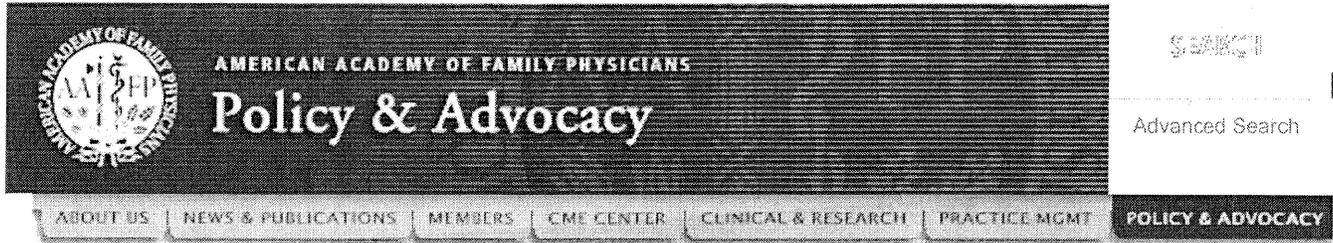




Commission to Study Primary Care Medical Practice

Background Information

<u>Item</u>	<u>Page #</u>
1. Definition of Primary Care Practice	1
2. Excerpt from report “Primary Care Safety Net Environmental Scan”	3
-- includes maps of some Primary Care Sites and Hospitals in Maine.....	11
3. Historical Data on Physicians and Primary Care Physicians in Maine	13
4. Excerpt from “2006 Healthcare Occupation Report”	17
5. Article “Finances driving physicians out of solo practice	45
6. Example of Hospital Payor Mix	51
7. Number of Physicians in Hospital-owned Practices.....	53



The banner features the AAFP logo on the left, the text "AMERICAN ACADEMY OF FAMILY PHYSICIANS" and "Policy & Advocacy" in the center, and a search bar on the right with a "SEARCH" button and "Advanced Search" link. Below the banner is a navigation menu with buttons for "ABOUT US", "NEWS & PUBLICATIONS", "MEMBERS", "CME CENTER", "CLINICAL & RESEARCH", "PRACTICE MGMT", and "POLICY & ADVOCACY".

[Home Page](#) > [Policy & Advocacy](#) > [AAFP Policies](#) > [Primary Care](#)

Primary Care

In defining primary care, it is necessary to describe the nature of services provided to patients, as well as to identify who are the primary care providers. The domain of primary care includes the primary care physician, other physicians who include some primary care services in their practices, and some non-physician providers. However, central to the concept of primary care is the patient. Therefore, such definitions are incomplete without including a description of the primary care practice.

The following five definitions relating to primary care should be taken together. They describe the care provided to the patient, the system of providing such care, the types of physicians whose role in the system is to provide primary care, and the role of other physicians, and non-physicians, in providing such care. Taken together they form a framework within which patients will have access to efficient and effective primary care services of the highest quality.

Definition #1 - Primary Care

Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate.

Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.

Definition #2 - Primary Care Practice

A primary care practice serves as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services. Primary care practices provide patients with ready access to their own personal physician, or to an established back-up physician when the primary physician is not available.

Primary care practices provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).

Primary care practices are organized to meet the needs of patients with undifferentiated problems, with the vast majority of patient concerns and needs being cared for in the primary care practice itself. Primary care practices are generally located in the community of the patients, thereby facilitating access to health care while maintaining a wide variety of specialty and institutional consultative and referral relationships for specific care needs. The structure of the primary care practice may include a team of physicians and non-physician health professionals.

Definition #3 - Primary Care Physician

A primary care physician is a generalist physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's care. Such a physician must be specifically trained to provide primary care services.

Primary care physicians devote the majority of their practice to providing primary care services to a defined population of patients. The style of primary care practice is such that the personal primary care physician serves as the entry point for substantially all of the patient's medical and health care needs - not limited by problem origin, organ system, or diagnosis. Primary care physicians are advocates for the patient in coordinating the use of the entire health care system to benefit the patient.

Definition #4 - Non-Primary Care Physicians Providing Primary Care Services

Physicians who are not trained in the primary care specialties of family medicine, general internal medicine, or general pediatrics may sometimes provide patient care services that are usually delivered by primary care physicians. These physicians may focus on specific patient care needs related to prevention, health maintenance, acute care, chronic care or rehabilitation. These physicians, however, do not offer these services within the context of comprehensive, first contact and continuing care.

The contributions of physicians who deliver some services usually found within the scope of primary care practice may be important to specific patient needs. However, the absence of a full scope of training in primary care requires that these individuals work in close consultation with fully-trained, primary care physicians. An effective system of primary care may utilize these physicians as members of the health care team with a primary care physician maintaining responsibility for the function of the health care team and the comprehensive, ongoing health care of the patient.

Definition #5 - Non-Physician Primary Care Providers

There are providers of health care other than physicians who render some primary care services. Such providers may include nurse practitioners, physician assistants and some other health care providers.

These providers of primary care may meet the needs of specific patients. They should provide these services in collaborative teams in which the ultimate responsibility for the patient resides with the primary care physician. (1975) (2006)

*In this document, the term physician refers only to doctors of medicine (M.D.) and osteopathy (D.O.).

Use of Term

The AAFP recognizes the term "primary care" and that family physicians provide services commonly recognized as primary care. However, the terms, "primary care" and "family medicine" are not interchangeable. "Primary care" does not fully describe the activities of family physicians nor the practice of family medicine. Similarly, primary care departments do not replace the form or function of family medicine departments. (1977) (2006)

State of Maine Primary Care Safety Net Environmental Scan

FINAL REPORT February 2006

Submitted to:

Maine Health Access Foundation
150 Capitol Street, Suite 4
Augusta, Maine 04330



Strategic solutions for Maine's health care needs

Submitted by:

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Jonathan Stewart, Senior Analyst
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Ashley Marks, Project Coordinator



TABLE OF CONTENTS

	<u>Page #</u>
EXECUTIVE SUMMARY	i
I. PROJECT PURPOSE APPROACH AND ACTIVITIES	1
A. Purpose of the Project	1
B. Approach	1
C. Project Limitations	2
II. OVERVIEW OF PRIMARY CARE SAFETY NET IN MAINE	3
A. The Need for a Primary Care Safety Net in Maine	3
B. Safety Net Provider Types	4
III. SAFETY NET PROVIDERS	7
A. Safety Net Organizations Serving as Medical homes	8
B. Safety Net Organizations NOT Serving as Medical homes	33
IV. OPPORTUNITIES TO EXPAND AND STRENGTHEN THE SAFETY NET	47
APPENDICES	51
1. List of Key Informant Interviews	
2. Secondary Data Sources/Literature Review	
3. Safety Net Provider Maps	
4. Listing of Safety Net Providers by Provider Group	
5. Summary Demographic and Socio-economic Characteristics	
6. Medical home Provider Matrix	
7. Non-Medical home Provider Matrix	



State of Maine

Primary Care Safety Net Environmental Scan

EXECUTIVE SUMMARY

Purpose of the Project and Approach

The Maine Health Access Foundation (MeHAF) contracted with John Snow Inc. (JSI) to assist the Foundation in conducting an environmental scan of the primary health care safety net in Maine. The goal of the environmental scan was to provide MeHAF with additional information about the range of health care providers that make up Maine's primary care safety net and help the Foundation target its resources to strengthen and expand the safety net.

The environmental scan addressed the following major questions:

1. What is the safety net system in Maine? What are the major components of the safety net including, primary medical care, oral health and mental health and substance abuse providers. What is the role of private-practice physicians providing uncompensated care?
2. Based on the following definition of a "medical home" (a "medical home" provides primary care and collaborates with patients and other providers to ensure that care is accessible, continuous, comprehensive, high quality, coordinated, compassionate, and delivered. Care is available 24 hours a day, seven days a week), which types of providers form the core of Maine's safety net system in terms of providing medical homes for the greatest numbers of the uninsured, underinsured, and underserved compared to other components of the safety net system? In addressing this question, the scan recognizes that the "medical home" concept is an ideal that may not be easily achieved when providing services to underserved, hard to reach populations, especially when safety net providers have limited and categorically constrained funding streams.
3. What services, if any, are not or generally not provided by existing safety net providers? Identify these gaps in terms of relevant characteristics, such as type of service, population affected, and geography?
4. Where are the Foundation's best opportunities to strengthen and expand the service capabilities and reach of existing Maine health care safety net providers?

JSI used a range of qualitative and quantitative approaches in conducting the environmental scan including: key informant interviews with nearly 50 people across the State; secondary data analysis utilizing existing reports and data available; primary data collection of components of the safety net focusing on describing the various component parts of the safety net and estimating the volume of service where not available from existing data sources; geo-mapping displaying the locations of the various types of safety net providers throughout the State; and a literature review on other safety net models



Project Limitations

The environmental scan was intended to provide MeHAF with a primer on the primary care safety net in Maine. In order to complete the study quickly and within a limited budget, the project was intentionally confined to describing the primary care safety net. MeHAF understands that the safety net must include the full scope of health care services including emergency, specialty, diagnostic and inpatient services as well as primary care, but these were outside the scope of this scan. Additionally, the scan did not include a detailed assessment of the need for safety net services in various parts of the State nor a comparison of need to available services. Looking further at other components of the safety net and quantifying the gap between need and current services are potential issues for further study.

Overview of the Primary Care Safety Net in Maine

As in most states, a major purpose of the safety net in Maine is to provide care to low income, uninsured and underinsured groups who have difficulty paying for services in the private sector. However, in many rural areas of the State, so-called safety net providers are essential to provide access for the entire population. Also safety net providers in Maine tend to serve Maine's non-English speaking and minority populations, because much of the private sector has not developed the linguistic and cultural capacity to serve these groups. Thus, the safety net in Maine has the role of filling all types of access gaps and in many rural parts of the State is the only system of care.

The environmental scan focused on primary health care services. For purposes of this project, primary care is broadly defined to include primary medical care, oral health, mental health and substance abuse. Based on this broad definition of primary care as well as the role of Maine's safety net in addressing geographic, language and financial barriers to care, many different types of provider groups make up Maine's safety net.

Primary Medical Care Providers

Many different primary medical care providers contribute to the safety net. Most of these serve as "medical homes" while others provide specific services or serve specific population groups. Key provider groups include: critical access hospitals (CAH) and other hospitals, Health Care Access Programs, Federally Qualified Health Centers (FQHC), Indian Health Service clinics, Rural Health Clinics (RHC), primary care residency programs, School Based Health Centers (SBHC), family planning clinics, public health department clinics, and free clinics. Furthermore, independent, privately practicing primary care physicians provide services to people who would otherwise access the safety net, although the extent of their contribution remains unquantified.

While the range of primary medical care providers contributing to Maine's health care safety net is extensive, considerable variation exists on how providers participate and the extent to they serve low income uninsured populations. Considerable variation also exists in the perceptions of policy-makers and different types of providers about which organizations form the core of the safety net.



Oral Health Providers

The safety net for oral health services is much more limited than the primary care safety net. It includes FQHCs (several new FQHC dental sites have been added in recent years), and a handful of non-profit organizations. Also, hygienists contribute to the safety net both through the hygienist education program and private hygienists providing direct service. Private hygienist services are limited in scope and not well understood or quantified yet. Due to the limited safety net for oral health services, low income people often turn to hospital emergency departments. However, hospitals are generally not equipped or staffed to provide oral health services so are not included as part of the safety net.

Mental Health and Substance Abuse Providers

Mental health and substance abuse services in Maine are provided by hundreds of providers that provide services across a spectrum of educational, diagnostic, crisis intervention, outpatient, inpatient, home-based and residential services. For purposes of this scan of the primary care safety net, we have focused on outpatient mental health and substance abuse counseling as the services most closely aligned to the primary care safety net. Although private practitioners and agencies clearly contribute to providing services to low-income uninsured clients, two main groups of providers comprise the safety net for outpatient mental health and substance abuse counseling services in the State: 1. FQHCs and 2. State-contracted agencies. State-contracts are issued separately for adult mental health services, children's mental health services and substance abuse services. For the most part, contracted agencies are private, not-for-profit mental health and/or substance abuse organizations, although some are multi-purpose agencies that also provide other health and human services. A few FQHCs are also among the State-contracted agencies.

Opportunities to Expand and Strengthen The Safety Net

In addition to describing the primary care safety net in Maine, the environmental scan is intended to help MeHAF target its resources to strengthen and even transform the safety net. Based on the scan, some major areas for MeHAF to consider in its future programming and grants-making activities include:

- Work to achieve greater integration among components of the safety net. Stimulating more and better collaboration among the component parts of the safety net is one place MeHAF can potentially help truly transform the safety net to make best use of the services currently available, improve quality, achieve efficiencies and ultimately lead to a true system of care both at the local level and Statewide. Opportunities for enhanced collaboration exist among all provider groups but are particularly urgent among mental health and substance abuse providers and between mental health, substance abuse and primary care.
- Support capacity development both through new safety net providers and enhanced capabilities within current providers. Greater collaboration is critical to strengthening Maine's safety net, but can not alone address all the gaps in services or unmet needs.



Some of the most critical needs noted in the scan include mental health counseling for adults and adolescents who are not diagnosed as seriously and persistently mentally ill, mental health and substance abuse services specifically focused for older adults, substance abuse counseling for people who have not come through the criminal justice system, psychiatry for children in the northern part of the State, and oral health services, particularly for adults, Statewide.

Providers need operating funds to support safety net services either to cover the costs of serving additional uninsured patients and/or providing non-reimbursable supportive services that are essential to effective access. MeHAF should continue to help programs obtain operational funding to enhance capacity; by supporting demonstration projects that position providers for more substantial funding, assisting in grant writing through educational forums or one-on-one assistance, or providing start-up funding for programs that can become self-sustaining.

MeHAF can also support activities that expand capacity without funding for new programs or services. For example, sharing “best practice” approaches and providing training to assist general medical providers provide some mental health and substance abuse services within the primary medical care setting (or conversely helping mental health and substance abuse providers identify primary medical care issues) can help extend capacity in key areas.

- Increase involvement of providers who may not normally be considered part of the safety net. Many providers are involved in providing safety net services, but are not always identified as being part of the safety net. These include hospitals and their physician practices, RHCs, primary care residency programs and independent private practitioners. Involving more diverse provider groups in discussions and initiatives related to the safety net could be accomplished by convening meetings including these groups or for these groups, as well as encouraging funding applications from places that have not historically applied for Foundation funding.

Involving independent private practitioners including physicians, licensed mental health and substance abuse professionals, dentists and hygienists represent a special challenge because they are so disperse and their practices are so variable. MeHAF could help involve more private practitioners in organized and coordinated care systems by building on the approach taken and lessons learned by the exiting Health Care Access Programs. These programs have been successful in organizing volunteer providers into care systems for the uninsured and are one important way to bring committed individuals into the system and support them.

- Move the Dialogue beyond Primary Care to Encompass all Safety Net Providers.

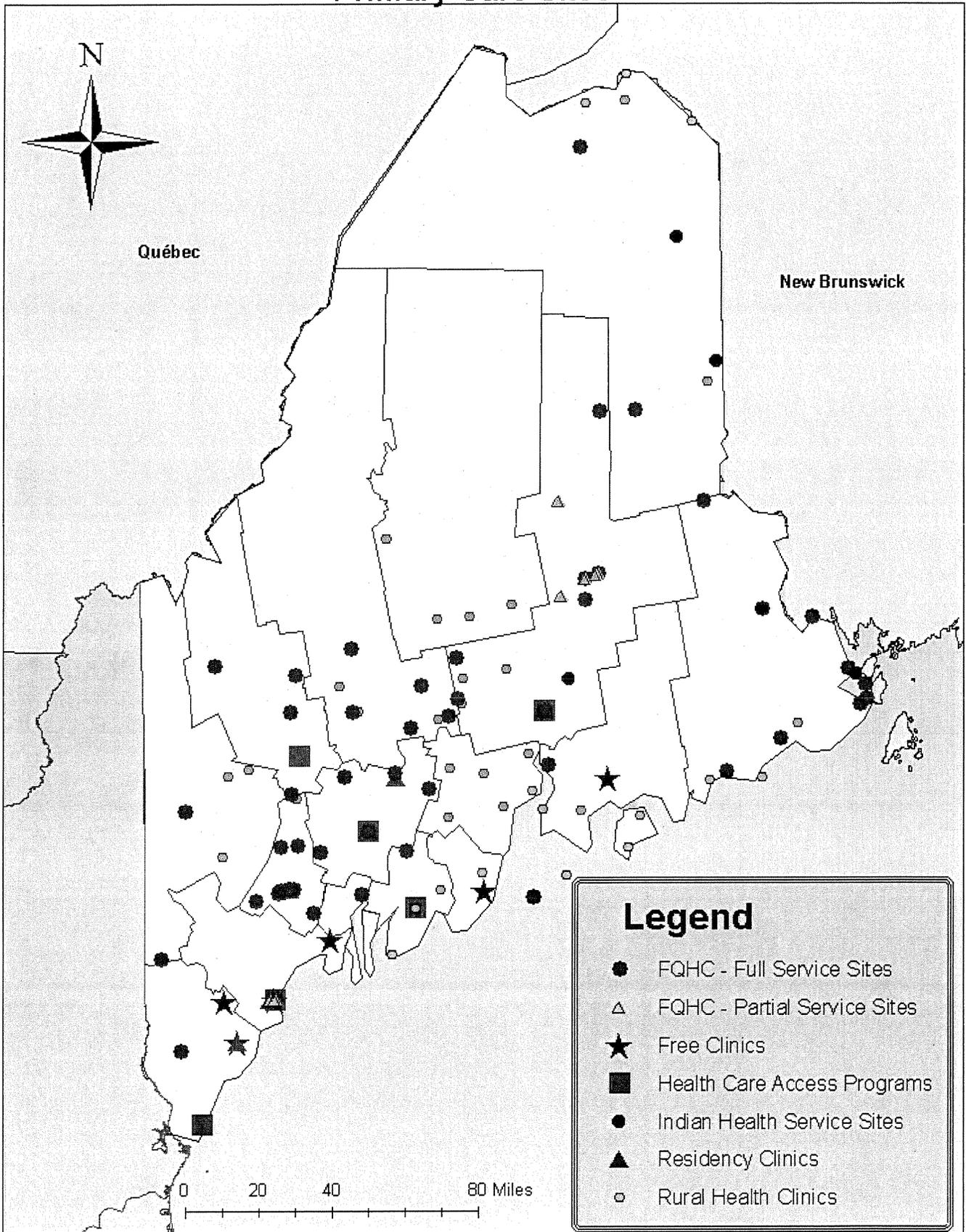


Additional efforts to integrate primary care components of the safety net are important to transforming the safety net system. However, until all components of the system (primary care, specialty care, hospital services, residential/long term care, home care etc) are strong and work together, the system will remain extremely fragile. Critically, recruiting and retaining the health professionals that sustain the safety net depends on having resources across the spectrum of care. While systemic change is inevitably a long-term, complex process, MeHAF has an opportunity to provide leadership in strengthening the full safety net system by better portraying the complete story of the safety net and taking a role in facilitating dialogue, joint planning and strategy development at community and State level.



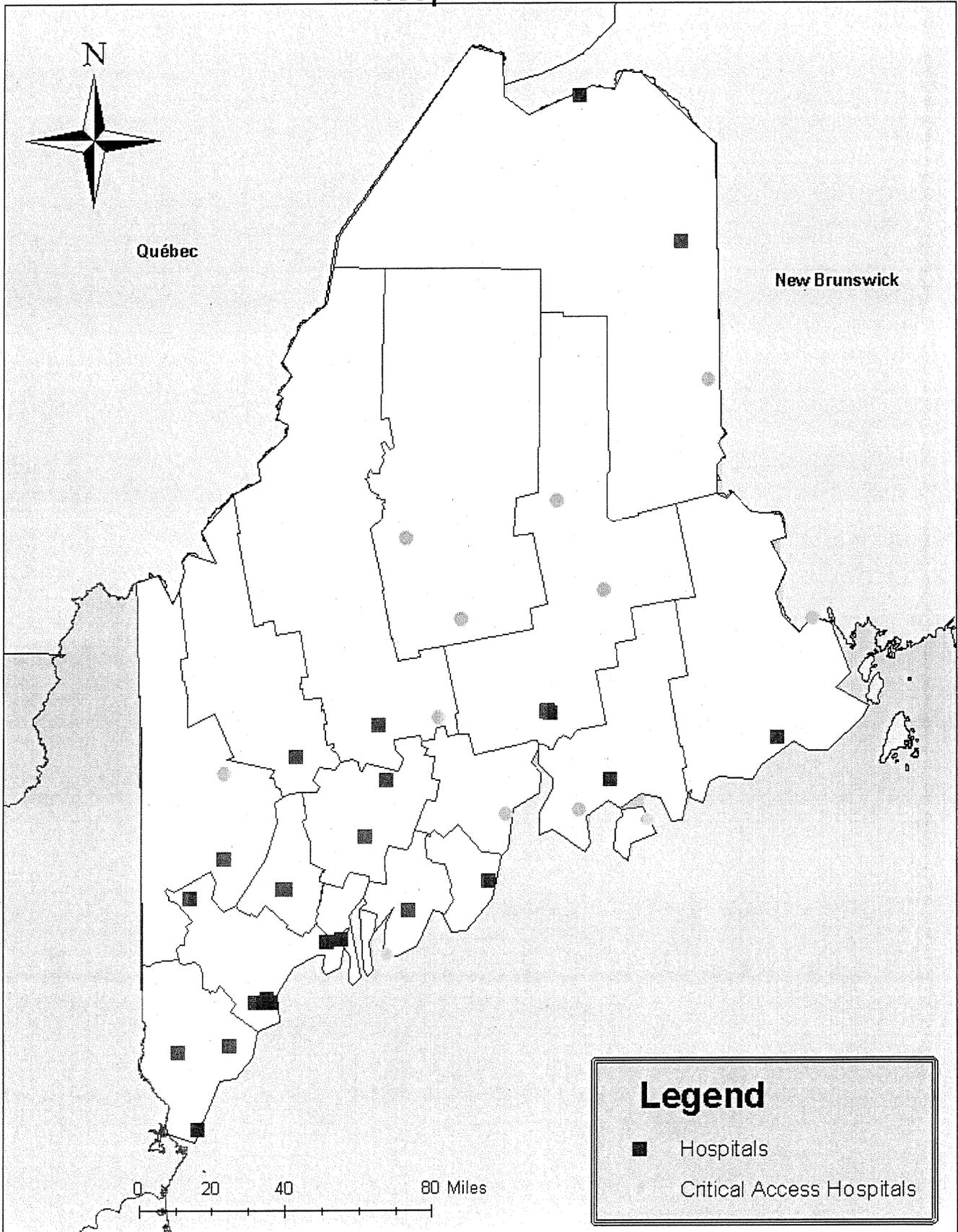
MeHAF Resource Inventory

Primary Care Sites



MeHAF Resource Inventory

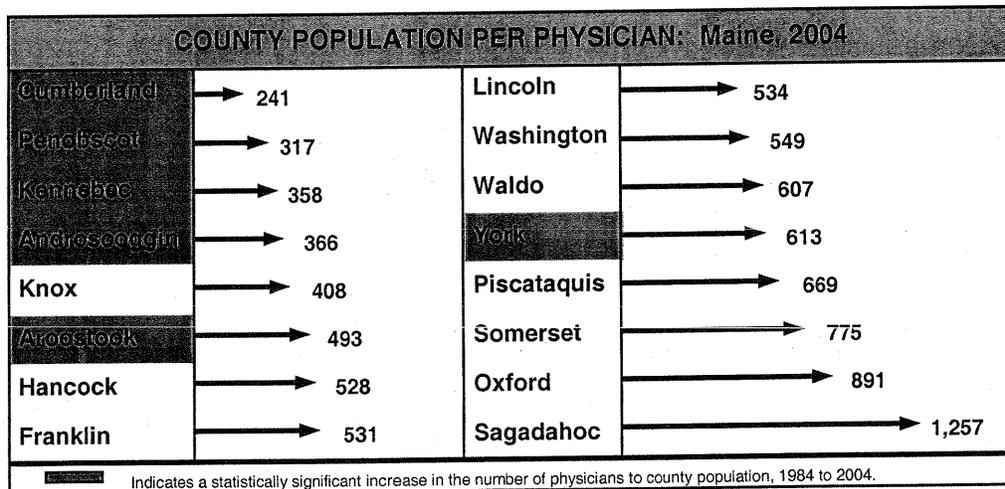
Hospital Sites



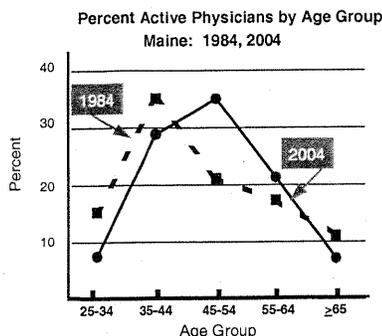
MAINE PHYSICIANS: 2004

Data are from the
MAINE HEALTH CARE WORKFORCE RESOURCE SYSTEM

- In 2004, 3,309 physicians worked in Maine: 2,865 allopathic physicians (MDs) and 444 osteopathic physicians (DOs) - a 72% increase over the number of physicians working in Maine in 1984 (1,922).
- This resulted in a ratio of 1 physician for every 395 Maine residents in 2004, a ratio significantly smaller than in 1984 when there was 1 physician for every 602 residents.
- Although there were more physicians working in Maine in 2004 than twenty years ago, Maine still had fewer physicians for its population than the US (there was 1 physician for 318 residents nationwide).¹
- Since 1984, all counties (with the exception of Sagadahoc) have improved their physician to population ratio, i.e. there were fewer residents for each physician to serve in 2004 than there were in 1984.



- The most frequently reported specialty in 2004 was family/general practice accounting for 660 physicians.
- While the number of primary care physicians (general practice, family practice, obstetrics, gynecology, internal medicine, and pediatrics specialties) has increased 67% since 1984, the percent of primary care physicians has remained at 38% of all physicians.
- The age composition of Maine's physician population changed during the past 20 years. While the profession as a whole grew by 72%, the proportion of physicians at either end of the age spectrum decreased—by 50% for those younger than 35 years old, and by 35% for those 65 years old and older. The proportion of physicians 45-54 years old increased by 66% and nearly 25% for physicians 55-64 years old.



Notes: Differences in rates and percentages are statistically significant unless noted, i.e., they could not be accounted for by chance alone. ¹Population Estimates, Office of Data, Research, and Vital Statistics and US Census Bureau. Full citations are available upon request.

→ The average age of Maine physicians was 49 years old in 2004, an average that is 2 years older than it was in 1984.

For further data on this topic, please contact:

the Office of Data, Research, and Vital Statistics, Maine Center for Disease Control and Prevention
244 Water Street, #11 State House Station, Augusta, Maine 04333-0011
The contact person is: Sue LeDoux - (207) 287-5500 (800) 606-0215 (TTY)

Please visit the ODRVS website at: <http://www.maine.gov/dhhs/bohodr/index.htm>

John Elias Baldacci
Governor



Brenda M. Harvey
Commissioner

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Number 1

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Series 14

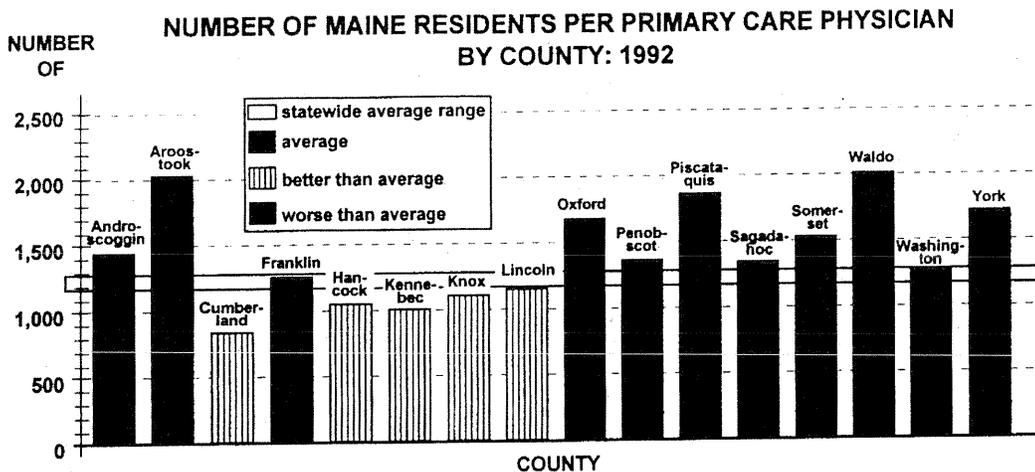
PHYSICIANS
MAINE: 2004

FACT SHEET

MAINE PRIMARY CARE* PHYSICIANS

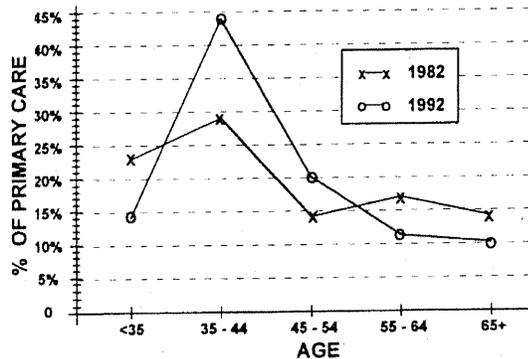
1992

- ➔ In 1992, 993 physicians reported that they were working in a primary care specialty in Maine (43% of active doctors). This is a 20% increase in physicians with these specialties over the previous decade when 830 physicians reported them as their primary practice area.
- ➔ Although there has been an overall improvement statewide in the ratio of primary care physicians to population over the past decade, this ratio has deteriorated in Androscoggin, Aroostook, Lincoln, Oxford, Piscataquis, and York counties.



- ➔ Proportionally, there are fewer primary care physicians in the youngest and oldest age groups than there were a decade ago. 64% of physicians are now in the 35 - 54 years old age group compared to 43% in 1982.

PERCENT MAINE PRIMARY CARE PHYSICIANS BY AGE: 1982, 1992



- ➔ In 1992, 93% of primary care physicians treated Medicaid patients. Of these, one third limited the percent of patients in their practices covered by Medicaid. 68% of primary care physicians in Maine accepted new Medicaid patients in 1992.

* Primary care physicians are licensed, actively practicing MDs and DOs who reported a primary specialty of general practice, family practice, pediatrics, obstetrics, gynecology, obstetrics and gynecology, or internal medicine.

For further data on this topic, please contact:
 the Office of Data, Research, and Vital Statistics, Bureau of Health
 at 35 Anthony Avenue, State House Station 11, Augusta, Maine 04333-0011
 The contact person(s) is: Marty Burns - (207) 624-5445

John R. McKernan, Jr.
Governor



Jane Sheehan
Commissioner

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TABLE 1
ACTIVE PHYSICIANS* IN MAINE WHO SPECIFIED PRIMARY CARE AS A FIRST SPECIALTY
SELECTED STATISTICS BY COUNTY OF EMPLOYMENT
ALLOPATHIC PHYSICIANS (DECEMBER 31, 2002) AND OSTEOPATHIC PHYSICIANS (JANUARY 1, 2002)

COUNTY OF EMPLOYMENT	TOTAL PHYSICIANS		AVERAGE PT CARE HOURS PER WEEK		2002 POPULATION	POPULATION PER PHYSICIAN		COMBINED
	MD	DO	MD	DO		MD	DO	
TOTAL	1133	221	39.61	41.54	1294464	1143	5857	956
Androscoggin	82	22	41.88	39.70	104805	1278	4764	1008
Aroostook	64	9	45.22	47.38	73122	1143	8125	1002
Cumberland	330	57	35.09	41.20	269083	815	4721	695
Franklin	27	3	35.19	45.33	29683	1099	9894	989
Hancock	55	5	38.26	35.20	52359	952	10472	873
Kennebec	111	24	38.22	44.13	118244	1065	4927	876
Knox	36	3	46.29	31.00	40477	1124	13492	1038
Lincoln	32	4	43.74	48.00	34407	1075	8602	956
Oxford	25	12	41.38	45.92	55604	2224	4634	1503
Penobscot	129	26	42.82	42.72	146015	1132	5616	942
Piscataquis	15	2	42.14	45.00	17203	1147	8602	1012
Sagadahoc	17	2	42.00	40.00	35983	2117	17992	1894
Somerset	35	10	39.46	40.00	50963	1456	5096	1133
Waldo	28	3	36.92	42.00	37628	1344	12543	1214
Washington	39	6	37.75	52.00	33401	856	5567	742
York	108	33	45.81	36.16	195487	1810	5924	1386

*LICENSED, ACTIVE PROFESSIONALS WORKING IN MAINE WHO RESPONDED TO THE SURVEY.

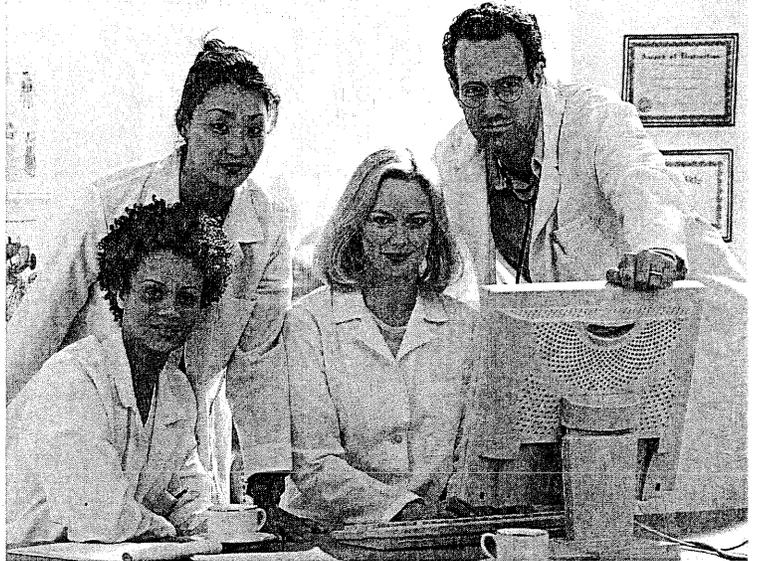
NOTES: THE CALCULATION OF AVERAGE PATIENT CARE HOURS PER WEEK EXCLUDES 90 PHYSICIANS WITH UNKNOWN PATIENT CARE HOURS. SOME PHYSICIANS REPORT MORE THAN ONE SPECIALTY. AVERAGE PATIENT CARE HOURS PER WEEK IN THIS TABLE REPRESENTS THE AVERAGE OF ALL PATIENT CARE HOURS REPORTED BY PHYSICIANS WITH PRIMARY CARE AS A FIRST SPECIALTY; SOME OF THESE HOURS MAY REPRESENT TIME SPENT IN ANOTHER SPECIALTY AREA.

SOURCES OF DATA: MAINE COOPERATIVE HEALTH MANPOWER RESOURCE INVENTORY, ODRVS AND US CENSUS BUREAU.

MAINE DEPARTMENT OF LABOR

Special Report

January 31, 2007



2006 Healthcare Occupations Report

By: Matthew Kruk

MAINE
DEPARTMENT OF
LABOR
Labor Market Information

Table of Contents

CHAPTER 1

INTRODUCTION

Introduction	1
Highlights	3
Recommendations	5

CHAPTER 2

HEALTHCARE INDUSTRY

Healthcare Industry	9
Maine's Healthcare Industry	17

CHAPTER 3

PHYSICIANS, SURGEONS, AND RELATED

Physicians and Surgeons, All	25
Physicians and Surgeons, Specialties	35
Physician Assistants	41
Surgical Technologists	45

CHAPTER 4

DENTISTRY AND RELATED

Dentist	51
Dental Hygienists	61
Dental Assistants	65

CHAPTER 5

OTHER DOCTORAL-LEVEL PRACTITIONERS

Chiropractors	69
Optometrists	73
Podiatrists	77

CHAPTER 6

NURSING

Registered Nurses	83
Licensed Practical Nurses	95

CHAPTER 7

DIRECT CARE WORKERS

Direct Care Workers	103
---------------------	-----

CHAPTER 8

THERAPISTS AND RELATED

Occupational Therapists	113
Occupational Therapist Assistants	117
Occupational Therapist Aides	121
Physical Therapists	123
Physical Therapist Assistants	127
Physical Therapist Aides	131
Radiation Therapist	133
Recreational Therapists	135
Respiratory Care Therapists and Technicians	139
Massage Therapists	143

CHAPTER 9

PHARMACISTS AND RELATED

Pharmacists	147
Pharmacy Technicians	153

CHAPTER 10

HEALTH TECHNOLOGISTS AND TECHNICIANS

Medical and Clinical Laboratory Technologists	159
Medical and Clinical Laboratory Technicians	163
Cardiovascular Technologists and Technicians	167
Diagnostic Medical Sonographers	171
Nuclear Medicine Technologists	175
Radiologic Technologists and Technicians	179
Emergency Medical Technicians and Paramedics	183

Highlights

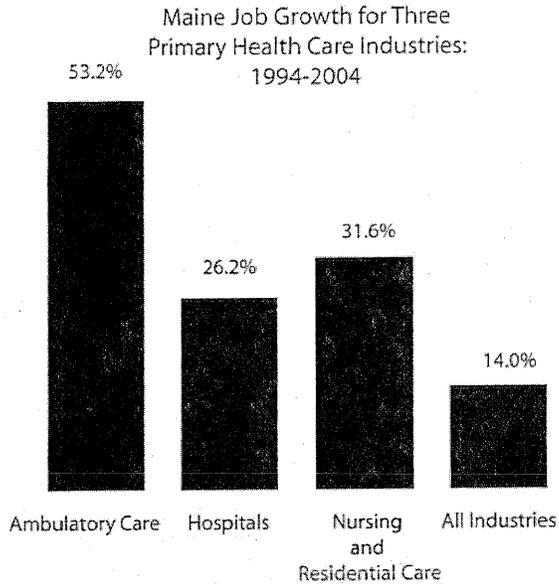
Serving as a valuable source of workforce information for the healthcare industry, this report is full of important data. This data is largely based upon the surveys completed during the relicensure process of various healthcare professionals. Because relicensure dates differ greatly between occupations, only four datasets are currently complete. As a result, most of the following highlights focus on these four occupations and represent the depth of information that may be obtained for all licensed occupations in the future. The following items are particularly noteworthy and reflect findings for Maine:

- The healthcare industry is the single largest industry in Maine with an average employment of over 75,000 in 2004; this accounted for 13% of all wage and salary employment in the state.¹ Wages paid within this industry totaled nearly \$2.7 billion, which was 14% of total wages paid in Maine. Nationally, healthcare accounted for nine percent of both employment and total wages—significantly less than that of Maine; this further emphasizes the importance of the healthcare industry to Maine’s economy and its people.
- Maine, as a state, is aging rapidly and at a rate faster than that of the rest of the country. Age is often associated as the most significant driver in the demand for healthcare-related services, and, subsequently, employment in healthcare occupations. Thus, the importance of an adequate supply of skilled healthcare professionals should be paramount in Maine, a state nearly unrivaled nationally in terms of aging.
- MaineCare, the state-managed program that is funded jointly by the state and federal government to provide health insurance and long-term care to eligible, low-income individuals, insures one out of every five people in Maine.
- Inactive licensed healthcare professionals generally report not intending to return to work; these individuals, ultimately, may not be a likely source of labor market participants—although they do maintain current licenses.
- A great deal of gender disparity exists within all of the occupations that possessed complete survey data sets.
- There are two types of Physicians: MDs—Doctors of Medicine—and DOs—Doctors of Osteopathic Medicine. In Maine, 79% of Physicians are MDs, yet Maine’s only medical school—the University of New England’s College of Osteopathic Medicine—graduates only DOs.
- Residency opportunities in Maine are relatively limited as only 26.4% of responding Physicians and Surgeons completed his or her residency in Maine. This is important as residency opportunities are one of the best tools in recruiting and retaining Physicians—especially when one considers how few Maine Physicians are educated in-state.

1 INTRODUCTION

- Roughly one out of every three Surgeons in Maine is over the age of 60, and one out of every five physicians is at or nearing typical retirement age.
- Physician recruitment for rural areas is challenged by lower earning potential, longer hours, and isolation from medical colleagues, coupled with heavy debt loads from over ten years of training, including college, medical school, internship and residency.
- The distribution of Specialty Dentists (Oral & Maxillofacial Surgeons, Orthodontists, and Prosthodontists) among Maine counties is extremely concentrated. Survey responses indicate that several counties do not even have one active specialist.
- Populations in rural communities find it proportionally more difficult to access dental care than urban populations.
- Over 30% of all Dentists in Maine are over the age of 60, and over 68% are over the age of 50. Clearly, impending retirements will have a significant impact on the supply of Dentists.
- The demand for Dentists is expected to grow substantially through the year 2012.
- Dental Hygienists are expected to be one of the fastest growing healthcare occupations in Maine through the year 2012.
- The number of job vacancies for Registered Nurses increased significantly from 2002 to 2005; in 2005 there were an estimated 853 vacancies—an increase of 215 from 2002.
- The average age of Registered Nurses in Maine is 48.9 years old. The age distribution of these professionals is uneven and ensuring an adequate supply of Registered Nurses in the future may prove problematic as over 13% of all Registered Nurses over the age of 52 expect to leave nursing within the next five years.
- There were 610 total graduates of Maine Nursing Programs during the 2004-2005 academic year.
- Over half of all Licensed Practical or Vocational Nurses (LPNs) are between the ages of 52 and 71. Thus, retirement concerns similar to that of RNs exist.
- Nursing Aides, Orderlies, and Attendants, a subset of Direct Care Workers, have experienced a persistence of significant vacancies. In 2005, the job vacancy rate has dropped only slightly from 2002, and there were an estimated 1,038 vacancies. Additionally, Personal and Home Care Aides, another subset of Direct Care Workers, has also experienced a persistence of significant vacancies. In 2005, there were an estimated 720 vacancies for this occupation.

Growth

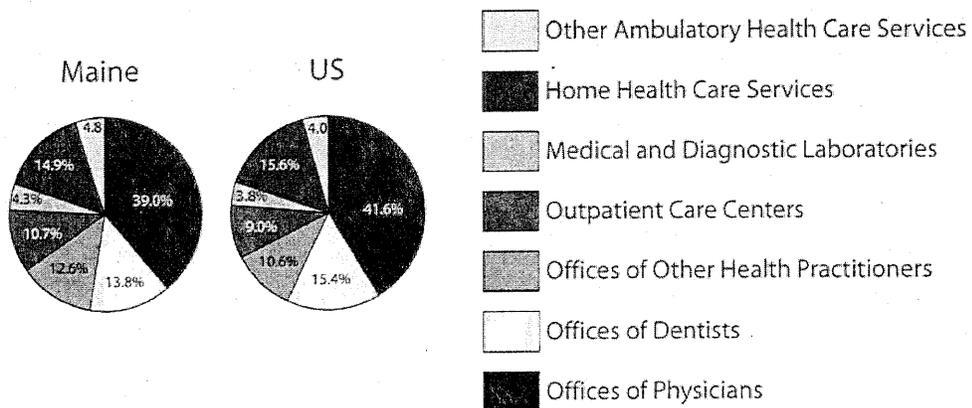


Employment in health care grew at nearly three times the all-industries average between 1994 and 2004. The fastest growth was among ambulatory health care providers and the slowest growth was in hospitals.

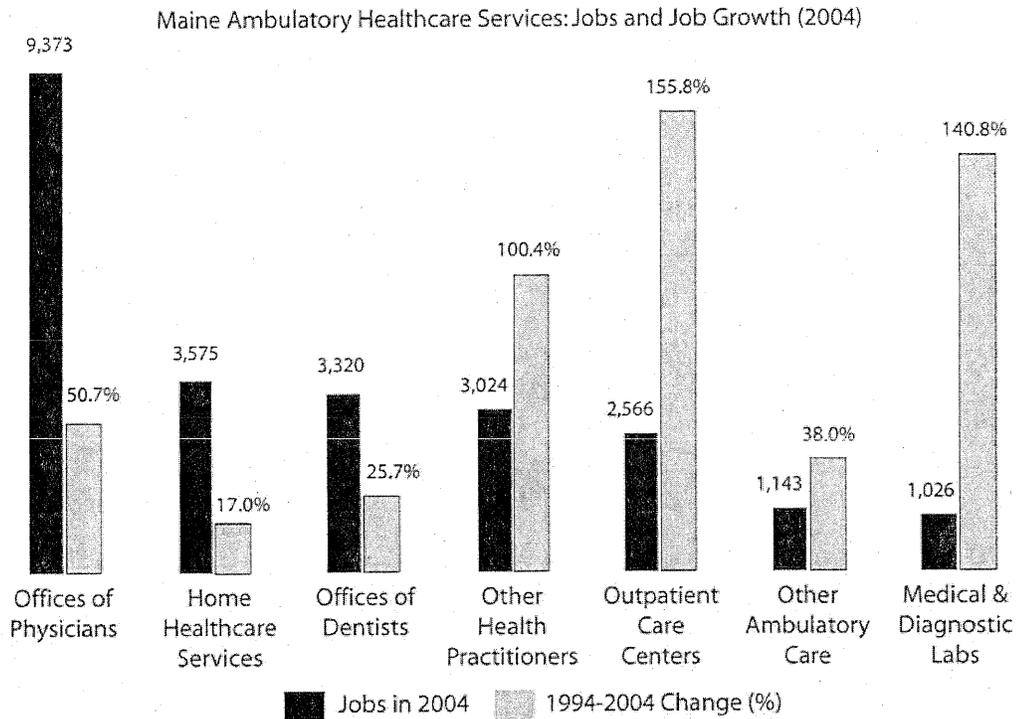
Ambulatory Healthcare Services

The structure of ambulatory healthcare services in Maine is similar to the nation, with nearly 68 percent of the 24,027 jobs in offices of physicians, home health care services, and offices of dentists in 2004.

2004 Structure of Ambulatory Health Care Services: Maine and National

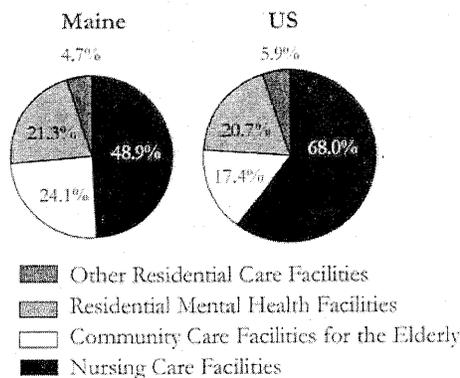


Between 1994 and 2004 the fastest ambulatory care job growth was among the smaller providers, particularly medical and diagnostic labs, up 141 percent; outpatient care centers, up 156 percent; and offices of other health care providers, up 102 percent. Other health care providers include offices of chiropractors, optometrists, mental health practitioners, specialty therapists, and podiatrists.



Nursing and Residential Care

Nursing and Residential Care Employment: 2004



The structure of Maine nursing and residential care employment differed somewhat from the nation, with a higher share in residential mental health care and a lower share in nursing care. Although Maine had a lower share in nursing care, the state still possessed a higher number of nursing care jobs relative to the size of its population.

Physicians, Surgeons, and Related

This chapter focuses on Physicians and Surgeons—both Allopathic and Osteopathic—and those directly assisting them. It is important to note that this group of Physicians and Surgeons has historically been surveyed by the Maine CDC and a complete dataset for these occupations exists and is used in the following analysis. Other doctoral-level health professions that are not surveyed by the Maine CDC are found in Chapter 5.

Physicians and Surgeons, All	25
Physicians and Surgeons, Specialties	35
Physician Assistants	41
Surgical Technologists	45

Physicians and Surgeons, All

Physicians and Surgeons serve a fundamental role within the healthcare industry and society. This group of healthcare professionals—which includes numerous specialties—diagnose illnesses and prescribe and administer treatment for people suffering from injury or disease. The importance of the care provided by these individuals is evident—as is the importance of ensuring an adequate supply of Physicians and Surgeons. However, ensuring this supply may also prove challenging as Physicians and Surgeons are part of an international—rather than national—labor market and the recruitment of needed specialists to specific geographic areas may prove problematic. Further complicating matters is the fact that, as a group, Physicians and Surgeons are comprised of numerous specialty-defined labor markets (e.g. anesthesiology or pediatrics) that may experience differing levels of supply, demand, and compensation, as well as differing needs of labor market participants.

In addressing the need for information to help ensure an adequate supply of Physicians and Surgeons, this report provides data at both the group (All Physicians and Surgeons) and specialty levels from the Occupational Employment Statistics (OES) Survey and a survey developed and administered during the relicensure process by the Maine CDC.

Characteristic Data

The licensure of Physicians and Surgeons in Maine is carried out by two separate, autonomous boards of licensure, the Board of Licensure in Medicine for allopaths and the Board of Osteopathic Licensure for osteopaths. The Maine CDC, in collaboration with these boards, designed a survey to be enclosed with the relicensure application, mailed, filled out voluntarily by licensees, and returned to the boards. The data from these responses was then entered and maintained in a data file by the Maine CDC. This data file contained 1,975 responses for the 2004 renewal, which indicated response rates of 97.0% for allopathic physicians and 93.7% for osteopathic physicians. The following data for Physicians and Surgeons, and, when possible, broken down by specialty, is designed to address the needs of health planners, educators, researchers, and policymakers, and is obtained from the aforementioned data file, which is updated every two years.

Additional data is provided from the Occupational Employment Statistics (OES) survey, which produces occupational employment and wage estimates on a semi-annual basis.

Both surveys indicate a consistent distribution by specialty among Physicians and Surgeons, as shown in the following table.

Survey Results: Physician Distribution by Specialty				
Specialty	Maine CDC		OES	
	Total Responses	Percentage	Employment	Percentage
Anesthesiologists	91	4.6%	124	3.9%
Family & General Practitioners	414	21.1%	825	25.8%
Internists, general	255	13.0%	291	9.1%
Obstetricians & Gynecologists	82	4.2%	134	4.2%
Pediatricians	125	6.4%	142	4.4%
Psychiatrists	170	8.6%	198	6.1%
Surgeons	179	9.1%	450	14.1%
Physicians & Surgeons, all other	650	33.1%	1,033	32.3%
Total	1,966	100.0%	3,197	100.0%

Physician and Surgeons are typically male-dominated occupations, and this, in fact, is the case in Maine. Of those Physicians and Surgeons either living in or working in Maine, 72.3% are male, and only 27.7% are female. This disparity may be a significant issue in the future as demand for Physicians and Surgeons increases. As demand rises, women will be a largely untapped resource of potential medical school, and, later, labor market entrants.

In determining and ensuring an adequate supply of healthcare professionals, age is a very important component as retirement will be a significant source of attrition for Physicians and Surgeons. Roughly one out of every five physicians is at or nearing typical retirement age in Maine.

Physicians & Surgeons: Characteristic Data		
Age	Mean	Over 60
	50.9	21.3%
Gender	Male	Female
	72.3%	27.7%
Activity Status	Number Inactive	Percentage
	108	5.5%

The number of inactive (or non-practicing) licensed Physicians also impacts supply as these individuals may renew their licenses, yet do not provide direct patient care. Although these individuals maintain licenses, they may work in fields such as administration, research or policy.

It is important to understand how many licensed, inactive professionals exist and their reasons for not practicing as these individuals could help fill critical gaps between supply and demand. Those reasons cited for inactivity, as well as age data for those reporting inactivity, are provided in the following table.

Licensed Physicians and Surgeons: Reasons Why Inactive				
Reason	Number	Percentage	Mean Age	Age Range
Working in another field and seeking work as a physician	2	1.9%	66	64 – 68
Working in another field and not seeking work as a physician	5	4.6%	57.6	46 – 74
Unemployed and seeking work as a physician	4	3.7%	54.5	34 – 66
Retired/not intending to return to work	79	73.1%	75.5	54 – 94
Not working due to household responsibilities	10	9.3%	45.1	38 – 50
In training	1	0.93%	50	NA
Other	6	5.6%	57.8	52 – 69

Of the 108 inactive Physicians and Surgeons, only six are actively seeking work as a physician. Thus, the impact of inactive licensees on the labor market may be minimal.

Another aspect of supply is the number of healthcare professionals licensed and living in Maine, but practicing elsewhere. Fifteen Physicians and Surgeons responded that they live in Maine, but work out-of-state; as expected, nearly half of these individuals are employed in New Hampshire. Out-of-state employment numbers, by state, are provided in the table below for Physicians and Surgeons living in Maine

Physicians & Surgeons: Residing in Maine, Working Out-of-State	
State	Number
Connecticut	2
Kansas	1
Massachusetts	2
Minnesota	1
New Hampshire	7
New York	1
Rhode Island	1

Of the seven Physician and Surgeons working in New Hampshire, five (71.4%) reside in York County.

Educational Requirements

It takes many years of education and training to become a physician: four years of undergraduate school, four years of medical school, and three to eight years of residency training, depending on the specialty selected. The minimum educational requirement for entry into a medical school is three years of college; most applicants, however, have at least a bachelor's degree, and many have advanced degrees. All States, the District of Columbia, and U.S. territories license physicians. When Physicians complete training, most take national certifying board examinations in their specialty and must meet license requirements to practice in a specific state or U.S. territory.

Schools

In looking at the schools in Maine's physician workforce, it is important to understand that there are two types of medical schools and physicians: MD—Doctor of Medicine—and DO—Doctor of Osteopathic Medicine. MDs are also known as allopathic physicians. While both MDs and DOs may use all accepted methods of treatment, including drugs and surgery, DOs place special emphasis on the body's musculoskeletal system, preventative medicine, and holistic patient care. DOs are more likely than MDs to be primary care specialists, although they can be found in all specialties. About half of DOs practice general or family medicine, general internal medicine, or general pediatrics. The role and distribution of MDs and DOs in Maine is especially noteworthy as Maine's only medical school is osteopathic—yet nearly four out of five physicians and surgeons are MDs; this indicates that nearly 80% of physicians in Maine attend school outside of the state. The following table indicates the percentage distribution of MDs and DOs in Maine.

Percentage Distribution of MDs and DOs			
	Total	MD	DO
All Physicians & Surgeons	1,966	79.0%	21.0%

As the only provider of a medical program in Maine, the graduate capacity of the University of New England's Osteopathic Medicine program is an important factor in ensuring an adequate supply of Physicians and Surgeons in Maine. Graduation data for the academic year 2003-2004 is provided in the following table.

Physicians & Surgeons: Educational Programs and Completers			
Institution	Program	Credential/Degree/Award	Completers
University of New England	Osteopathic Medicine/Osteopathy	First-professional degree	104

National Employment

In 2002, there were 583,000 Physicians and Surgeons employed in the United States. In 2012, it is projected that there will be 697,000; this represents an annual average growth rate of 1.8 percent, faster than the 1.4 percent growth rate for all occupations in the United States. The following table illustrates the net change, growth rate and expected employment for this occupation in 2012.

2002 Estimated Employment	2012 Projected Employment	Total 2002 – 2012 Employment Change	Annual Average Percent Change
583,000	697,000	114,000	1.8

Demand

Employment of physicians and surgeons will grow about as fast as the average for all occupations through the year 2012 due to continued expansion of health services. The growing and aging population will drive overall growth in the demand for physician services, as patients continue to demand high levels of care using the latest technologies, diagnostic tests, and therapies.

Demand for physicians' services is highly sensitive to changes in consumer preferences, healthcare reimbursement policies, and legislation. For example, if changes to health coverage result in consumers facing higher out-of-pocket costs, they may demand fewer physician services. Demand for physician services may also be tempered by patients relying more on other healthcare providers—such as physician assistants, nurse practitioners, optometrists, and nurse anesthetists—for some healthcare services. In addition, new technologies will increase physician productivity. Telemedicine will allow physicians to treat patients or consult with other providers remotely. Increasing use of electronic medical records, test and prescription orders, billing, and scheduling will also improve physician productivity.

Supply

Opportunities for individuals interested in becoming physicians and surgeons are expected to be favorable. Reports of shortages in some specialties or geographic areas should attract new entrants, encouraging schools to expand programs and hospitals to expand residency opportunities. However, because physician training is so lengthy, employment change happens gradually. In the short term, to meet increased demand, experienced physicians may work longer hours, delay retirement, or take measures to increase productivity, such as using more support staff to provide services. Opportunities should be particularly good in rural and low-income areas, because some physicians find these areas unattractive due to lower earnings potential, isolation from medical colleagues, or other reasons.

Unlike their predecessors, newly trained physicians face radically different choices of where

and how to practice. New physicians are much less likely to enter solo practice and more likely to take salaried jobs in group medical practices, clinics, and health networks.

In Maine, medical school opportunities are limited to the University of New England—and this school is New England's (rather than just Maine's) medical school. As a result, many Maine students are forced to leave the state for over ten years to obtain education, training, and residency. During these years, the aspiring physicians and surgeons establish lives outside of Maine, and may, ultimately, decide against returning to their home state. However, with the University of New England producing 104 annual completers of the Osteopathic Medicine program, it is important to consider that about half of all DOs practice general medicine.¹⁷ These facts indicate that ensuring an adequate supply of Family and General Practitioners may be far easier than that of other specialties with far lower percentages of DOs.

Analysis

Physicians & Surgeons: 2002-2012 Estimated Annual Employment Needs	
Specialty	Needs
Anesthesiologists	5
Family & General Practitioners	30
Internists, General	10
Obstetricians & Gynecologists	5
Pediatricians	5
Psychiatrists	7
Surgeons	17
Physicians & Surgeons, All Other	35
Total	114

2003-2004 UNE Osteopathy Completers	104
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The total estimated annual employment needs for all Physicians and Surgeons is expected to be 114; although this figure only slightly exceeds the graduate capacity of Maine's only medical program, limited residency opportunities will have a dramatic effect on the supply of these healthcare professionals.

After the completion of medical school, three to eight years of internship and residency, depending on the specialty, are required. Residency opportunities have a dramatic impact on the supply of physicians and surgeons in Maine.

Currently, there are five Family Practice Residency Programs in Maine: Maine Medical Center (Portland), Central Maine Medical Center (Lewiston), Maine-Dartmouth Residency (Augusta), Eastern Maine Medical Center (Bangor), and the University of New England (Biddeford). Each of these residency programs has between five and ten family practice residents per year, and several of these positions are reserved for University of New England students. In addition to these Family Practice Residency Programs, Maine Medical Center also offers Internal Medicine,

Anesthesia, General Surgery, and Pediatrics residency programs, as well as a number of subspecialty fellowship programs.¹⁸

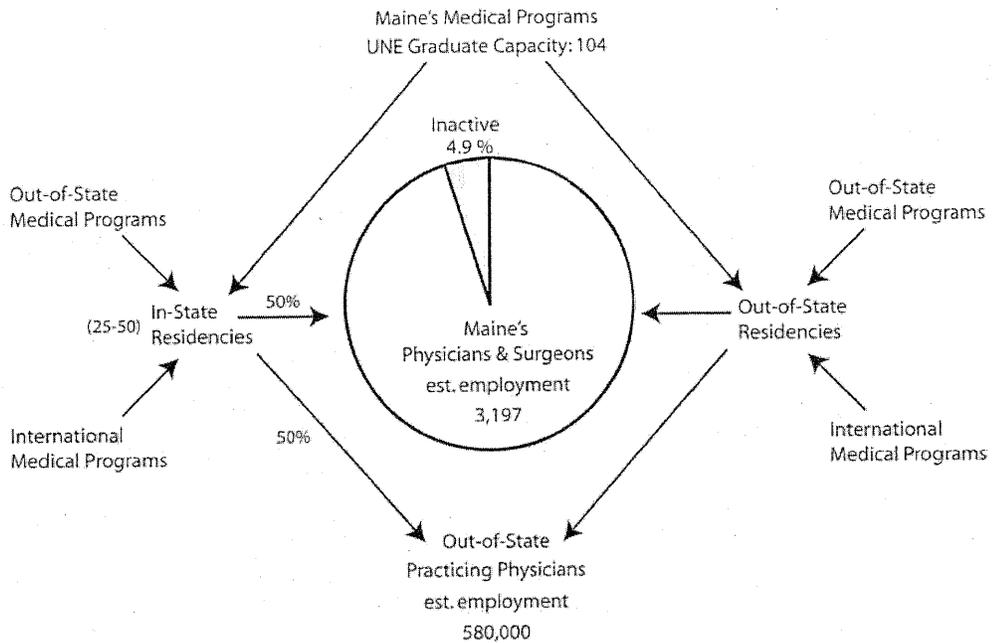
It must be noted that several of the aforementioned hospitals have relationships with out-of-state medical schools and provide residency opportunities for those students. Specifically, Maine Medical Center is a teaching site for the University Of Vermont School Of Medicine. The Family Practice Residency in Augusta is a rural training site for Dartmouth Medical Students. Also, Eastern Maine Medical Center has a relationship with Tufts Medical School.¹⁸

Importantly, the residency programs report that 50% or more of their graduates remain in-state after residency¹⁸; this retention is paramount in ensuring an adequate supply of these healthcare professionals. Survey data indicates that 26.4% of all Physicians and Surgeons in Maine completed residences in Maine. Residency program data for Physicians and Surgeons is provided in the following table.

Physicians & Surgeons: State of Residency Program		
State	Number	Percentage
Maine	481	26.4%
Massachusetts	212	11.6%
New York	207	11.4%
Pennsylvania	116	6.4%
Michigan	73	4.0%
California	70	3.8%

A significant portion of Physicians and Surgeons in Maine completed their residency in Maine. The relationship between state of residency program completed and state where practicing is unclear, but as the inaugural report in what is to be an annual series, this report is more indicative of the breadth of work possible rather than the depth. Over time, longitudinal analysis and refinement of the survey may indicate trends and uncover data useful in determining and maintaining the supply of healthcare professionals.

The supply of Physicians and Surgeons in Maine is clearly impacted by educational opportunities, residency opportunities, and the recruitment of physicians from outside the state. Facts and the general relationships among these factors are presented in the following figure.



Residency opportunities are especially vital to the supply of Physicians and Surgeons in Maine, as these programs report that 50% or more of their graduates remain in-state after residency; survey data indicates that of all responding licensed physicians and surgeons, 26.4% completed their residency in Maine.

Where in-state educational opportunities and, later, residency opportunities fail to provide the necessary supply of Physicians and Surgeons, recruitment of these professionals by hospitals and healthcare providers must succeed. One major step in the recruitment of Physicians and Surgeons to Maine occurred with the formation of the Maine Recruitment Center in 1999.

Representing the needs of the vast majority of hospitals and practices across the state, the Maine Recruitment Center (MRC) is staffed by specialists who are salaried employees of the Maine Hospital Association. This collaborative effort between hospitals and the Maine Hospital Association operates as an easy, one-step resource for job seekers interested in healthcare employment opportunities in Maine.¹⁹ One particular service provided by the MRC is the maintenance of a database of candidates interested in specific situations within Maine. A physician registers to indicate interest in a particular setting or region of the state, and the MRC alerts the registrant when an opening meeting the those criteria arises.¹⁹

While the formation of the MRC has been an important recruiting tool, a general shift in desired professional setting among physicians and salary levels has made it increasingly difficult to attract Physicians to Maine—particularly in rural areas. Physicians are less interested in private practices because of the business, legal, regulatory, and human resource demands inherent in running a private practice. Also, “rural physician, on average, work more and earn less than their urban counterparts.”¹⁷ In ensuring an adequate supply of Physicians and Surgeons in Maine, two

issues are glaringly important—the number of residency opportunities available and the placement of Physicians and Surgeons in medically underserved, rural areas.

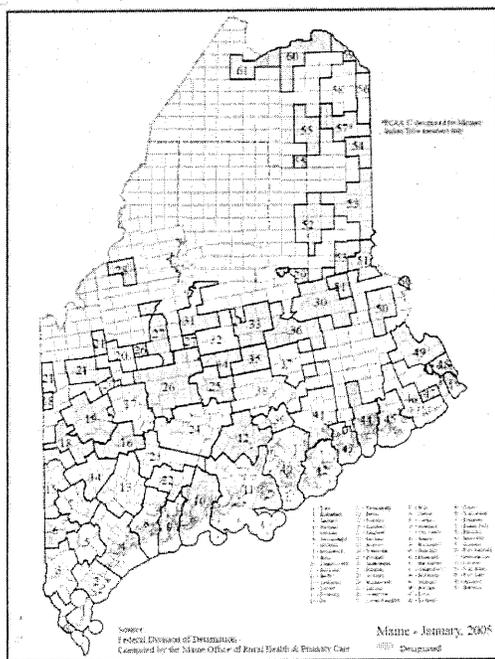
Given the high cost of physician recruitment, as well as the social costs associated with patients forced to wait for treatment, an increase in the number of residency opportunities could facilitate the recruitment and placement of physicians in Maine.

Ensuring an adequate supply of Physicians and Surgeons extends far beyond the mere number of these professionals and into the geographic distribution of Physicians and Surgeons across Maine—particularly in medically underserved, rural areas.

Rural primary care has become of lesser interest to those physicians and surgeons just entering the workforce. At this point in their careers, these professionals are saddled with the incredible costs of medical school, which, often, are in excess of \$200,000. This tremendous financial burden encourages students to consider more lucrative careers in specialty medicine.

To improve the distribution, supply, and quality of healthcare professionals in medically underserved areas, private, state, and federal loan repayment initiatives must be undertaken. Four such loan repayment programs already exist: The National Health Service Corps (NHSC) Loan Repayment Program, the State Loan Repayment Program (SLRP), the Finance Authority of Maine (FAME), and Maine hospitals. All are repayment options for those who want to practice primary care in Maine, and all are contingent upon geography; the NHSC loan repayment program, SLRP, and FAME all offer repayment options for those working in medically underserved areas (as designated by the federal government). Loan repayments by select Maine hospitals are used as market equalizers in attracting physicians and surgeons. Not coincidentally, those in underserved areas offer repayment options, while those in southern Maine, which possesses adequate staffing levels, do not.

Federally Designated Primary Care Health Professional Shortage Area



The extent that these programs are necessary and their impact on the supply of Physicians and Surgeons are evident when one considers the Federally Designated Primary Care Health Professional Shortage Areas, which are depicted in the map at left. A full size map can be found at www.maine.gov/dhhs/bohodr/links.htm.

A Health Professional Shortage Area (HPSA) is defined as population groups and facilities with a shortage of health professionals according to rural and geographic areas. This designation allows both public and non-profit organizations to apply for National Health Service Corps personnel as well as other federally funded programs.

Ensuring an adequate supply of Physicians and Surgeons in Maine will likely require increased educational and training opportunities, as well as the continued efforts of the Maine Recruitment Center. In turn, this supply, through the successful application of loan repayment programs, will need to be distributed accordingly so that an adequate supply of physicians and surgeons is met at both state and sub-state levels.

Complicating these efforts to ensure an adequate supply of Physicians and Surgeons in Maine is the fact that this labor market is comprised of smaller, specialty-defined labor markets; thus, occupational data at the specialty level is necessary to address labor market concerns. The need for information at the specialty level is addressed in the following section.

Physicians and Surgeons: Specialty Labor Markets

Physicians work in one or more of several specialties, including, but not limited to, anesthesiology, family and general medicine, general internal medicine, general pediatrics, obstetrics and gynecology, psychiatry, and surgery. It is important to note that each of these specialties operates as a unique labor market, and, as such, numerous differences exist; many of these differences are captured in the following content.

Occupational Descriptions

Anesthesiologists focus on the care of surgical patients and pain relief. These critical specialists are responsible for the maintenance of the patient's vital life functions—heart rate, body temperature, blood pressure, and breathing—through continued monitoring and assessment during surgery.

Family and General Practitioners are often the first point of contact for people seeking healthcare and act as the traditional family doctor. They assess and treat a wide range of conditions, ailments, and injuries, from sinus and respiratory infections to broken bones and scrapes. Patients with more serious conditions are referred to specialists or other healthcare facilities for more intensive care.

General Internists diagnose and provide care mainly for adults who have a wide range of problems associated with the internal organs, such as the stomach, kidneys, liver, and digestive tract. Like General Practitioners, General Internists are commonly looked upon as primary care specialists, referring patients to other specialists when more complex care is needed.

Obstetricians and Gynecologists (Ob/Gyns) are specialists whose focus is on women's health. They are responsible for general medical care for women, but also provide care related to pregnancy, the reproductive system, and childbirth.

Pediatricians provide care from birth to adulthood. These professionals specialize in the diagnosis and treatment of a variety of ailments specific to young people and track their patients' growth to adulthood.

Psychiatrists are the primary caregivers in the area of mental health. They assess and treat mental illnesses through a combination of psychotherapy, psychoanalysis, hospitalization, and medication.

Surgeons are physicians who specialize in the treatment of injury, disease, and deformity through operations. Using a variety of instruments, and with patients under general or local anesthesia, a surgeon corrects physical deformities, repairs bone and tissue after injuries, or performs preventive surgeries on patients with debilitating diseases or disorders.

Specialty Characteristic Data

Obtained from the 2004 Physicians and Surgeons data file, the information provided in the table at right is presented at the specialty level and is designed to address the needs of health planners, educators, researchers, and policy makers. Highlights of this data are presented below.

- Roughly one out of every three Surgeons is over the age of 60
- Psychiatrists tend to be over 60 (28.2%)
- General Practitioners have the smallest percentage of those over 60 (15.2%)
- Gender distribution varies a great deal between specialties
- Almost 90% of Surgeons are male, whereas only 51.6% of Pediatricians are male
- Pediatricians and Ob-Gyns have the largest percentages of inactive licensees
- The percentage and number of inactive licensees for Internists are significant

Physicians & Surgeons: Characteristic Data				
		Age	Mean	Over 60
Specialty	Anesthesiologists		50.6	18.7%
	General Practitioners		49.4	15.2%
	Internists		49.6	18.8%
	Ob-Gyn		51.1	22.0%
	Pediatricians		49.3	22.4%
	Psychiatrists		53	28.2%
	Surgeons		53.5	35.2%
		Gender	Male	Female
Specialty	Anesthesiologists		78.9%	21.1%
	General Practitioners		62.0%	38.0%
	Internists		68.5%	31.5%
	Ob-Gyn		56.1%	43.9%
	Pediatricians		51.6%	48.4%
	Psychiatrists		68.1%	31.9%
	Surgeons		89.9%	10.1%
		Activity Status	Number Inactive	Percent
Specialty	Anesthesiologists		3	3.3%
	General Practitioners		20	4.8%
	Internists		20	7.8%
	Ob-Gyn		8	9.8%
	Pediatricians		13	10.4%
	Psychiatrists		7	4.1%
	Surgeons		11	6.1%

Percentage Distribution of MDs and DOs			
	Total	MD	DO
Anesthesiologists	91	91.2%	8.8%
General Practitioners	414	54.6%	45.4%
Internists	255	85.1%	14.9%
Ob-Gyn	82	85.4%	14.6%
Pediatricians	125	92.0%	8.0%
Psychiatrists	170	86.5%	13.5%
Surgeons	179	93.9%	6.1%
All Physicians & Surgeons	1,966	79.0%	21.0%

The distribution of MDs and DOs differs greatly among specialties. Considering that Maine’s only medical program produces on DOs, it is clear that ensuring an adequate supply of General Practitioners (45.4% of whom are DOs) will be much easier than that of Surgeons, Pediatricians, and Anesthesiologists (of whom only 6.1%, 8.0%, and 8.8%, respectively, are DOs).

Identifying where Physicians and Surgeons live and work can add insight to the identification of areas that may be underserved or experiencing difficulties in recruiting specialists. Residence and employment information, as reported through the survey of Physicians and Surgeons, indicates the following key points.

- 97.8% of responding Anesthesiologists reported working in Maine; 100% reported living in Maine
- 9.3% of Anesthesiologists reported living in York county, but only 4.3% reported working in York county
- 97.8% of responding Family and General Practitioners reported working in Maine; 99.2% reported living in Maine.
- 100% of Internists reported working in Maine; 99.2% reported living in Maine.
- 98.6% of responding Ob-Gyns reported working in Maine; 100% reported living in Maine
- 0 Ob-Gyns reported living or working in Piscataquis county
- 100% of responding Pediatricians live and work in Maine
- 100% of responding Psychiatrists live and work in Maine
- 98.2% of responding Surgeons reported working in Maine; 100% reported living in Maine
- For Family and General Practitioners, in terms of both residence and employment, all 16 counties were represented.
- Cumberland and Penobscot counties, generally, were the largest counties in terms of both employment and residence.

Complete county employment and residence data by specialty is provided in the Appendix.

Statewide Employment

The annual growth rate for all specialties is roughly 2.0 percent. This number exceeds the 1.0 percent growth rate for all occupations in Maine. Estimated state employment for 2002, projected employment for 2012, net employment change, and annual average percent change for each specialty are provided in the following table.

Physicians & Surgeons: Estimated and Projected State Employment By Specialty				
	2002 Estimated Employment	2012 Projected Employment	Net Employment Change	Annual Average Percent Change
Anesthesiologists	124	152	28	2.1%
General Practitioners	825	1,012	187	2.1%
Internists	291	355	64	2.0%
Ob-Gyn	134	165	31	2.1%
Pediatricians	142	175	33	2.1%
Psychiatrists	198	242	44	2.0%
Surgeons	450	556	106	2.1%

Growth and Replacement Needs

Job openings arise from both employment growth and replacement needs.

Physicians & Surgeons: Growth and Replacement Needs By Specialty			
	Total Annual Average Openings	Annual Openings Due To Growth	Annual Openings Due To Replacement
Anesthesiologists	5	3	2
General Practitioners	30	19	11
Internists	10	6	4
Ob-Gyn	5	3	2
Pediatricians	5	3	2
Psychiatrists	7	4	3
Surgeons	17	11	6

Replacement needs arise as workers leave occupations to retire, return to school, assume household responsibilities or transfer to other occupations.

Openings due to growth reflect the growth of the occupation, as well as the industry.

Wages

Physicians and Surgeons have among the highest earnings of any occupation. Maine and national wage data at the specialty level is provided in the following table.

Physicians & Surgeons: Maine and National Wages By Specialty						
	Average Wage	Maine Hourly	National Hourly	Maine Annual	National Annual	Percent of National
Specialty	Anesthesiologists	\$92.16	\$83.95	\$191,693	\$174,610	109.8%
	General Practitioners	\$60.27	\$66.33	\$125,362	\$137,980	90.9%
	Internists	\$70.29	\$75.38	\$146,203	\$156,790	93.2%
	Ob-Gyn	\$88.89	\$83.89	\$184,891	\$174,490	106.0%
	Pediatricians	\$66.04	\$67.31	\$137,363	\$140,000	98.1%
	Psychiatrists	\$76.64	\$72.78	\$159,411	\$151,380	105.3%
	Surgeons	\$94.69	\$87.43	\$196,955	\$181,850	108.3%

State wages for General Practitioners, Internists, and Pediatricians all are below that of national averages.

Physician Assistants

Physician Assistants are formally trained to provide diagnostic, therapeutic, and preventive healthcare services, as delegated by a Physician.

Occupational Description

Physician Assistants work under the supervision of a physician; however, they may be the principal care providers in rural or inner city clinics, where a physician is present for only one or two days each week. These individuals may take medical histories, examine and treat patients, order and interpret laboratory tests and x-rays, make diagnoses, and prescribe medications.

Characteristic Data

The licensure of Physician Assistants in Maine is carried out by two separate, autonomous boards of licensure, the Board of Licensure in Medicine for those supervised by allopaths and the Board of Osteopathic Licensure for those supervised by osteopaths. The Maine CDC has developed a survey to accompany the relicensure process, and survey efforts have been undertaken, and, assuming acceptable response rates, data will be available in the following edition of this report.

Educational Requirements

All states require that new Physician Assistants complete an accredited, formal education program. As of July 2001, there were 129 accredited or provisionally accredited educational programs in the U.S. for physician assistants; 64 of these programs offered a master's degree. The rest offered either a bachelor's degree or an associate degree. Most PA graduates have at least a bachelor's degree. PA programs usually last at least 2 years. Admission requirements vary, but many programs require 2 years of college and some work experience in the healthcare field.

Schools

Only the University of New England offers a Physician Assistant program in Maine. For the 2003 -2004 academic year, this program had 43 graduates.

Provider	Title	Credential Attained	Completers
UNE	Physician Assistant	Master's Degree	43

Statewide Employment

There were 624 Physician Assistants employed in Maine in 2002, and this occupation is expected to experience more rapid growth (4.5% annually) than that of the all occupations average (1.0%). The following table lists relevant employment and projection data.

2002 Estimated Employment	2012 Projected Employment	Total 2002 – 2012 Employment Change	Annual Average Percent Change
624	967	343	4.5

The above 10-year employment change reflects the growth that this occupation is expected to experience, but replacement needs must also be considered. An additional 10 annual openings for Physician Assistants are projected and attributed to replacement needs. The following table illustrates annual growth and replacement needs for Physician Assistants.

	Total Annual Average Openings	Annual Average Openings Due to Growth	Annual Average Openings Due to Replacement
Physician Assistants (Total)	44	34	18
Physician Assistants (%)	100%	77.4%	22.6%
All Occupations (%)	100%	33.7%	66.3%

Most Physician Assistants are employed in ambulatory healthcare services (with 59.5% of all Physician Assistants), and hospitals (36.1%).

Maine Job Vacancies

For Physician Assistants, there were an estimated 19 job vacancies in 2005, which, when compared to total employment for the occupation, yielded a job vacancy rate of 2.8%. Data for 2002 for this occupation is unavailable.

Wages

The average wage for Physician Assistants in Maine is more than \$3.00 an hour greater than the national average. Annual and hourly wage data for entry-level and experienced Physician Assistants, as well average state and national wages, are shown in the following table.

	Maine		Maine	National	% of National
	Entry	Experienced	Mean	Mean	
Hourly	\$28.40	\$40.01	\$36.14	\$32.93	109.7%
Annual	\$59,070	\$83,230	\$75,171	\$68,494	

National Employment

In 2002, there were an estimated 63,000 Physician Assistants employed in the United States. In 2012, it is projected that there will be 94,000; this represents an annual average growth rate of 4.1 percent, significantly faster than the 1.4 percent growth rate for all occupations in the United States, as shown in the following table.

2002 Estimated Employment	2012 Projected Employment	Total 2002 – 2012 Employment Change	Annual Average Percent Change
63,000	94,000	31,000	4.1

Outlook

Employment of Physician Assistants is expected to grow much faster than the average for all occupations through the year 2012, due to anticipated expansion of the health services industry and an emphasis on cost containment, resulting in increasing utilization of Physician Assistants by physicians and healthcare institutions.

Physicians and institutions are expected to employ more Physician Assistants to provide primary care and to assist with medical and surgical procedures because Physician Assistants are cost-effective and productive members of the healthcare team. Physician assistants can relieve physicians of routine duties and procedures. Telemedicine—using technology to facilitate interactive consultations between physicians and physician assistants—also will expand the use of physician assistants. Job opportunities for Physician Assistants should be good, particularly in rural and inner city clinics, because those settings have difficulty attracting physicians.

Besides the traditional office-based setting, Physician Assistants should find a growing number of jobs in institutional settings such as hospitals, academic medical centers, public clinics, and prisons. Additional Physician Assistants may be needed to augment medical staffing in inpatient teaching hospital settings as the number of hours physician residents are permitted to work is reduced, encouraging hospitals to use Physician Assistants to supply some physician resident services. Opportunities will be best in states that allow Physician Assistants a wider scope of practice.

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THE NEWSPAPER FOR AMERICA'S PHYSICIANS

BUSINESS

Finances driving physicians out of solo practice

The business of medicine has doctors moving into large groups or employed situations, studies find.

By Bob Cook, AMNews staff. Sept. 10, 2007.

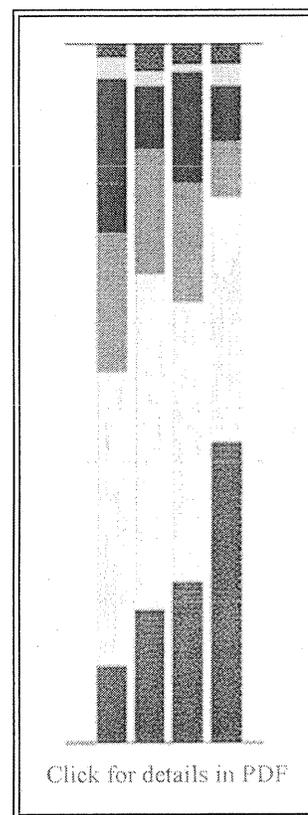
The "herding cats" metaphor long used to describe the difficulty of organizing physicians into large groups appears to be on its way out.

A survey released in August by the Center for Studying Health System Change found a marked increase in the percentage of doctors joining large, single-specialty groups, as well as entering employed situations. The survey, covering 1996 to 2005, also found a marked decrease in the percentage of physicians in solo or two-doctor practices, as well as a large drop in the percentage of doctors who have an ownership stake in their practices. The finding was especially apparent among older physicians.

The CSHSC did not ask physicians why they worked where they did. But the center and other observers say financial pressures and the desire for work-life balance is driving physicians to the relative security of an employed or large-group situation. That way, they can keep semi-regular hours, have less responsibility for the business side of medicine, and possibly gain greater leverage in contract talks with health plans.

Observers say this trend is not going away anytime soon and might well reflect a growing cultural change among physicians.

As further evidence, the national physician search firm Merritt, Hawkins & Associates revealed in July a large increase between 2006 and 2007 in the number of hospitals retaining the firm to find physicians to employ, while also showing a large decrease in solo practice spots to fill.



With this article

"Physicians are like anybody else -- they like their individual freedom, but they also like to feed their family," said William

- [Where physicians are heading](#)
- [Hospital recruitment soaring](#)
- [Links](#)
- [See related content](#)

Jessee, MD, president and CEO of the Medical Group Management Assn. It released its own report in August showing physicians in most specialties had salaries that were not keeping up with inflation, even though productivity increased.

Family physician Eric Holmberg, MD, left an employed position in public health to open his own solo practice in Petaluma, Calif., 3½ years ago. Since then, five internists have shut down their practices, with no one replacing them. Dr. Holmberg, 56, says he might have to follow their lead.

He has tried for two years to hire a second physician, with no takers. The high cost of living and the low reimbursement in northern California, as well as the long hours and constant call, make solo practice difficult to maintain, he said. He said he might have to close shop and go back to being an employee or join a large group, even though he prefers staying in practice for himself and his patients.

"How long do I see this going? I'm not sure I can answer that easily," Dr. Holmberg said. "I go through declines in energy periodically when the workload gets to be excessive. I feel at those times that I will wait until my lease expires and call it quits. And then, two weeks later things may feel less weighty.

"I made a commitment to my family that something would be different by the end of this year. I'm not sure I have the confidence I might have felt earlier in the year."

The CSHSC found the proportion of one- and two-physician practices declined from 40.7% in 1996-97 to 32.5% in 2004-05. While the primary care rate of 36% was stable, the proportion of specialists in such practices fell to 26.1% from 38.1%. Meanwhile, the percentage of doctors in single-specialty groups of six to 50 doctors increased to 17.6% in 2004-05 from 13.1% in 1996-97. The center said those numbers reflect consolidation among specialists. Dermatology was the only specialty in which a majority (61.6%) remained in solo or two-doctor practices.

Financial pressure is driving these trends, said Joy H. Grossman, PhD, a CSHSC senior researcher and co-author of the report. In informal conversations with the doctors, many had the perception that a bigger practice could absolve them of the everyday business pressures and possibly help with reimbursement negotiations.

Dr. Grossman said the desire for greater work-life balance also has been brought up as a factor for fewer doctors in solo practice -- and not just younger doctors. During the period studied, physicians were less likely to have an ownership stake in their practices, down to 54.4% in 2004-05 from 61.6% in 1996-97. Physicians 40 and younger experienced a 3.5 percentage point decrease (28.3% to 24.8%). But doctors 51 and older represent the steepest decline: down 12.7 percentage points, from 51.5% in 1996-97 to 38.8% in 2004-05.

Daniel Wild, MD, 58, a Buffalo, N.Y., orthopedic surgeon, isn't reflected in those numbers. It was only in July he started working under the banner of the multispecialty Buffalo Medical Group after selling his solo practice.

Dr. Wild said his practice was financially sound. But he's planning to retire in about 10 years, so he was reluctant to make a major investment in electronic medical records. Also, he sold the building in which his practice was located, which left him facing relocation costs.

Most orthopedic surgeons in Buffalo have merged in large single-specialty groups, Dr. Wild said. But he opted for the multispecialty group, which hadn't had an orthopedic surgeon in about a decade. He said the structure allows the independence he had as a solo physician but without the business headaches.

"I'm glad not to be a landlord," he said. "I'm glad to not have to worry if the electricity goes out on my sign, or if the snowplow guy doesn't come."

Multispecialty practices actually declined (30.9% to 27.5%) over the period the center studied, which Dr. Grossman attributed to changing financial incentives.

In 1996-97, it was thought the multispecialty model might win out because of the HMO gatekeeper model. But the model waned as patients moved to more open PPO networks, and many of the groups formed during that time broke up.

Many of the primary care physicians in those groups moved to solo or small practices and stayed there, as reflected in the overall lack of decline in those numbers, the center said.

However, there are signs primary care doctors are increasingly having to question their future in solo practice. Merritt Hawkins' survey of its clients' job-search requests found the number of positions based in hospitals nearly doubled from 2006 to 2007, from 654 to 1,297. Meanwhile, the number of requests to fill solo slots and partnerships were nearly halved.

Merritt Hawkins spokesman Phil Miller said these numbers also reflect physicians' preferences.

"The first wave [in the mid-1990s] was selling the doctors on being employees. You remember the whole herding cats thing," Miller said.

"Today, you have a lot of doctors, a lot of them specialists, who actually are coming to the hospital and saying, 'I'm sick of dealing with malpractice, I'm sick of fighting for reimbursement, I'm sick of dealing with a fractious staff -- just hire me.' "

[Back to top.](#)

ADDITIONAL INFORMATION:

Where physicians are heading

More physicians are joining larger, single-specialty groups or other salaried settings.

Practice setting	1996-97	2004-05
1-2 physicians	40.7%	32.5%
3-5 physicians	12.2%	9.8%
6-50 physicians	15.9%	21.8%
Single-specialty, 6-50 physicians	13.1%	17.6%
Multispecialty	30.9%	27.5%
Other*	31.2%	36.0%

* Includes physicians employed by medical schools, HMOs, hospitals (including office-based practices), community health centers, freestanding clinics and other settings, and independent contractors.

Source: Center for Studying Health System Change Telephone survey of 6,600 physicians (2004-05) and 12,000 physicians (1996-97). The sample was drawn from the American Medical Association and the American Osteopathic Assns. master files and included active, nonfederal, office- and hospital-based physicians who spent at least 20 hours a week in direct patient care.

[Back to top.](#)

Hospital recruitment soaring

A survey released in July by the national search firm Merritt, Hawkins & Associates finds a marked increase in recruiting by hospitals, much of it at the expense of smaller groups. The firm says it's not just places that employ physicians looking for doctors -- it's also doctors seeking work at places that employ physicians. The findings show trends highlighted in a Center for Studying Health System Change survey covering 1996-2005 are not abating.



Source: Merritt, Hawkins & Associates 14th annual review of search and consulting assignments conducted on behalf of its own clients

[Back to top.](#)

Weblink

Center for Studying Health System Change report on physician practice patterns (www.hschange.com/CONTENT/941)

"2007 Review of Physician and CRNA Recruiting Incentives," Merritt, Hawkins &

Associate, in pdf

(www.merrithawkins.com/pdf/2007_review_of_physician_and_crna_recruiting_incentives.pdf)

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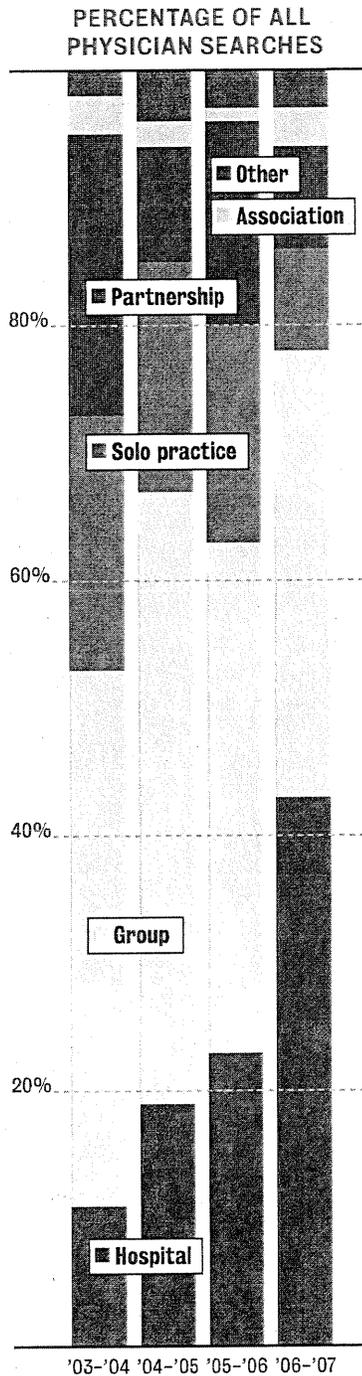
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HOSPITAL RECRUITMENT SOARING

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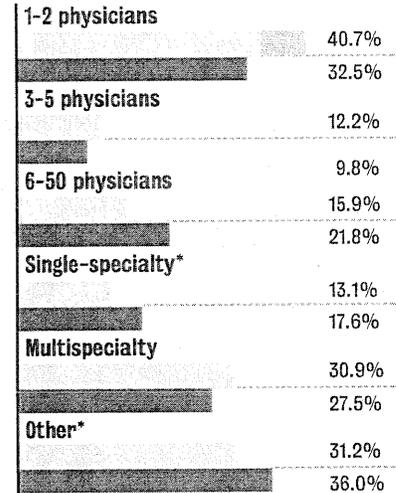
SOURCE: MERRITT, HAWKINS & ASSOCIATES 14TH ANNUAL REVIEW OF SEARCH AND CONSULTING ASSIGNMENTS CONDUCTED ON BEHALF OF ITS OWN CLIENTS



WHERE PHYSICIANS ARE HEADING

More physicians are joining larger, single-specialty groups or other salaried settings.

Percentage in practice setting
 ■ 1996-1997 ■ 2004-2005



* "SINGLE-SPECIALTY" INCLUDES GROUPS OF 6-50 DOCTORS. "OTHER" INCLUDES PHYSICIANS EMPLOYED BY MEDICAL SCHOOLS, HMOS, HOSPITALS (INCLUDING OFFICE-BASED PRACTICES), COMMUNITY HEALTH CENTERS, FREESTANDING CLINICS AND OTHER SETTINGS, AND INDEPENDENT CONTRACTORS.

SOURCE: CENTER FOR STUDYING HEALTH SYSTEM CHANGE

Payer Mix for office visits to hospital based physician
 October, November and December 2006
 Based on the Outpatient data submitted to the Maine Health Data Organization

9/11/2007

	Total Visits	Medicare	Medicaid	Commercial Insurance*	Self Pay	Tricare (Military)	Worker's Comp	Other
Hospital A	12045	24.22%	32.56%	39.06%	3.50%	0.53%	0.13%	0.00%
Hospital B	11440	29.34%	21.14%	43.88%	4.12%	0.87%	0.66%	0.00%
Hospital C	47300	28.92%	18.06%	49.40%	2.06%	0.81%	0.68%	0.08%
Total	70785	28.18%	21.03%	46.75%	2.63%	0.77%	0.59%	0.05%

* Includes Medicare supplemental plans

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Hospital B	11440	29.34%	21.14%	43.88%	4.12%	0.87%	0.66%	0.00%
Hospital C	47300	28.92%	18.06%	49.40%	2.06%	0.81%	0.68%	0.08%
Total	70785	28.18%	21.03%	46.75%	2.63%	0.77%	0.59%	0.05%

* Includes Medicare supplemental plans

Hospital Employed Physician's
September 12, 2007

Hospital Name	Department Name or Practice Name	Employed Physicians
Acadia	Psychiatry	15
	Pediatrics	2
	Internal Medicine	1
	Neurology	1
The Aroostook Medical Center	Emergency Services	6
	Anesthesia	4
	Clinics-Dermatology	2
	HHS-Occupational Health	2
	HHS-Orthopedics	4
	HHS-Aroostook Pediatrics	4
	HHS-OBGYN	5
	HHS-Psychiatric	3
	HHs-Pulmonary	1
	HHS-Surgical Svcs	4
	TAMC Hospitalists	4
	HHS-Ft. Fairfield Health	2
	HHS-Limestone	1
	HHS Central Aroostook Health Center	1
	HHS-Washburn Regional	1
	HHS-Madawaska Health	1
	HHS-Presque Isle	1
	HHS-Caribou	1
	HHS Aroostook Family Practice	4
	HHS-Infectious Disease	1
HHS-Oncology	2	
HHS-Sleep Studies	1	
HHS-Cardiology	1	
Blue Hill Memorial	Blue Hill Family Medicine	8
	Bucksport Family Medicine	3
	Castine Community Health Services	1
	Island Family Medicine	1
	Blue Hill Women's Health Center	2
	Blue Hill Memorial Hospital	1
Bridgton Hospital	Oncology - Physicians	1
	Fryeburg General Practice	1
	Naples Family Practice	2
	North Bridgton Family Practice	2
	Family Medicine Of Fryeburg	2
	BH Pediatrics	3
	BH Surgical Specialists	2
	BH Ob/Gyn	2
	Internal Medicine	5
	Orthopedics	1
Calais Regional	Radiology	1
	CRMS Surgical Service (Hospital Based Clinic)	2
	CRMS Orthopedic Clinic (Hospital Based Clinic)	1
	CRMS Rural Health Center (Hospital Based Department)	8
Cary Medical	Emergency Room	2
	Anesthesia	2
Central Maine Medical	Bariatric Surgery	1
	Breast Care Center	1
	CM Family Practice	6
	CM Gray Practice	2

Hospital Employed Physician's
September 12, 2007

Hospital Name	Department Name or Practice Name	Employed Physicians
	CM Infectious Disease	5
	CM Intensivist	1
	CM Internal Medicine	8
	CM Lisbon Practice	3
	CM Neurology	5
	CM Ob/Gyn	5
	CM Pediatrics	8
	CM Pulmonology	5
	CM Womens Health	3
	CMMC Cardiology	12
	ED- Physicians	28
	Endocrinology	2
	Family Health Care Associates	3
	Family Practice Residency	26
	Hospitalist	9
	Mechanic Falls Practice	2
	NICU - Physicians	2
	Nuclear Medicine	1
	Oncology - Physicians	2
	Perfusion	2
	Plastic Surgery	2
	Poland Health Clinic	2
	Radiation Therapy	1
	Surgical Specialists - NS	3
	Urology	2
	Vascular Surgery	2
Charles A. Dean Memorial	Emergency Department	3
	Operating Services	2
	Northwoods Healthcare Rural Health Center	2
	Northwoods Healthcare: Monson, ME	1
	Northwoods Healthcare: Guilford, ME	2
Down East Community	Milbridge Medical Center	1
	Orthopedic	1
	Pediatrics	3
	Neurology	1
	Internal Medicine	1
	OB	3
	Pulmonology	1
	Urology	1
	ER	4
	Imaging	2
Eastern Maine Medical	Brewer Norumbega	3
	Cancer Care of Maine	10
	Cardiovascular Surgery of Maine	3
	Diabetes, Endocrine & Nutrition Center	3
	Eastern Maine Inpatient Care	29
	Eastern Maine Medical Center	14
	Eastern Maine Medical Center - Emergency	18
	Eastern Maine Medical Center - Walk-n Care	1
	Eastern Maine Retina Associates	1
	EMMC - Department of Anesthesiology	26
	EMMC - Family Practice Center	63
	EMMC - NICU	8
	EMMC - OB/GYN - On Call	5

Hospital Employed Physician's
September 12, 2007

Hospital Name	Department Name or Practice Name	Employed Physicians
	EMMC - Oral and Maxillofacial Surgical	1
	EMMC - PICU	3
	EMMC - Women's Care of Maine	1
	EMMC Clinical Research	1
	EMMC Employee Health Service	1
	EMMC ENT Service	2
	EMMC Healthcare Mall	1
	EMMC Neurophysiology Lab	1
	EMMC Pediatric Service	3
	EMMC Pediatric Surgery	1
	Husson Internal Medicine (Family Practice Residents)	4
	Maine Thoracic Associates	2
	Medical Director Dirigo Pines	1
	Norumbega Evergreen Woods	1
	Norumbega Husson Family Practice	3
	Norumbega Orono Family Practice	4
	Norumbega Pediatrics	6
Franklin Memorial Hospital	Anesthesia	3
	Emergency Department	3
	Hospitalists	4
	Franklin Orthopedics	2
	Franklin Surgery	3
	Medical Affairs & Education	1
	Pine Tree Family Practice	4
	Pine Tree Internal Medicine	3
	Pine Tree Pediatrics	4
	Pine Tree Women's Care	4
	Rockomeka Family Practice	2
	Wilton Family Practice	2
	Western Maine Center for Heart Health	1
H.D. Goodall	Goodall Health Partners	12
	Center for Women's Health	5
	Goodall Express	1
Houlton Regional	Anesthesiology	2
	Emergency Department	4
Inland	Inland Hospital	6
	Inland Hospital - Department of OMT	1
	Inland Hospital - Emergency Department	8
	New Horizons Health Care	4
	Waterville Surgical Associates	3
Maine Coast Memorial	Ellsworth Internal Medicine	8
	Maine Coast Pediatrics	3
	Ellsworth Family Practice	5
	Maine Coast Women Care	1
	Maine Coast Urology	1
	Maine Coast Rheumatology	1
	Maine Coast Otolaryngology	1
	Down East Dermatology	1
	Maine Coast Geriatrics	1
	Frenchman's Bay Orthopedics	3
	Eleanor Widner Dixon Clinic -Gouldsboro(Family Practice)	5
	Southwest Harbor Clinic- (Family Practice)	3
	Maine Coast General Surgery	1

Hospital Employed Physician's
September 12, 2007

Hospital Name	Department Name or Practice Name	Employed Physicians
	Maine Coast Hand and Shoulder	1
Maine Medical Center (1/07)	OB/GYN	3
	Circ Disease	1
	Clinic - Emp Health	1
	EDIP NIMH	1
	Emergency	21
	Epidemiology & Infection Preve	1
	Executive Mgmt	1
	Fam Med	16
	Geriatrics	1
	Gorham Village Family Physicians	2
	Greater Portland Medical Group	9
	Greater Portland Pediatric Associates	21
	Lake Region Primary Care	4
	Maine Centers for Endocrinology and Diabetes	6
	Maine Children's Cancer Program	4
	Maine Hospitalist Service	12
	Maine Pediatric Specialty Group	16
	Medicine	9
	MMCRI - Swartz	1
	MMCRI - Wennberg	2
	MMCRI Admin	1
	Neurosurgery and Spine Associates	13
	Ob/Gyn Associates	9
	Ped Critical Care	2
	Pediatrics	12
	Psy Cons & Liason	1
	Psych	4
	Psych - Child	3
	Psych - Geriatric	3
	Psych - I/P	3
	Psych Adult O/P	7
	Scarborough Family Physicians	4
	Surgery - Admin	1
	Surgical Associates	6
	MMP-Maine Centers for Endocrinology and Diabetes	6
	MMP-Greater Portland Medical Group	14
	MMP-Greater Portland Pediatric Associates	21
	MMP-Lake Region Primary Care	4
	MMP-Gorham Village Family Physicians	2
	MMP-Scarborough Family Physicians	4
	MMP-Maine Children's Cancer Program	4
	MMP-Maine Pediatric Specialty Group	16
	MMP-Neurosurgery and Spine Associates	13
	MMP-Ob/Gyn Associates	9
	MMP-Surgical Associates	6
	MMP-Maine Hospitalist Service	12
	MMP-VP-Medical Affair	2
MaineGeneral Medical Center	Wound Clinic	1
	Behavioral Health Services	10
	Workplace Health	5
	Center for Health & Rehab.	2
	Emergency Dept.	22
	Urology Clinic	3

Hospital Employed Physician's
September 12, 2007

Hospital Name	Department Name or Practice Name	Employed Physicians
	Kennebec Pediatrics	5
	Hospice & Palliative Care	1
	Medical Oncology	5
	MaineGeneral Health	1
	Pulmonology Dept.	2
	Jackman Regional Health Center	2
	Nephrology Dept.	3
	Augusta Orthopedics	6
	Cardiology Dept	1
	Hospitalist Svc	1
	Winthrop Family Practice	7
	Augusta Family Physicians	2
	Gardiner Family Practice	5
	Winthrop Pediatric & Adol. Medicine	2
	MGRNC	1
	Evergreen Family Practice	1
	Surgery Dept.	1
	Psychiatry Dept.	3
Mayo Regional	Mayo Women's Health	2
	Corinna Family Practice	1
	Milo Family Practice	3
	Dexter Internal Medicine	1
	Guilford Medical Associates	1
	Dover Family Medicine	3
	Mayo Orthopaedics	2
	Substance Abuse Counseling	1
	Mayo Surgical Associates	2
	Anesthesia	1
	Hospitalist	2
Mercy	Mercy Primary Care-North Deering (Dept)	2
	Mercy Primary Care-Westbrook (Dept)	4
	Mercy Primary Care 5-South*(Dept)	3
	Mercy Primary Care- Forest Avenue*(Dept)	2
	Mercy Primary Care- Express Care*(Dept)	5
	Fore River Urology*(Dept)	2
	Mercy Hospital-Pulmonary Dept*(Dept)	4
	Breast Care Specialist Of Me*(Dept)	3
	Mercy Hospital-Oncology Dept*(Dept)	2
	Mercy Health Center*(Dept)	1
	Mercy Hospital-Hospitalist Service*(Dept)	9
	Mercy Hospital-Emergency Dept.*(Dept)	14
	Mercy Hospital-Behavioral Health*(Dept)	2
	Mercy Hospital-Recovery Center-Mercy Westbrook*(Dept)	5
	Mercy Hospital-Eating Disorder Program*(Dept)	1
	Portland Othopaedic Foot & Ankle Center*(Dept)	3
Mid Coast	Mid Coast Hospital - Primary Care Bath	8
	Mid Coast Hospital - Primary Care Topsham	4
	Mid Coast Hospital - OB/GYN	6
	Mid Coast Hospital - Psychiatry	3
	Mid Coast Medical Group - Surgical Care	4
	Mid Coast Hospital - Neurology	1
Miles Memorial	Miles Family Medicine	1
	MMG Waldoboro	3

Hospital Employed Physician's
September 12, 2007

Hospital Name	Department Name or Practice Name	Employed Physicians
	MMG Internal Medicine	5
	MMG Wiscasset	1
	MMG Orthopaedics	3
	MMG General Surgery	2
	The Women's Center	2
	MMG Pediatrics	3
	Anesthesiology	1
	Emergency Department	9
Millinocket Regional	Northern Penobscot Orthopedics	1
	Millinocket Surgical Associates	2
	Millinocket Urology	1
	White Birch Medical Center	4
Mount Desert Island	Behavioral Health Center	1
	Cadillac Family Practice	1
	Community Health Center	1
	Cooper-Gilmore Health Center	2
	Emergency Department	1
	Family Health Center	2
	Hospitalist	2
	Orthopedic Clinic	2
	Trenton Health Center	4
New England Rehab	<i>No physician's employed at this facility</i>	0
Northern Maine Medical Center	Northern Maine Medical Center	23
Parkview Adventist Medical	Pulmonology @ PAMC	1
	Family Health @ PAMC	3
	Pediatrics @ PAMC	2
	Oncology @ PAMC	1
	Women's Health @ PAMC	2
Penobscot Bay Medical Center	Penobscot Bay OB/GYN Associates	3
	Internal Medicine	2
	Penobscot Bay Urology	3
	Pediatrics	1
	ENT	2
	Hospitalists	3
	Waldoboro Family Medicine	3
	Surgery	3
	Penobscot Bay Orthopedics Hand & Sports Medicine	5
	Neurology	3
	Cancer Care Center	2
	Psychiatry	4
	Pediatrics	1
	Emergency Physicians Services	8
Penobscot Valley	Penobscot Surgical (Dept of the Hospital)	1
	Hospitalist	1
Redington-Fairview	RMPC Internal Medicine	5
	Oncology Department	1
	RMPC Hospitalist Service	1
	Locum Hospitalist Service	5
	RMPC Orthopedics	1
	Orthopedic Locums	7
	Redington OB/GYN	1
	Pathology	8
	Emergency Department	14

Hospital Employed Physician's
September 12, 2007

Hospital Name	Department Name or Practice Name	Employed Physicians
Rumford	Elsemore/Dixfield Center	2
	Swift River Health Care	3
	River Valley Internal Medicine	3
	Surgical Specialists	2
Sebasticook Valley	Somerset Surgical Associates	1
	Sebasticook Regional Walk-In Care	1
	Orthopedic Surgeon Practice	1
	Sebasticook Regional Family Care	1
Southern Maine Medical Center	Emergency	15
	Hospitalist	6
	Occupational Health	3
St Andrews	John F. Andrews Family Care Center	4
	Emergency Department	9
	St. Andrews Hospital Pain Management Center	1
St Joseph	Emergency Department	14
	Bangor Internal Medicine	11
	NIMS	12
	St Joseph Ambulatory Care Inc:	7
St Mary's Regional Medical	Emergency Department	9
	Oncology AKA Center for Cancer and Blood Disorders	2
	Neurology AKA St. Mary's Neurology Associates	2
	Pulmonology AKA Central Maine Pulmonary Associates	3
Spring Harbor	Spring Harbor Hospital	12
	Spring Harbor Counseling	1
	Spring Harbor - Outpatient	4
	Integrated Behavioral Healthcare, Inc.	1
Stephens Memorial	Emergency Department	9
Waldo County General	Emergency Department	7
	Internal Medicine	2
	Internal Medicine (Waldo Cardiovascular Medicine)	1
	Arthur Jewell Community Health Center	1
	Donald S. Walker Health Center	1
	Stockton Springs Regional Health Center	2
	Lincolnton Regional Health Center	1
	Internal Medicine (Waldo County Internal Medicine)	2
	Belfast Neurology Associates	1
	Surgery	5
	Surgery (Belfast OB/GYN Associates)	2
York	Coastal Obstetrics and Gynecology	7
	Psychiatry Practice	1
Total		1506