AMA
AMERICAN MEDICAL ASSOCIATION

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April 10, 2025

The Honorable Donna Bailey
Senate Chair
Joint Standing Committee on Health Coverage, Insurance & Financial Services
Room 220, Cross State Office Building
Augusta, ME 04330

The Honorable Lori Gramlich
House Chair
Joint Standing Committee on Health Coverage, Insurance & Financial Services
Room 220, Cross State Office Building
Augusta, ME 04330

Re: AMA Opposition to LD 961

Dear Chair Bailey and Chair Gramlich:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express **our strong opposition to Legislative Document 961 (LD 961)**, which would allow all nurse practitioners, including new graduates, the ability to independently and autonomously provide medical care without any physician involvement. The AMA is deeply concerned that this legislation will threaten the health care safety of patients by creating an arbitrary shortcut for one profession to provide autonomous medical care to patients while maintaining the time-tested and higher standards required of physicians to practice medicine in the state of Maine. Moreover, LD 961 as drafted will not meet the purported emergency need, as decades of data and multiple studies have shown that nurse practitioner scope expansions have failed to improve access to care in rural areas. Claiming that they will is simply a false promise. **For these reasons, the AMA strongly encourages you to put patients first and oppose this alarming, dangerous, and unnecessary legislation.**

Education plays a critical role in patient safety.

The AMA is alarmed that LD 961 jeopardizes the health and safety of patients in Maine by removing the current supervision requirements and allowing all nurse practitioners, including new graduates, to practice medicine. Shockingly, LD 961 would also allow nurse practitioners to change specialties throughout their career without any additional formal training in that specialty. Standardized post-graduate training is essential to attain the competency necessary to provide high quality health care that patients expect and deserve. It takes years to bridge the "knowing-doing gap" to refine one's ability to safely evaluate, diagnose, treat, and manage all aspects of a patient's medical needs. This is why physicians complete more than 12,000 hours of highly standardized rigorous clinical training during their four years of medical school and three-to-seven-year residency programs. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure.

At this point, medical students "match" into a three-to-seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain more experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. This standardized education and training is critical to physicians achieving the competence to become a fully licensed MD or DO.

Gaps in nurse practitioner education and training put your constituents, Maine patients, at risk.

In sharp contrast, nurse practitioners must complete just 500-750 hours of clinical training during their two-to-three-year program, a mere fraction of the clinical training completed by physicians. But it is more than just the difference in hours, nurse practitioner programs also lack the rigor and standardization of medical school and physician residency programs. **For example, over 60 percent of nurse practitioner programs are offered mostly or completely online, severely limiting crucial hands-on clinical experience**. Plus, most nurse practitioner programs require students to arrange their own clinical training, resulting in inconsistent skills development and many new graduates feeling ill-prepared in caring for patients after graduation.

An alarming and growing body of evidence exists documenting severe gaps in basic competencies by newly graduated nurse practitioners and the impact of this inadequate preparation on patient care. For example:

- Studies reveal that only 34 percent of nurse practitioner clinical practicum time is spent in direct patient care.
- A study published in the *Journal of Nursing Regulation* revealed severe deficiencies in basic clinical competencies among newly graduated family nurse practitioners, including inadequate preparation in performing comprehensive physical examinations, prescribing medications, and ordering diagnostic imaging.[1]
- According to another study, 75 percent of nurse respondents reported being either "not confident" or only "somewhat confident" in their ability to interpret basic skeletal radiographs, and 78 percent reported being "not confident," "somewhat confident," or "unsure" of their ability to interpret a basic chest radiograph.[2]

Given these massive gaps in nurse practitioner education and clinical experience, it is not surprising that many nurse practitioner students have expressed a lack of confidence in their preparation and ability to practice independently upon graduation.[3],[4],[5]

The impact of these inadequacies on patient care is exemplified in a high-quality economic analysis which found that care provided by nurse practitioners resulted in worse patient outcomes and higher costs.[6] In this first-of-its-kind study of nurse practitioners practicing independently in emergency

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[1] McNelis AM, Dreifuerst T, Beebe S, et al. Types, frequency, and depth of direct patient care experiences of family nurse practitioner students in the United States. *Journal of Nursing Regulation*, 2021;12(1):19-27.

[2] Kirkland S, Champion J. Radiologic imaging content in family nurse practitioner programs: a needs assessment. *The Journal for Nurse Practitioners*. 2018;14(3):e63-e66.

[3] Hart AM, Bowen A. New nurse practitioners' perceptions of preparedness for and transition into practice. *The Journal for Nurse Practitioners*, 2016;12(8):545–552.

[4] Nicoteri J. Meeting FNP students' and faculty clinical needs: Two perspectives. *Journal of the American Association of Nurse Practitioners*. 2020;32(10):676–681.

[5] Taylor I, Bing-Jonsson P, Wangensteen S, et al. The self-assessment of clinical competence and the need for further training: A cross-sectional survey of advanced practice nursing students. *Journal of Clinical Nursing*. 2020;29(3–4):545–555.

[6] Chan DC, Chen Y. The productivity of professions: evidence from the emergency department, *National Bureau of Economic Research*. 2024.

departments in the Veterans Administration, the authors **confirmed that allowing nurse practitioners to practice independently is associated with lower quality of care, finding that nurse practitioners achieved worse outcomes, despite using more resources.** The authors of the study suggest that these worse outcomes may reflect poorer decision-making by nurse practitioners over whom to admit to the hospital or that nurse practitioners produce a lower quality of care conditional on admitting decisions compared to physicians. **The study also found that nurse practitioners' prescribing patterns are consistent with lower levels of skill compared to physicians.** While nurse practitioners are important members of the care team, this study demonstrates the real-world consequences of the inadequacies in nurse practitioner education and training. Yet shockingly, despite clear gaps and limits in their training which have a demonstrable negative impact on patient care, LD 961 would allow all nurse practitioners to independently care for patients, including new graduates.

Allowing specialty practice by advanced practice nurses, without residency, sets a dangerous precedent.

In addition, something not often considered by lawmakers is the growing trend of nurse practitioners practicing in specialty care. Again, in sharp contrast to physicians, whose accredited residency training focuses on a specific specialty under the supervision of an experienced physician faculty, a nurse practitioner can switch specialties during their career without any additional formal education or training. Not only is this permitted in the existing licensing structure, but it is often encouraged. Astonishingly, however, the American Association of Nurse Practitioners (AANP) regularly promotes new "specialties" for nurse practitioners. As an example, AANP recently promoted a new specialty for nurse practitioners in ophthalmology even though nurse practitioners receive no education or training in eye care. Specifically, the article notes the complex nature of detecting abnormalities in the eye and the lack of any formal training on the eye in nurse practitioner programs. **Yet, LD 961 would allow a nurse practitioner to complete their practice hours in family medicine and then open an independent practice in dermatology, cardiology, or ophthalmology. Shockingly, this would be permitted without any additional education or training and without any physician involvement.** This shift from primary care to specialty care without any additional training is not a theory or a hypothetical–it is happening. According to a survey by AANP, 92.8 percent of nurse practitioners obtain no advanced specialty certification, yet AANP data and several state workforce studies have shown an increase in nurse practitioners practicing in specialties, including nurse practitioners who are certified in primary care.[7] More concerning is the fact that patients are typically unaware of these factors including the potential lack of training a nurse practitioner may have, particularly in a given medical specialty. This alarming trend is yet another reason Maine lawmakers should stand up for patients and unequivocally reject LD 961.[8]

Scope expansions are not the solution to increase access to care.

LD 961 has been filed as an emergency to "address Maine's health care workforce shortage and improve access to care." While workforce shortages are a real problem in many states, evidence has shown that expanding the scope of practice for nurse practitioners has not improved workforce shortages in those areas most in need. **In looking at the data and reviewing the actual practice locations of primary care physicians compared to nurse practitioners, it is clear that physicians and nurse practitioners tend to practice in the same areas of the state.** This is true even in those states where nurse practitioners have expanded their scope of practice, including in Maine, which has time-limited supervision of nurse practitioners and allows a physician or another nurse practitioner to provide such supervision. As

[7] American Association of Nurse Practitioners. *2024 Nurse Practitioner Practice Report*. 2024. Oregon Center for Nursing. Primary Care Workforce Crisis Looming in Oregon: Nurse Practitioners Vital to Filling the Gap, But Not Enough to Go Around. Portland, OR: Oregon Center for Nursing; 2020. Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017.

[8] American Association of Nurse Practitioners. *2024 Nurse Practitioner Practice Report*. 2024.

illustrated in the attached GEOMAPS maps, which show the practice location of nurse practitioners and primary care physicians in Maine in 2013 and 2022, one can see that despite the number of nurse practitioners almost doubling over this time period (on pace with the rest of the country) they continue to practice in the same highly populated areas of the state—not the rural areas most in need of health care providers**. Simply put, promises that scope expansions will increase access to care have not proven true here in Maine or in other parts of the country.** Other studies support this finding, including the Graduate Nurse Demonstration Project (the Project) conducted by the Centers for Medicare & Medicaid Services.[9] One goal of the Project was to determine whether increased funding for advanced practice registered nursing programs would increase the number of advanced practice registered nurses practicing in rural areas. The results found that this did not happen. In fact, only nine percent of nursing alumni from the program went on to work in rural areas. In addition, one often unmentioned result of the growth of the nurse practitioner workforce is its impact on the registered nurse (RN) workforce. According to an analysis of the Bureau of Labor Statistics, between 2014 and 2024 an estimated one million new RNs will be needed across the country.[10] At this same time, however, the growth of the nurse practitioner workforce has reduced the size of the RN workforce by up to 80,000 nationwide.[11] **In short, the evidence is clear that expanding the scope of practice of nurse practitioners will not necessarily lead to improved access to care, particularly in those areas most in need.**

Collaborate with us to find a path forward and finally solve the access to care problems in Maine.

Rather than support an unproven path forward, legislators should consider proven solutions to increase access to care and reduce health care costs. We urge Maine legislators to consider other proven solutions to increase access to care such as expanding coverage and payment for high-quality telehealth and increasing the physician workforce by providing state funding for graduate medical education and supporting loan repayment programs. If you are interested, the AMA stands ready, alongside the Maine Medical Association, to explore these proven solutions further.

The bottom line is this: nurse practitioner education programs fall short in providing the training and skills necessary to provide care independently and autonomously to patients. In addition, LD 961 will fail to address the purported emergency need to address Maine's heath care workforce shortage and improve access to care. **As such, we urge you to protect the health and safety of Mainers and oppose LD 961.**

Thank you for the opportunity to provide these comments. If you have any questions or want to discuss proven workforce solutions as discussed above, please contact Kimberly Horvath, JD, Senior Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,

James L. Madara, MD

Attachments
cc: Maine Medical Association

[9] Centers for Medicare and Medicaid Services. The Graduate Nurse Education Demonstration Project: Final Evaluation Report. Baltimore, MD; August 2019.
[10] Health Care Employment Projections, 2014-2024: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation, Center for Health Workforce Studies, School of Public Health, SUNY Albany; (2016).
[11] David I. Auerbach, Peter I. Buerhaus, and Douglas O. Staiger, "Implications of the Rapid Growth of the Nurse Practitioner Workforce in the US," Health Affairs; 39, 2 (Feb. 2020).

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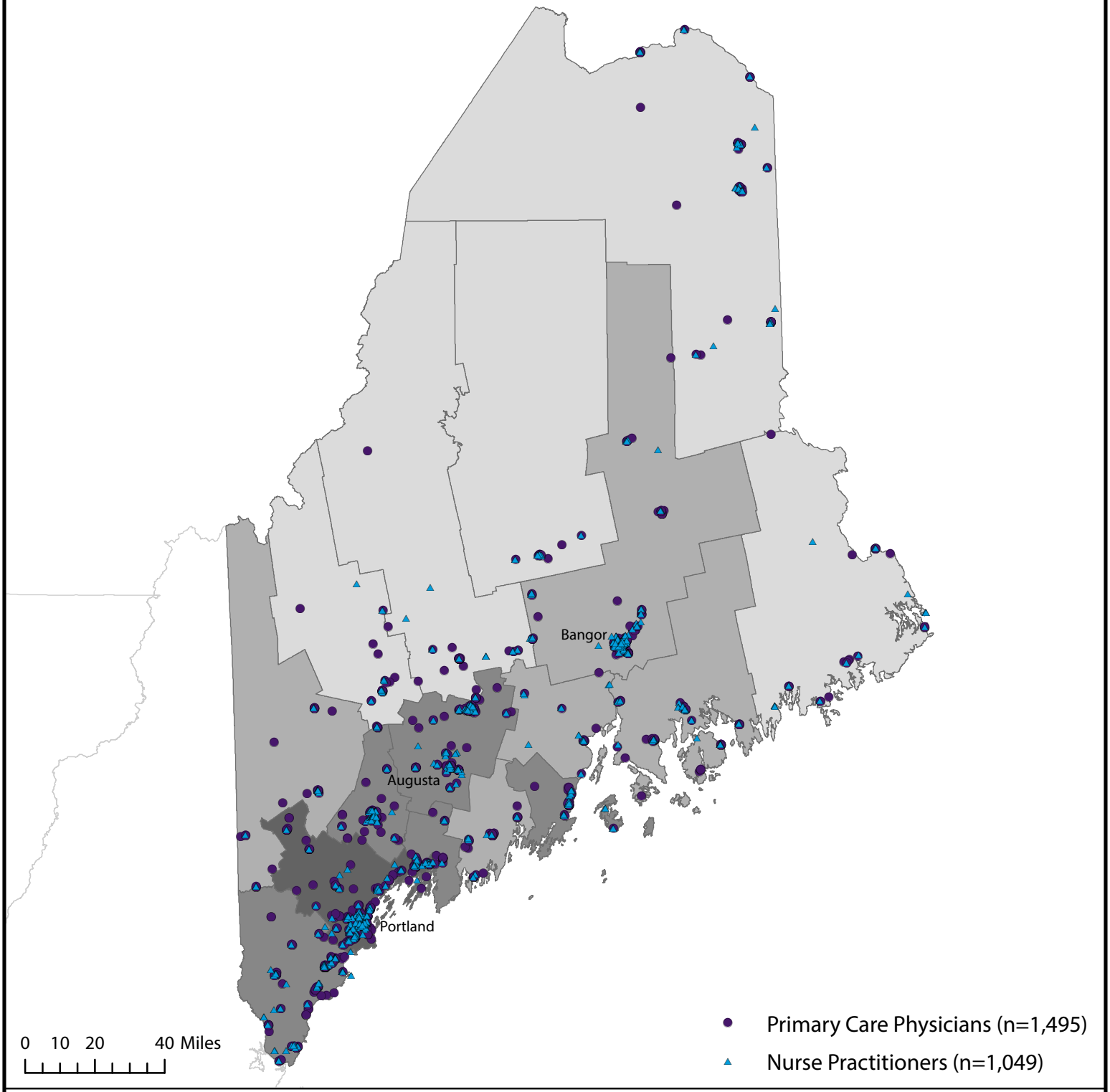
Primary Care Physicians to Nurse Practitioners

Maine



Population per square mile

Source: 2012 American Community Survey

<=25 | 26 - 75 | 76 - 250 | 251 - 1,000 | >1,000

Source Notes: AMA Physician Masterfile 2013; Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System 2013; US Census county and state shapefiles 2010

Created by The Robert Graham Center

Primary Care Physicians to Nurse Practitioners

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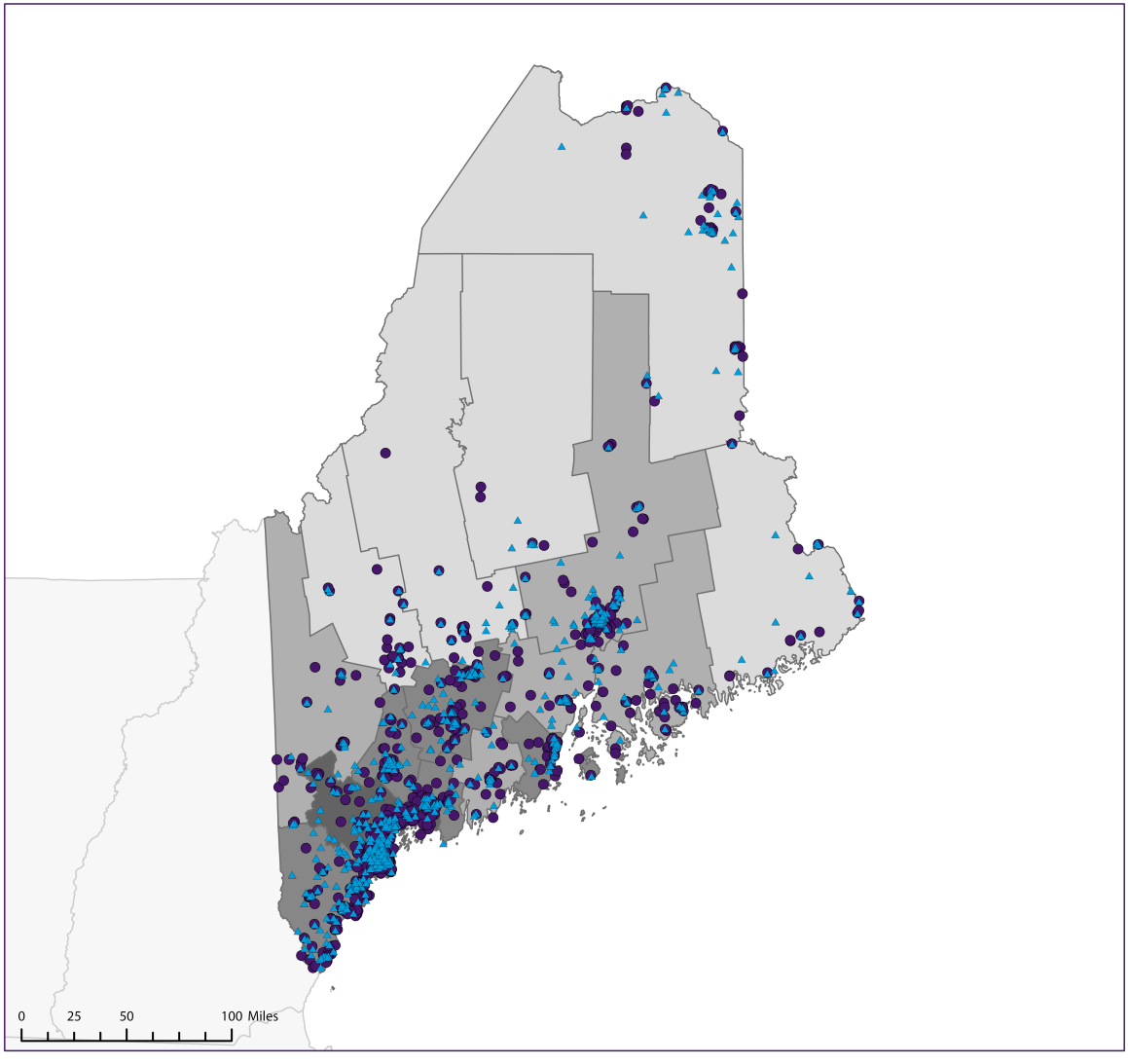

- Primary Care Physicians (n=1,607)
- Nurse Practitioners (n=1,858)

Population per square mile
Source: 2017-2021 American Community Survey

<=25	26 - 75	76 - 250	251 - 1,000	>1,000

Source Notes: AMA Physician Masterfile 2022; U.S. Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System 2022; U.S. Census Bureau county and state shapefiles 2020