Dear Members of the Maine Legislature,

I am writing as an osteopathic physician practicing in Maine to express concerns regarding the proposed expansion of naturopathic scope of practice under 32 MRS §12522. I want to be clear that my perspective is not rooted in opposition to naturopathic medicine as a discipline. I believe naturopathic doctors (NDs) play a valuable role in preventive care, lifestyle counseling, and patient engagement. My concern is not about whether NDs should practice, but about ensuring that any expansion of scope aligns with training, patient safety, and continuity of care.

The proposed changes would allow NDs to order contraceptive devices (excluding IUDs), medical appliances, contrast agents for diagnostic imaging, antibiotics for sexually transmitted diseases, and a broad range of biologically active substances. While these may appear incremental, they represent a meaningful expansion into areas that require deeper clinical training in diagnostic reasoning, risk stratification, and longitudinal management.

One of my primary concerns is the authorization for NDs to order diagnostic imaging, particularly with contrast. Appropriate imaging selection is not simply a technical decision—it requires a nuanced understanding of pre-test probability, differential diagnosis, radiation exposure, contrast risks, and how results will guide management. In my experience, inappropriate imaging can lead to incidental findings, unnecessary anxiety, downstream testing, and increased healthcare costs. More importantly, there is a pattern—seen not only with NDs but also with other non-physician providers—where diagnostic tests are ordered, but the responsibility for interpretation and management is deferred to physicians. This creates fragmentation of care and places an additional burden on the healthcare system.

Similarly, expanded prescribing authority raises concerns. Therapies such as chelation carry serious risks, including hypotension, arrhythmias, electrolyte disturbances, kidney injury, nutrient depletion, allergic reactions, and interactions with other medications. These treatments are FDA-approved only for heavy metal toxicity; off-label use can be dangerous.

A core principle in medicine is that providers should not order tests unless they are prepared to interpret the results and manage the outcomes. Expanding ordering authority without ensuring equivalent training in clinical decision-making risks violating this principle. It is not a matter of intent, but of training depth and clinical exposure.

I am also concerned that the proposed one-year collaborative supervision period is insufficient for ensuring patient safety with this expanded scope. In contrast, physician assistants (PAs) must have all orders reviewed or co-signed under defined supervision protocols throughout their careers in high-risk areas. Limiting ND supervision to a single

year, with quarterly review of orders, does not provide the same safeguards for ongoing clinical competency, particularly when ordering diagnostic imaging, prescribing antibiotics, or managing complex therapies. A more continuous oversight model would be more appropriate and better protect patients.

There are additional concerns that warrant consideration:

- **Antibiotic stewardship:** Allowing prescribing for sexually transmitted infections requires adherence to evolving guidelines, resistance patterns, and public health reporting. Misuse contributes to antimicrobial resistance, a growing public health threat.
- **Care fragmentation and liability ambiguity:** When multiple providers operate with overlapping but unequal scopes, it becomes unclear who is responsible, or liable, for follow-up, abnormal results, and complications.
- **Health system costs:** Inappropriate testing and duplicated workups increase costs for patients and insurers without improving outcomes.

A broader safety principle must also be emphasized: the most dangerous scenario is not lack of knowledge, but lack of awareness of one's limits. This is not unique to any one profession but becomes particularly relevant when expanding scope without proportional increases in training and oversight.

To be constructive, I respectfully recommend that if this legislation moves forward, it include the following amendments:

1. **Imaging restrictions:** Limit ordering of advanced imaging and contrast studies to providers with formal radiologic training or require ongoing documented collaborative agreements with physicians for such orders.
2. **Clear responsibility standards:** Require that the ordering provider is responsible for interpretation, patient communication, and initial management of results.
3. **Antibiotic prescribing safeguards:** Require adherence to CDC guidelines, participation in antibiotic stewardship programs, and defined limits on prescribing authority.
4. **Formulary limitations:** Narrow the definition of allowable biological substances to those with established safety and evidence, excluding unregulated or experimental therapies.
5. **Collaborative care requirements:** Extend supervision beyond one year for expanded scope areas, particularly in diagnostic and pharmacologic domains.

6. **Education and credentialing standards:** Tie any expanded privileges to additional, verifiable training and competency assessment.

I want to reiterate that this position is not about restricting naturopathic practice but about ensuring that scope expansions are thoughtful, evidence-based, and centered on patient safety. There is meaningful opportunity for collaboration between NDs and physicians, but that collaboration must be structured in a way that minimizes risk and maximizes clarity in patient care.

Thank you for your time and consideration of this important issue.

Respectfully,

Erin Oakley, DO