurse Anesthetists to gain licensure. CRNAs must complete continuing education and recertification every four years to maintain that licensure. While all CRNAs begin their career as critical care

Registered Nurses (RNs), CRNAs practice the distinct advanced practice profession of nurse anesthesia

As a Clinical Director/Assistant Director at the University of Maryland, School of Nursing, a Doctor of Nursing Practice program, I oversee a three-year curriculum grounded in evidence-based practice. Our students enter with extensive ICU experience and graduate with more than 2,000 clinical hours and 700–900 anesthesia cases. This workforce pipeline is designed to produce autonomous providers capable of practicing in any setting such as urban, rural, military, or independent facilities.

In my clinical practice, I precept SRNAs caring for patients with multi-system organ failure, traumatic injuries, and life-threatening comorbidities. These cases demand advanced decision-making and independent judgment when seconds matter. Decades of peer-reviewed research demonstrate that CRNAs provide safe, high-quality anesthesia care with outcomes comparable to physician-led models.

From a workforce perspective, Maryland faces anesthesia shortages, particularly in rural and underserved areas. CRNAs are often the sole anesthesia providers in critical access hospitals. AAs must practice under anesthesiologist supervision and therefore cannot expand access in areas where anesthesiologists are not present. This proposal risks increasing system costs without solving the access problem.

For reasons of patient safety, workforce efficiency, military readiness, rural access, and preservation of educational integrity, I respectfully urge this committee to oppose House Bill 1558. Thank you for your time and for your commitment to Maryland patients.

Sincerely,

Jacqueline C. Mitchell

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