Opponent Testimony HB 508
Kristin Englund, MD
Board Member, Academy of Medicine Education Foundation
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Chair Gross, Vice Chair Barhorst, Ranking Member Baker, and members of the House Medicaid Committee, thank you for this opportunity to provide testimony on House Bill 508.

My name is Dr. Kristin Englund. I am an infectious disease specialist, and prior to retiring I worked for more over 20 years serving the Cleveland community, and specifically those with limited access to care. I am here today in my capacity as a member of the Academy of Medicine of Cleveland & Northern Ohio. The AMCNO represents more than 7,000 physician and medical student members in Northeast Ohio, and for more than 200 years, we've been dedicated to promoting the best possible practice of medicine.

I come to you today in strong opposition to House Bill 508 and the implications it has for patients in Ohio. As physicians, we deeply value team-based care, and working across the different educational backgrounds and training that exist between doctors, nurses, physician assistants, and other providers in the medical setting. All of us have critical roles in managing the care of patients that are based on our own fields of expertise, but this legislation directly threatens that clarity and recognition of differences in medical knowledge.

The level of education and training required for physician to practice independently of an attending physician is high, in recognition of the sheer breadth and depth of knowledge these providers need to manage the care of patients. All must first receive a bachelor's degree, traditionally a 4-year program, followed by a typically 4-year medical school, culminating in a Doctor of Medicine or Doctor of Osteopathic Medicine degree. Med school is intense, comprising classroom learning, hands-on rotations in a variety of specialties, constant exams, and for many students, extensive research and extracurricular work to be a competitive

applicant for residency. While the specific clinical hours that are completed by MDs and DOs vary by medical school and the sites they partner with, students in these programs will spend about 1.5 years in clinical settings prior to graduation, which amounts to an estimated 6,000 hours working with patients[1].

Following graduation, these MDs and DOs are still not able to practice independently until after completing residency, which can range from 3 to 7 years, depending on the specialty. These residencies are managed by the ACGME national accrediting body that maintains standards for all physician training programs as a means of ensuring quality control among the doctors that are going into practice. Residents spend thousands upon thousands of hours in clinical practice under the supervision of more senior residents and attending physicians, all while continuing to study for board exams and participate in regular didactic education. All told, it takes approximately 11 years for most physicians to be able to diagnose, treat, and prescribe independently[2].

Compare this to the education and training requirements of APRNs. Broadly, APRNs complete a 4-year bachelor's degree, often a Bachelor of Science in Nursing that prepares them to work as a registered nurse once licensed. After the 4-year degree, individuals who want to become APRNs then complete a master's degree in an accredited program that has clinical and classroom components and then must pass a certification or credentialing program. The master's programs themselves can vary, with some not requiring students have a BSN or nursing background before beginning the program. With the rise in distance learning, there are many online programs that offer accelerated formats to completed MSN degrees. After completing this degree, no residency is required, meaning that it can take a total of 5.5 to 7 years for an individual to become a nurse practitioner.

House Bill 508 proposes that 5,000 clinical hours in a standard care arrangement – which the bill allows to now be made with an APRN, not just a physician – is appropriate to allow an APRN to practice without collaboration. Meanwhile, physicians need nearly triple this amount for the ability to practice independently.

I want to pause here to emphasize, again, that NPs are critical to patient care, and that their training gives them unique practice in patient education, population health, and wellness. But they are not physicians, and the education and roles are different.

This has been borne out in the research. In one study comparing the quality of referrals of patients, NPs had lower quality clarity in the referral questions, understanding of

[1] https://www.tafp.org/media/advocacy/scope-education.pdf
[2] https://pmc.ncbi.nlm.nih.gov/articles/PMC3354979/

pathophysiology, and adequate evaluation and documentation compared to physicians[3]. Another study from the Centers for Disease Control in 2016[4] found a higher frequency of antibiotic prescribing in ambulatory care visits with NPs versus physician-only visits, a trend that was also seen in previous studies[5]. This is particularly worrisome because antibiotic-resistance poses a threat to public health, and there are risks of adverse drug events in the overprescription of antibiotics.

We are also concerned with this bill's changes to the standard care arrangements that would still exist under it – allowing providers to enter into a greater number of arrangements, eliminating the acceptable travel time between APRN prescribers and collaborators, and eliminating the physician signing of a death certificate – all serve to weaken what collaboration would continue with this legislation.

This bill sets a dangerous precedent of lowering the bar for being able to provide healthcare to our patients. It will erode team-based healthcare, which as physicians we recognize is critical to comprehensively addressing the needs of patients. We recognize that there is a serious health access problem in this country – restrictive insurance companies, cuts to state and federal safety nets, a lack of meaningful growth in medical residency spots, and disinvestment from our rural communities has left so many Ohioans desperate for medical care.

Changing the standard care agreements doesn't give them access to better care, nor will it meaningfully address gaps in our workforce, especially as those gaps persist in bedside nursing.

If Ohio truly wants to promote access to care, we need to invest actual dollars into the care of our patients, not just lower the standards for what care people are able to get. We ask that you oppose House Bill 508.

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[3] https://www.mayoclinicproceedings.org/article/S0025-6196(13)00732-5/abstract
[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC5047413/
[5] https://pubmed.ncbi.nlm.nih.gov/15922696/