Good Evening Senator Bailey, Representative Mathieson, and Members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services,

I wanted to share my personal experiences as a physician who works with and trains nurse practitioners, for the committee to consider before the work session on Wednesday for LD 961, An Act to Address Maine's Health Care Workforce Shortage and Improve Access To Care. I urge the Committee to vote Ought Not To Pass on this bill, as it is currently written.

I have been a practicing Family Medicine physician since 2013, when I graduated from residency at Maine Medical Center. During residency I developed a strong interest in women's health, and this has been a significant part of my practice since then. I have concerns about gaps in physical exam skills among new graduates of nurse practitioner programs, and the mistakes that can be made when an under-trained primary care provider doesn't know what they don't know. Below are a series of anecdotes from my own training, and my mentorship of nurse practitioner students who I've trained.

"Find the Cervix"
My first example is of one of my own deeply humbling errors, during my first obstetrics rotation as a new Family Medicine resident at Maine Medical Center (MMC), in 2010. I was one of several overnight residents managing the obstetrics floor at MMC and it was early morning, around 2am. A young mother came in with a question of preterm labor. All other residents were busy with deliveries, and I was tasked with doing a simple cervical exam to assess whether there were signs of early labor.
By this time I'd had two years of clinical rotations as a 3rd and 4th year medical student, and had done dozens of cervical exams on my own, and helped deliver several babies. I knew the mechanics of setting up a sterile speculum exam, and I had a nurse right next to me to assist, so in my mind, this would be fairly straightforward.
However, I was completely unable to find the cervix. I didn't understand at the time that there are several different sizes of specula that can be used, and some vaginal canals are longer than others. I eventually found what I *thought* was the cervix, an indentation between two folds of skin, and what appeared to be a blob of dark blue fluid protruding out of it. Alarmed, I reported to the attending, via page, what I'd thought I'd seen. Not realizing my level of inexperience, the attending sounded the alarm, and before I knew it, an entire surgical team had been mobilized for concern for a possible umbilical cord protruding from a dilated cervix.
Long story short, I was nowhere near the cervix. Another (more competent) resident did a proper exam with a properly sized speculum, retrieved some benign cervical mucus from between two folds of vaginal skin (what I'd seen that sounded the alarm), and easily found the actual cervix, which was thankfully healthy appearing and fully closed. No emergency c-section was needed, the patient was not in labor, and she went home within the hour.

As embarrassing as this lesson was, it helped me greatly one year later, when I was placed in a similar situation.
I was examining another mother who was preparing for induction of labor. Several providers had tried to find her cervix and been unable. I was the resident in charge of starting the induction,

and I noted a history of herpes exposure, so I took the extra time needed to find a correctly sized speculum, and locate a special plastic spacing tool that would allow me to hold the vaginal walls apart long enough to get a clear view. I was surprised to see herpetic lesions on the cervix, in a patient with no other symptoms of infection. This is a crucial finding, as vaginal delivery would have caused a high likelihood of neonatal herpes infection, which can be fatal. In this case, taking the extra time to get a proper exam was very important. The patient consented to a c-section and the baby was born without herpes infection.

“See One, Do One, Teach One”
There used to be a phrase used among physicians (expressing a certain amount of overconfident bravado), that a resident should be able to see something once, do it themselves once, and then be able to teach this procedure themselves thereafter. I have had too many humbling experiences to have any faith in this logic. Expertise comes from practice, and this isn’t something that can come from seeing something just once.

I love teaching, and have mentored many students and residents in the 12 years since residency. Among my favorite students are my nurse practitioner students, and I try to get each one as much hands-on experience as possible.
The gaps in physical exam teaching and oversight for nurse practitioner students really hit home for me when I mentored my first NP student, around 9 years ago.
This student, who had worked in a gastroenterology office as an RN for many years, and was now only a month away from her full NP license, came to me for her final rotation. She admitted to me during her last week with me that she had never, ever in her career, done a single vaginal exam. Only having a week left with me (and in her training), I helped her get the first (and only) cervical exam she would ever do, before becoming a fully licensed NP. She was planning to practice primary care family medicine, as an independent primary care practitioner, including women’s health and pap smears.

I think about this student often. She entered medicine because a family member died from a cancer that would have been prevented by access to a competent medical exam. She was hoping to fill that gap.
My concern, however, is that she, and others like her, could inadvertently make the problem worse. An inadequate gynecologic exam may be worse than no exam at all. It gives a false sense of security.
A negative pap smear is less trustworthy if the swab never reaches the cervix (cancer can be missed).
A falsely negative gonorrhea test, due to a shallow or incomplete swab, can have serious consequences for a sexually active person with multiple partners (they could become sterile, have life threatening infections later on, and pass their infection to others, or brush off symptoms of infection because they falsely believe they are negative).
A “normal” vulvar exam, when a person actually has lichen sclerosus, precancerous changes that can lead to vulvar cancer, can be devastating. This last example hits home for me because I had a patient die earlier this year who trusted an inexperienced provider to treat a ‘wart’ on her vulva with herbal remedies. That ‘wart’ was actually metastatic cancer, and killed her.

There are many excellent nurse practitioners I work with who I would trust my life to (and have), who are many years more experienced than I am in this field. However, my concern is the lack of adequate standards for graduation with a nurse practitioner degree. 500 clinical hours is nowhere near sufficient to practice medicine independently. For this reason, I urge the Committee to vote against LD 961. We need collaborative training support for our nurse practitioner students. I agree that the current system of ‘supervision’ is inadequate, but doing away with it entirely is also not the answer.

Respectfully submitted,
Please reach out to me with any questions,

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