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Good afternoon. My name is Steffen Meiler. I am the Chair of the Department of Anesthesiology and Perioperative Medicine at the Medical College of Georgia and have served on the department faculty for the last 21 years.

I appreciate the opportunity to share with your committee insights and data about our physician training programs and their contributions to the physician anesthesiologist workforce in the State of Georgia.

Our anesthesia residency program functions under the umbrella of the State's only public medical school and is one of only two anesthesia residency programs in the State, Emory being the other program.

Our anesthesia residency program is a fully integrated, 4-year program, which includes the categorical or intern year followed by 3 years of clinical anesthesia training. In addition to the residency program, we provide fellowship subspecialty training in pediatric anesthesia, critical care, and chronic pain, and we are in the process of adding an Acute Pain fellowship.

For the purpose of this presentation, we reviewed annual graduation statistics for our anesthesia residency program dating back to FY13.

During this period, we graduated 116 anesthesia residents, 22 or roughly 19% of these residents came from GA, the other residents joined us from other states or other countries. 45 graduates, or approximately 38% of the 116 stayed in Georgia. Of these 45 graduates, 15 joined our faculty and 30 joined private practice. Of note, out of the 22 residents who came from GA, 19 or 86% ended up practicing in GA, which is more than twice the retention rate compared to the total group average of 38%.

Like most states, GA is facing a severe anesthesiologist workforce shortage. Nationally, the numbers are similar in GA, 57% of practicing anesthesiologists are 55 years or older, our specialty suffered from the great resignation following COVID-19 with four years of retirements occurring in one year, and following this and the future waves of retirements, we are confronted with a serious supply deficit of anesthesiologists in their prime years due to low anesthesia resident training enrollment in the 1990s.

The American Society of Anesthesiologists Center for Anesthesia Workforce Studies is acutely aware of these issues and is actively working on several proposed solutions. In the "Supply" category of solutions, CMS is a major funder of graduate medical education positions. Unfortunately, this funding has been frozen with few exceptions since the 1997 Balanced Budget Act. Advocating for increased CMS funding, and building private partnerships supported by private funding to increase residency training opportunities are among the high priorities.

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Locally, we have the following opportunities to add anesthesiologists to the State's workforce. 1. Increasing the size of our anesthesia training program, 2. increasing the percentage of anesthesia residents from Georgia, and 3. adding our department to the group of departments and specialties that have already been approved for the MCG3+ program. Enrollment of MCG medical students under the MCG3+ program would mean that these students would train with us and, following graduation, would serve the rural anesthesia needs for a minimum of 3 years.

Finally, I would like to comment on the anesthesia care model in our department. Our residents "grow up" witnessing in their daily training the benefits that a physician-led anesthesia care team brings to our patients. We are fortunate to attract a very talented group of CRNAs from Augusta University's College of Nursing year-after-year. Under the medical direction of a physician anesthesiologist, our CRNAs are a critical component of the care of our surgical patients. We have excellent relationships with our CRNAs, our CRNAs work hard, have excellent skills, and support the clinical and training mission of our department.

In the 30 years that I have practiced my specialty, I have not only enjoyed, but my experience has taught me that the physician-led anesthesia care team model provides by far the best care environment to serve the anesthesia needs of our patients. In addition to the physician's knowledge guiding the anesthesia plan, accounting for the critical nuances of underlying illness and the surgical needs, updating anesthesia plans based on new research findings and participation in this research, there are many examples of untoward events in anesthesia. The lost airway, the unexpected massive bleed, a life-threatening anaphylactic allergic drug reaction, a potentially fatal heart rhythm disorder are among the examples where a physician-coordinated team response will always surpass the emergency response of a single anesthesia provider, as would be the case for the independently practicing CRNA.

Based on my longstanding experience, I am very clear that the physician anesthesiologist-led anesthesia care team protects each member of the patient care team, the CRNA, the anesthesiologist, the surgeon, most importantly it reduces the risk of avoidable harm to our patients, as well as the liability risk to our health systems. It is my hope and strong recommendation that our deliberations and proposed solutions will focus on what is in the best interest of our surgical patients and seek to secure the same standard of care of the physician-led anesthesia care team model without bias as to whether this care is provided in an urban or rural setting.

Thank you,

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