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Dear Physician:

Whether you are currently a hospitalist or assessing what kind of practice will ultimately be best for you, we can help. The New England Journal of Medicine is the leading source of information about job openings for physicians in the United States. Because we want to assist you in this important search, a complimentary reprint of the physician jobs section of the March 27, 2014, issue of NEJM is enclosed. To further aid in your career advancement we’ve also included a couple of recent selections from our Career Resources section, “The Hospitalist Physician: Contracting for Success” and “Using Digital Networking to Propel the Physician Job Search.”

The NEJM CareerCenter website (NEJMCareerCenter.org) continues to receive positive feedback from physicians. Because the site was designed based on advice from your colleagues, many physicians are comfortable using it for their job searches and welcome the confidentiality safeguards that keep personal information and job searches private.

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A reprint of the February 6, 2014, article “Clinical Practice: Community-Acquired Pneumonia,” is also included in this booklet. Our popular Clinical Practice articles offer evidence-based reviews of topics relevant to practicing physicians.

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On behalf of the entire New England Journal of Medicine staff, please accept my wishes for a rewarding career.

Sincerely,

Jeffrey M. Drazen, MD
The Hospitalist Physician: Contracting for Success

By Thomas Crawford, PhD, MBA, FACHE, Faculty, Department of Urology, College of Medicine, Affiliate Faculty, Department of Health Services Research, Management and Policy College of Public Health and Health Professions

Introduction

Over the last 20 years, I have had the opportunity to witness the continuous evolution of the health care industry. This transformative process, produced by a growing demand, declining remuneration, and increased regulatory oversight, has yielded numerous changes to the health care profession. As a rural health care executive, I vividly recall hearing about a new specialty of medical practice for dedicated hospital-based physicians — the Hospitalist. However, with an average inpatient census of 18 patients, I never imagined that I would find myself in a position to establish such a program. Nevertheless, due to increasing capacity issues in the outpatient setting, coupled with an aging populace that presented acuity levels that were becoming more difficult to manage from the office setting, I found myself in a position of needing to partner with my medical staff to establish a 24/7 hospitalist service and, consequently, contract and employ a requisite number of hospitalist physicians. Based on the hospitalist profession being relatively new, coupled with the increasing number of hospitalist opportunities around the country, the purpose of this article is to highlight the contractual nuances that are unique to hospitalist physicians and to underscore the top 10 issues I have found in the innumerable contracts that I have read and helped seasoned physicians and early careerists navigate over the last two decades.

Hospitalist Contractual Nuances

The contractual nuances I ask hospitalist physicians to pay close attention to fall into the following three categories: 1) work schedule, 2) vacation time, and 3) productivity expectations. Although these three elements of employment relationships will be found in all physician contracts regardless of specialty, the impact on the hospitalist physician could be amplified if not addressed prior to commencing his/her hospital-based practice.
Work Schedule

Although hospitalist positions are generally shift-based, a number of positions may require you to cover a period of time that extends past your assigned shift. Example, if you may be assigned a rotation of 7 consecutive 12-hour shifts, followed by 7 days off; however, depending on how the off hours (evenings and nights) are staffed, you could be responsible for all 24 hours for 7 consecutive days. To ensure the cost effectiveness of their hospitalists programs, smaller hospitals will deploy an MD/DO-hospitalist provider during the peak hours and deploy an extender (PA/ARNP) during the less busy times. Who covers for the extender if there are questions or if the acuity of a patient exhausts the capacity of his/her training? The hospitalist provider who has already worked a 12-hour shift. The potential continuous responsibility of the hospitalist physician provides the natural segue for the next nuance — vacation time.

Vacation Time

One of the trends within hospitalist contracts is not to provide paid vacation and/or continuing medical education time (CME) off. This is based on the premise that most hospitalists work a schedule that equates to one week on and have one week off (26 out of 52 weeks) and that vacation coverage would increase the expense exposure of the hospitalist program and unfairly provide the hospitalist physician time off that generally isn't afforded to physicians within other specialties. However, depending on your work schedule, this may be a flawed perspective. Consider the following: working every other week and being responsible for 24 hours of care each day equates to providing 336 hours per month of coverage versus a primary care provider who is working 12-hour days, 5 days per week providing care coverage for 240 hours within the same month. The difference? The primary care provider will be allotted vacation time, holidays off, and, generally, CME time — while you may have no, or a limited amount, of time away available to you. With this stated, you need to understand your work schedule (hours of responsibility), if you're allotted vacation time, and how this will impact your work/life balance.

Productivity Expectations

Like your work schedule, you will need to ensure that you have realistic productivity expectations and the resources required to meet them. How many patients will you be caring for per day? What is your responsibility to the emergency department? Do you have access to additional help depending upon the volume? Conversely, if the inpatient volume is low,
are you held accountable for the lack of volume? The overarching premise behind a hospitalist program is to improve the efficacy and the quality/safety of the care delivered; however, if your expected productivity is to cover the “house,” support the emergency department for admissions and, potentially, co-manage patients with surgical providers, your efforts could be diluted and despite having a dedicated hospital-based resource, an antithetical impact could occur. To ensure you do not find yourself in a work context that is unmanageable or in which you are held accountable for a lack of hospital-based volume, ensure that your work expectations are clearly articulated contractually. In addition to the afore-referenced hospitalist-contractual nuances, please ensure that you address the subsequent top 10 physician contract issues.

The Top 10 Contractual Issues

1. Know and fully comprehend how your pay will be calculated

   Will your pay be shift-based, productivity-based, based on the net receipts less hospitalist practice overhead, etc.? Ensure that your base-pay and, if applicable the formula for bonus pay, are clearly spelled out contractually and that you afford yourself an opportunity for cost of living allowance (COLA) raises in subsequent years.

2. Know that there is enough volume to support your practice and salary expectations (use benchmark data when applicable)

   As previously stated under productivity expectations and depending upon how your salary will be calculated, you need to ensure that hospital/practice has performed their business due diligence and that there is enough volume to support your hospital-based practice and income expectations.

3. Understand the type of malpractice insurance you have and who will cover the cost of the tail insurance

   What type of malpractice insurance will you be covered by and what are the coverage limits? There are generally two types of malpractice policies (Per Occurrence and Claims Made) and if you are covered by a claims-made policy, you will need to negotiate that your employer covers the “tail” insurance to ensure that you have no large out-of-pocket costs when leaving the hospital/practice. Additionally, the national standard for coverage limits is $1,000,000 per occurrence and $3,000,000 in aggregate; with this stated, based on the high acuity and complexity of the patients that you will be providing care for within a hospitalist role, you should not accept coverage less than the industry standard.
4. Make sure your work expectations are spelled out in your contract

Although this has already been covered under “work schedule,” it provides me with an opportunity to reiterate that your opportunity to ensure a sustainable work/life balance begins with clear contract language.

5. Free money = time commitment

Upfront money (sign-on bonus, tuition reimbursement etc.) is, in most instances, forgiven over time. With this stated, if you accept upfront money, ensure that a prorated amount of the lump sum is forgiven over the term of the contract. Example: if you accept a $10,000 sign-on bonus and the term of the contract is three years, the contract should ensure that 1/36th of the $10,000 is forgiven for each month worked. Too many contracts call for the $10,000 to accrue interests and not be forgiven until the third anniversary of your employment.

6. Term and termination covenants (180-day rule)

Can you find another job, find a place to live, and relocate your family in 90 days? Hospital credentialing and insurance enrollment generally will take up to 90 days; with this stated, do not place yourself in a potential position of not having an income or living apart from your family by allowing your employer to terminate you without cause with a 90-day notice. I always recommend extending this “notice” period to 180 days to allow you a reasonable opportunity to secure your next position, find a home, etc.

7. Non-compete covenants (eliminate or mitigate)

Non-compete/restrictive covenants are defined by time and mileage. Ensure your non-compete is no longer than a year and within a reasonable footprint of the physical address of the hospital that you’re providing services at (versus the hospitals that may comprise a system).

8. Review copies of the Medical Staff Bylaws and the Rules and Regulations of the Medical Staff

It is imperative that you read these documents before signing your contract. These documents will outline your care and citizenship responsibilities. Your ability to remain employed will depend upon your hospital privileges and these documents will outline the expectations not covered within your contract and your due process.
9. Understand the culture that you will be working in and how it will impact your satisfaction

Most physicians will leave their places of employment because they simply are not the right fit. With this stated, perform cultural due diligence by talking to other hospitalists, other members of the medical staff, nurses, and employees working within the institution. This qualitative process will ensure that unwanted surprises are mitigated and that you understand both the formal and informal expectations of your position.

10. Ensure that the “spirit” of your agreement is captured contractually

To ensure that the “spirit” of your agreement is captured, ensure that every recruitment promise made to you is reflected in the contract and is easily interpreted. A vast preponderance of all contracts have an “Entire Agreement” term that stipulates that any promises made to you either orally or in writing are void and that the contract that you sign represents the “entire agreement” between the parties.


Conclusion

Hospitalist physicians are filling a necessary niche in the systemic delivery of care across the country and the increasing demand for services is translating into an unprecedented number of employment opportunities. With this stated, remember that you are a scarce commodity and that you need to negotiate contractual terms that will balance the delicate ecology that exists between your professional satisfaction and personal happiness.

References


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Using Digital Networking to Propel the Physician Job Search

By Bonnie Darves, a Seattle-based freelance health care writer

Online job searching and professional networking call for coherent strategies that will present a prospective candidate in the best possible light. Selection of appropriate digital resources, discretionary use of indirect networking, and detailed knowledge of prospective employers are requisites for a successful search. In line with the core physician competency of professionalism, the use of mobile devices, social media, and the management of information flow necessitate respectful, personalized, and timely interactions.

— John A. Fromson, M.D.

Strategies to effectively network, explore, and manage the job search professionally are essential to prevent information overload and to ensure successful job placement.

Physicians looking for a practice opportunity in the fast-evolving digital age will find that it’s much easier to get information than it used to be. Prospective hiring organizations, potential colleagues, and even the medical-services marketplace and competitive environment in geographic areas of interest are all readily accessible. With a little extra e-digging, tech-savvy physicians who persist might even be able to get the inside scoop on hospital or health system physician politics, finances, or public image — information that might ultimately influence their job choice.

However, it cuts both ways. Organizations seeking physicians to join their practice or augment their medical staff are getting savvy at checking out potential candidates long before they extend the offer of an on-site interview, and possibly even before an introductory phone conversation occurs. The physician with a sloppy, unprofessional online presence or an ostensibly haphazard approach to their job search could end up losing out on good opportunities before starting the search in earnest.

What this means in the current fast-paced job-search environment is that it’s equally important for opportunity-seeking physicians and hiring entities to use the digital tools at their disposal strategically and efficiently. If the mutual objective is to find a good professional fit, it is essential physicians create an optimal online presence and tap into expanded digital networking opportunities.
“Times have definitely changed in how physicians looking for practice opportunities use communication in the digital era,” said Allan Cacanindin, the senior executive vice president of client services at Cejka Search in St. Louis, an expert in the area of digital networking in physician job search. “What we’re seeing is that physicians want their information about practice opportunities — and they want it now. Candidates are also doing a lot more research than they used to, on health care organizations and practices, and much more indirect networking.” In the realm of LinkedIn and other business-focused professional networking sites, he explained, it’s becoming increasingly common for physicians to be introduced digitally — often indirectly, these days — to a physician, recruiter, or even a potential colleague who is willing to offer guidance.

“It used to be who you know, but now, there is much more indirect networking going on — with physicians being introduced digitally to someone in another physician’s network, or to a practice opportunity they didn’t know about,” Mr. Cacanindin explained.

In addition, physicians who are exploring opportunities are being more strategic in using electronic communication and networking to seek answers to perennial job-networking questions like: Who do you know at X organization? What have you heard about X practice or the physician political climate in X hospital? Or, for example, where is the best place in the Chicago area to practice surgical oncology?

This somewhat haphazard, random movement of information and the rapidity with which physicians can explore workplaces or potential opportunities is putting increasing pressure on health care organizations seeking top physician talent. In a period characterized by physician under-supply in many specialties, organizations must try to stay one step ahead of the game and also maintain an active physician-friendly presence on their websites and online. “I think that organizations sometimes fail to understand that physicians are consumers, too, and that most are going to do some homework and networking before they consider an opportunity,” Mr. Cacanindin said.

On the other side of that fence, health care organizations are expecting job-seeking physicians to be reasonably well-informed when they express interest in an opportunity in their group, facility, or health system, Regina Levison, president of the national firm Levison Search Associates, advises. “If you are receiving emails or invitations about an opportunity from search firms or in-house recruiters, take the time to at least check out
the organization before you respond,” Ms. Levison said. “We do that before we present a candidate, so we expect that the physician will do the same.”

Navigating a changing landscape

Avenues for connecting and exploring the practice options appear just about infinite now, with the increasing use of social media sites such as LinkedIn, Facebook, and Twitter by both job-seeking physicians and recruiters and entities seeking to connect with potential candidates. The Mayo Clinic Healthcare Social Media list, for example, indicates that more than 1,500 U.S. hospitals now have an active social media presence on sites such as Facebook, LinkedIn, YouTube, and Twitter. Many of these organizations devote some of that activity to electronically source candidates and promote practice opportunities.

The annual social media and mobile device survey conducted by ANM Healthcare, the parent of the national physician search firm Merritt Hawkins, found that 41% of physicians use mobile devices to access job and industry-related information, up from 21% three years ago.

“Digital technologies have completely changed the way physicians search for and apply for jobs,” said Miranda Grace, the physician recruiter at Lewiston Hospital in Lewiston, Pennsylvania. “Because they’re constantly on the go, their job search must be as well.” For that reason, many organizations now make job postings accessible on smart phones and tablets, Ms. Grace observes, and some are using QR codes to link physician candidates to their jobs or a recruiter’s contact information.

What are young job-seeking physicians expecting these days in way of digital technology usage by prospective hiring organizations? Besides being given the red carpet treatment because of the current demand for many physician specialties, physicians also expect to receive opportunity details and a rapid response to their expressed interest.

Marci Jackson, MA, physician recruitment manager at Marshfield Clinic in Wisconsin, the country’s largest private medical practice, knows well the challenges meeting prospective candidates’ expectations in this virtual-whirlwind environment. “Younger physicians expect to receive most information electronically. They want access to information 24/7,” Ms. Jackson notes, “so our recruitment information [must be] out on the Internet in various forms.”
Marshfield maintains a presence not only on job boards with links back to the clinic’s website and online applications, but also on LinkedIn, Facebook, Pinterest, YouTube, and Twitter. And until a physician has “absolutely expressed interest,” Ms. Jackson adds, “all communication is usually electronic.”

Managing digital-information flow challenging

If all of this wireless wooing sounds like a bonanza for the job-seeking physician, it is. But therein lies the flip side: staying on top of and managing the communication trails can be daunting. That’s where a well-defined strategy is helpful and forethought essential, according to Tommy Bohannon, divisional vice president of recruiting for Merritt Hawkins. “The digital information flow makes things more convenient for physicians — they can obtain details on a broad range of jobs instantaneously, and they can review that information in between patients or while they’re on the train,” Mr. Bohannon said. “But it also means that physicians might receive a thousand text messages or emails a week if they don’t narrow their parameters and proactively manage the information flow.”

To tailor the job search and reduce information overload, it’s advisable to set up a separate email account just for the related activity, both Mr. Bohannon and Mr. Cacanindin advised, and to create structured, well-written, and error-free boilerplate initial responses that can be sent out quickly and customized appropriately. It’s also smart to develop a list of initial questions about the issues or parameters that are especially important to the physician, such as amount of call, schedule structures, or employment or compensation models, for example, and to pose those early on in the communication.

“This new age of digital technology enables physicians to cast a much wider net for practice opportunities — well, a worldwide net,” said Lori Norris, a senior physician recruiter at Dignity Health’s Chandler Regional Medical Center in Phoenix, Arizona. “With a click, tap, or voice command they can send their CVs to every potential employer, recruiter, or practice in their desired location. This is great for the candidate, but sometimes not so great for the groups or employers who are trying to recruit that candidate.” For example, it’s entirely possible, Ms. Norris notes, that competing groups in the same city might all be vying for the same candidate because most physicians truly are shopping around these days — and that digital information flow makes it apparent that’s happening. That might
not sit well with some prospective employers, when they discover that they’re “being shopped,” but it’s a reality and it doesn’t reflect poorly on the physician. Physicians’ responsibility, in such situations, is to behave as graciously as possible while obtaining enough detail to start narrowing the field — and then drop out of the running reasonably quickly for any opportunity they won’t pursue.

All of this suggests that physicians looking for a practice opportunity would be wise to try to put themselves in recruiters’ shoes as they move around digitally, to avoid putting people to a lot of trouble about an opportunity in which the physician isn’t really interested. It’s just common courtesy, Mr. Bohannon stressed, to narrow the initial field by indicating the must-meet parameters — whether that’s geography or a desired subspecialty practice focus, or both. He cites a recent example of how not to proceed in this regard. “We occasionally see physicians who see 25 jobs in their field posted on our website, and check all of the boxes indicating they would like more detail on the opportunity,” he said, “when it’s unlikely they’re truly interested in all of those opportunities. That’s not an effective way to gather information.”

Besides annoying the individual who must sort through all of those “clicks,” physicians who use “select-all” approach risk giving the impression that they have no idea what they want. “It’s much more effective to choose five or six opportunities to explore completely,” Mr. Bohannon advised, “and plan on getting on a plane to look at three of them.”

It’s also important to respond cordially, quickly and reasonably completely to anyone who sends details electronically of an opportunity that the physician is likely to pursue, all sources interviewed for this article concurred. For example, rather than simply firing off a text or email stating, “Please send more details,” list some of the details sought and indicate when it would be convenient for a recruiter to call to discuss the opportunity. “If I have six responses in my inbox in the morning, and five say ‘send more details,’ and one says ‘this sounds like a good fit for me, and I’d like more details. Please call me at 5 p.m. Monday,’ guess who I contact first?” Mr. Bohannon said.

Even in the digital era, professional standards and old-school conduct codes still apply. Those include acknowledging communications received — whether it’s a text message, email, or a phone call — about any opportunity in which the physician has expressed interest. Ideally, that’s within 24 to 48 hours of the communication, not a week or two later. And thanking
anyone who helps out during the journey to finding a practice opportunity, either directly or indirectly by connecting the physician to another individual, is a must.

A word about networking etiquette is in order. Physicians who behave in a self-centered manner when they network, by asking individuals for help or advice and then effectively “disappearing” until the next time they ask for help, risk offending their connections, several sources warned. “Take the time to thank the people who help you, and keep them in the loop as you continue or conclude your search,” Mr. Cacanindin said. For example, after sending the initial thank-you note, let the individual know down the road if the connection facilitated led to an interesting conversation or a site interview, or a job offer.

Finally, in part because the high demand for their services, some physicians take a somewhat cavalier attitude about responding to recruiters who email, text, or call about the opportunity the physician expressed interest in. “Even though the supply-and-demand situation is in the physician’s favor, it’s important to remember that if the job sounds good to you, it likely does to other qualified physicians as well,” Mr. Bohannon said.

Kaitlin Olson, a social media marketing specialist at HealtheCareers, describes some of the digital networking practices she sees physicians use now that, in her view, provide potentially fruitful support for an effective first, or subsequent job search. “Many young physicians are really staying up to date with their connections, especially with so many social channels available now on LinkedIn. Many are also using Facebook and Twitter not just to make connections but also to follow industry thought leaders — and some are becoming thought leaders on their own,” reported Ms. Olson, who spends considerable time daily monitoring social media activity in the physician-recruiting and opportunity-search realms. “Physicians appear to be using social media not only for networking but also to build their brand and [plot] their careers, and that’s helpful when they are looking for practice opportunities.”

**Tips for using digital networking effectively**

Avoid relying primarily on 100-word blurbs or catchy push emails to start narrowing the field, Mr. Bohannon cautions. “The downside of the digital transformation is that it has somewhat dehumanized the environment. Reading three-paragraph blurbs doesn’t give physicians a complete picture
of the opportunity,” he said. “Looking for a practice opportunity should be a “high-touch” activity too, so physicians should do themselves the service of seeking first-source information about the opportunity through a phone conversation.”

- Before starting to network, ensure that your CV is complete, well-written, error free, and accompanied by a professional photo. Using digital tools to launch the CV is easy to do, but once it’s out there in cyberspace it can be nearly impossible to rectify an error — and very difficult to “pull it back.”

- Optimize online profiles on social media sites such as LinkedIn, and Ozmosis, and refresh them occasionally to let colleagues and potential hiring organizations know of new career developments.

- Don’t post your CV everywhere, indiscriminately, or indicate interest in opportunities if it’s not genuine. Doing so, Mr. Cacanindin explained, could make it appear that the physician is either not confident, or, worse, a bit desperate, even if neither is the case.

- Act like a consumer and do research before you start networking about or communicating electronically with organizations you might be interested in joining. Look at their website and read local (and national, if applicable) coverage on the entity. Recruiters certainly do that before they introduce a potential opportunity to a prospective candidate.

- Conduct an online search on yourself, using Google and other search engines, regularly, to see what shows up. Physicians are sometimes unpleasantly surprised to discover that others have posted images or content that identifies the physician in an unfavorable light professionally. “Remember that whatever you’re seeing, the recruiters or potential hiring organizations are seeing too,” Ms. Levison said. And it goes without saying that anything that reflects poorly on a candidate and can be removed, or appropriately contested, should be.

- Be proactive about monitoring your presence on the physician-rating sites such as HealthGrades, RateMDs, and Vitals, and encouraging patients who’ve been pleased with your care to add a brief review. Even though physicians rightly claim that such venues aren’t necessarily “fair” or balanced, and that some reviews are inaccurate, top marks by patients may give candidates a slight edge in recruiting circles.
• Steer clear of using any kind of digital communication, however friendly or well-intentioned, that might appear informal or unprofessional. Recruiters report, for example, that some physicians overuse emoticons such as smiley faces in their communications, or use text abbreviations in what should be formal correspondence about a practice opportunity. Neither is appropriate in the decidedly serious realm of job seeking.

Did you find this article helpful? What other topics would you like to see covered? Please send us an email to let us know what you thought at resourcecenter@nejm.org.
Recent achievements in medicine have resulted in progress beyond what many could have imagined just decades ago. New science and technology have empowered physicians to make better, faster treatment decisions. Our understanding of the human genome and targeted drug research is producing major improvements in treatments for cancer, heart disease, and many other chronic illnesses.

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A 67-year-old woman with mild Alzheimer’s disease who has a 2-day history of productive cough, fever, and increased confusion is transferred from a nursing home to the emergency department. According to the transfer records, she has had no recent hospitalizations or recent use of antibiotic agents. Her temperature is 38.4°C (101°F), the blood pressure is 145/85 mm Hg, the respiratory rate is 30 breaths per minute, the heart rate is 120 beats per minute, and the oxygen saturation is 91% while she is breathing ambient air. Crackles are heard in both lower lung fields. She is oriented to person only. The white-cell count is 4000 per cubic millimeter, the serum sodium level is 130 mmol per liter, and the blood urea nitrogen is 25 mg per deciliter (9.0 mmol per liter). A radiograph of the chest shows infiltrates in both lower lobes. How and where should this patient be treated?

THE CLINICAL PROBLEM

Pneumonia is sometimes referred to as the forgotten killer. The World Health Organization estimates that lower respiratory tract infection is the most common infectious cause of death in the world (the third most common cause overall), with almost 3.5 million deaths yearly. Together, pneumonia and influenza constitute the ninth leading cause of death in the United States, resulting in 50,000 estimated deaths in 2010. This number is probably underestimated, since deaths from sepsis (for which pneumonia is the most common source) and deaths attributed to other conditions (e.g., cancer and Alzheimer’s disease) for which pneumonia is the terminal event are coded separately.

Community-acquired pneumonia that is severe enough to require hospitalization is associated with excess mortality over the subsequent years among survivors, even among young people without underlying disease. Admission to the hospital for community-acquired pneumonia is also costly, especially if care in an intensive care unit (ICU) is required.

Because of the economic cost, associated mortality, and heterogeneity of management, community-acquired pneumonia has been a focus of Centers for Medicare and Medicaid Services (CMS) and the Joint Commission (TJC) quality-improvement efforts, public reporting of outcomes, and possible pay-for-performance initiatives. This article focuses on management strategies for community-acquired pneumonia, with particular emphasis on interventions to reduce mortality and costs.

DIAGNOSIS

The diagnosis of community-acquired pneumonia is not difficult in patients who do not have underlying cardiopulmonary disease. A triad of evidence of infection
(fever or chills and leukocytosis), signs or symptoms localized to the respiratory system (cough, increased sputum production, shortness of breath, chest pain, or abnormal pulmonary examination), and a new or changed infiltrate as observed on radiography usually accurately identifies a patient with community-acquired pneumonia. Table 1 reviews the differential diagnosis of community-acquired pneumonia.

In patients with lung cancer, pulmonary fibrosis or other chronic infiltrative lung disease, or congestive heart failure, the diagnosis of community-acquired pneumonia can be very difficult. Atypical presentations also complicate diagnosis. Confusion may be the only presenting symptom in elderly patients, leading to a delay in diagnosis. Infiltrates on radiographs may also be subtle: an individual radiologist may miss infiltrates in up to 15% of cases, and two radiologists reading the same chest radiograph disagree in 10% of cases.

INITIAL MANAGEMENT

Choice of Antibiotic Therapy

Three interrelated decisions must be made almost simultaneously when a patient first presents — the choice of antibiotic therapy, the extent of testing to determine the cause of the pneumonia, and the appropriate location of treatment (home, inpatient floor, or ICU).

Numerous antibiotics are approved for the treatment of community-acquired pneumonia by the Food and Drug Administration on the basis of randomized, controlled trials comparing them to other antibiotics previously approved for community-acquired pneumonia. The key to appropriate therapy is adequate coverage of Streptococcus pneumoniae and the atypical bacterial pathogens (mycoplasma, chlamydophila, and legionella).

For outpatients, the coverage of atypical bacterial pathogens is most important, especially for young adults, for whom herd immunity from widespread vaccination of infants and children with a conjugate pneumococcal vaccine has decreased the rates of pneumococcal pneumonia. The primary factors in the choice of agent for a particular episode among the large number of approved oral antibiotics are recent antibiotic use (which may be associated with a risk of class resistance) and cost. Macrolides, doxycycline, and fluoroquinolones are the most appropriate agents for the atypical bacterial pathogens.

For patients admitted to a regular hospital unit, guidelines from the Infectious Diseases Society of America and the American Thoracic Society (IDSA–ATS) recommend first-line treatment with either a respiratory fluoroquinolone (moxifloxacin at a dose of 400 mg per day or levofloxacin at a dose of 750 mg per day) or the
combination of a second-generation or third-generation cephalosporin and a macrolide. These recommendations are based primarily on large inpatient administrative databases that show reduced mortality with recommended antibiotics as compared with other antibiotics or combinations. Quality-improvement projects also consistently show that as adherence to these recommended antibiotics increases, mortality and length of hospital stay decrease.

Although *S. pneumoniae* remains the most common cause of severe community-acquired pneumonia requiring ICU admission, combination therapy consisting of a cephalosporin with either a fluoroquinolone or a macrolide is recommended. Observational evidence suggests that the macrolide combination may be associated with better outcomes. Since fluoroquinolones have essentially the same antibacterial spectrum as macrolides, the better outcome with macrolides may be explained by nonbactericidal effects, such as immunomodulation.

**Timing of Initiation of Therapy**

A CMS–TJC quality metric for community-acquired pneumonia is administration of the first antibiotic dose within 6 hours after presentation. This cutoff was modified from retrospective analyses of large Medicare databases showing that an interval of more than 4 hours between the initial presentation and the first antibiotic dose was associated with increased in-hospital mortality. However, efforts to decrease the time to the first administration of antibiotic therapy have resulted in an increase in inappropriate antibiotic use in patients who do not have community-acquired pneumonia, with adverse consequences such as *Clostridium difficile* colitis, and have not resulted in corresponding decreases in mortality. A shorter time to antibiotic administration may simply be a marker of multiple beneficial care patterns (e.g., less crowding in the emergency department, prompt fluid resuscitation, and the recognition of and early intervention for incipient respiratory failure) that are associated with improved patient outcomes.

The current IDSA–ATS guidelines do not recommend a specific time to the administration of the first antibiotic dose but instead encourage treatment as soon as the diagnosis is made. An exception is made for patients in shock; antibiotics should be given within the first hour after the onset of hypotension. An observational study involving patients with septic shock showed a decrease in survival rates of 8% for each hour of delay.

**Duration of Antibiotic Treatment**

The currently recommended duration of antibiotic therapy for community-acquired pneumonia is 5 to 7 days. There is no evidence that prolonged courses lead to better outcomes, even in severely ill patients, unless they are immunocompromised.

**TREATMENT OF PATIENTS AT RISK FOR RESISTANT ORGANISMS**

Although the above recommendations apply to the majority of patients with community-acquired pneumonia, physicians need to identify patients who are at increased risk for bacteria resistant to these empirical antibiotic regimens. Most common among these are patients with risk factors for health care–associated pneumonia (Table 2). Health care–associated pneumonia has been categorized as a discrete entity, with the goal of identifying patients with pneumonia that develops outside the hospital yet is caused by pathogens usually associated with hospital-acquired pneumonia or even ventilator-associated pneumonia.

---

**Table 1. Differential Diagnosis of Community-Acquired Pneumonia.**

<table>
<thead>
<tr>
<th>Abnormal chest radiograph</th>
<th>Congestive heart failure with associated viral syndrome to explain infectious symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration pneumonitis</td>
<td></td>
</tr>
<tr>
<td>Pulmonary infarction</td>
<td></td>
</tr>
<tr>
<td>Acute exacerbation of pulmonary fibrosis</td>
<td></td>
</tr>
<tr>
<td>Acute exacerbation of bronchiectasis</td>
<td></td>
</tr>
<tr>
<td>Acute eosinophilic pneumonia</td>
<td></td>
</tr>
<tr>
<td>Hypersensitivity pneumonitis</td>
<td></td>
</tr>
<tr>
<td>Pulmonary vasculitis</td>
<td></td>
</tr>
<tr>
<td>Cocaine-induced lung injury (“crack lung”)</td>
<td></td>
</tr>
<tr>
<td>Normal chest radiograph</td>
<td>Acute exacerbation of chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Acute bronchitis</td>
<td></td>
</tr>
<tr>
<td>Pertussis</td>
<td></td>
</tr>
<tr>
<td>Asthma with associated viral syndrome to explain infectious symptoms</td>
<td></td>
</tr>
</tbody>
</table>

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N ENGL J MED 370;6 NEJM.ORG FEBRUARY 6, 2014
including methicillin-resistant *Staphylococcus aureus* (MRSA) and multidrug-resistant (MDR) gram-negative pathogens.

In reports of data from tertiary care centers, patients with culture-positive health care–associated pneumonia were more likely than patients who did not meet the definition for health care–associated pneumonia to have these resistant pathogens and to receive initially inappropriate antibiotic therapy, which has been associated with increased mortality among these patients.30,31

Empirical broad-spectrum therapy with dual coverage for *Pseudomonas aeruginosa* and routine MRSA coverage has therefore been recommended for patients with risk factors for health care–associated pneumonia (Table 2).28 However, there is increasing recognition that using all these risk factors as indications for broad-spectrum therapy may lead to antibiotic overtreatment of many patients. The appropriate criteria for initial broad-spectrum therapy remain controversial (see the Areas of Uncertainty section). Another group of patients at risk for pathogens resistant to the usual antibiotics for community-acquired pneumonia are those with structural lung disease (bronchiectasis or severe chronic obstructive pulmonary disease [COPD]) who have received multiple courses of outpatient antibiotics; the frequency of *P. aeruginosa* infection is particularly increased in this population.13

Whereas MRSA is commonly identified in patients with risk factors for health care–associated pneumonia, a community-acquired strain of MRSA that causes community-acquired pneumonia in previously healthy patients without health care–associated pneumonia or other risk factors for MDR pathogens has increasingly been recognized.32,33 Exotoxin production by this strain (as well as by the methicillin-sensitive variant) results in characteristic presenting features (Table 3). Because the clinical presentation of this infection is disproportionately exotoxin-mediated, treatment is recommended with antibiotics that suppress toxin production, such as linezolid or clindamycin (added to vancomycin); these regimens have been associated with reduced mortality.33

### Diagnostic Testing

The extent of testing that is warranted to identify the causative microorganism in community-acquired pneumonia is controversial. Because the recommended antibiotic regimens are effective for the majority of patients, diagnostic testing will rarely affect therapy. Table 4 reviews conditions in which specific testing may lead to different treatment. Extensive diagnostic testing is most helpful in patients with risk factors for health care–associated pneumonia3 or with severe community-acquired pneumonia requiring ICU admission,13 in whom the probability of the presence of bacteria that are resistant to usual therapy is greatest.

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**Table 2. Criteria for Health Care–Associated Pneumonia.**

<table>
<thead>
<tr>
<th>Original criteria*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization for ≥2 days during the previous 90 days</td>
</tr>
<tr>
<td>Residence in a nursing home or extended-care facility</td>
</tr>
<tr>
<td>Long-term use of infusion therapy at home, including antibiotics</td>
</tr>
<tr>
<td>Hemodialysis during the previous 30 days</td>
</tr>
<tr>
<td>Home wound care</td>
</tr>
<tr>
<td>Family member with multidrug-resistant pathogen</td>
</tr>
<tr>
<td>Immunosuppressive disease or therapy†</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pneumonia-specific criteria‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization for ≥2 days during the previous 90 days</td>
</tr>
<tr>
<td>Antibiotic use during the previous 90 days</td>
</tr>
<tr>
<td>Nonambulatory status</td>
</tr>
<tr>
<td>Tube feedings</td>
</tr>
<tr>
<td>Immunocompromised status</td>
</tr>
<tr>
<td>Use of gastric acid suppressive agents</td>
</tr>
</tbody>
</table>

* Original criteria are from the American Thoracic Society and Infectious Diseases Society of America.28
† This criterion was not included in the original criteria but is frequently included in many studies of health care–associated pneumonia.
‡ Pneumonia-specific criteria are from Shindo et al.29

**Table 3. Clinical Features Suggesting Community-Acquired MRSA Pneumonia.**

| Cavitary infiltrate or necrosis |
| Rapidly increasing pleural effusion |
| Gross hemoptysis (not just blood-streaked) |
| Concurrent influenza |
| Neutropenia |
| Erythematous rash |
| Skin pustules |
| Young, previously healthy patient |
| Severe pneumonia during summer months |

* MRSA denotes methicillin-resistant *Staphylococcus aureus*.18
Influenza testing in the appropriate season is the diagnostic test that is most likely to affect treatment. Depending on current local influenza rates, antiviral treatments may be started empirically and stopped if testing is negative, or they may be started only in response to a positive test.

**SITE OF CARE**

**Hospital Admission**

A physician’s decision to hospitalize a patient with community-acquired pneumonia is the major determinant of cost. Between 40% and 60% of patients who present to the emergency department with community-acquired pneumonia are admitted. Considerable variation in this decision among patients with similar clinical characteristics emphasizes the opportunity for standardization.

Scoring systems that predict short-term mortality, such as the Pneumonia Severity Index (PSI) and the CURB-65 scores, were developed specifically to make admission decisions more objective. Use of the PSI results in fewer admissions of patients with mild illness, with no increase in adverse outcomes. However, calculating the PSI score is complex, requiring formal scoring or electronic decision support (http://pda.ahrq.gov/clinic/psi/psicalc.asp). The CURB-65 score (which assigns 1 point each for confusion, uremia [blood urea nitrogen ≥20 mg per deciliter], respiratory rate ≥30 breaths per minute, systolic blood pressure <90 mm Hg or diastolic blood pressure ≤60 mm Hg, and age ≥65 years, with a score ≥3 indicating the need for hospitalization) is easy to remember and calculate but has not been as well validated as the PSI score. Although both scores are valid for the analysis of groups of admissions for quality improvement or research in community-acquired pneumonia, individual decisions that are inconsistent with the score are often made for legitimate reasons, both objective (e.g., low arterial saturations) and subjective (e.g., unreliable home support and concern regarding adherence to therapy).

**ICU Admission**

Decisions regarding initial admission to the ICU of patients with community-acquired pneumonia and questionable cardiopulmonary stability probably have the greatest potential effect on mortality. Patients transferred to the ICU within 48 hours

<table>
<thead>
<tr>
<th>Condition and Response to Test Result</th>
<th>Blood Culture</th>
<th>Pleural Fluid Culture</th>
<th>Respiratory Tract Culture</th>
<th>Condition and Response to Test Result</th>
<th>Blood Culture</th>
<th>Pleural Fluid Culture</th>
<th>Respiratory Tract Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe community-acquired pneumonia†</td>
<td>Strongly recommended if there is tracheal aspirate or bronchoalveolar-lavage aspirate in an intubated patient; strongly recommended if there is productive cough in a nonintubated patient</td>
<td>Strongly recommended if there is tracheal aspirate or bronchoalveolar-lavage aspirate in an intubated patient; strongly recommended if there is productive cough in a nonintubated patient</td>
<td>Recommended</td>
<td>Strongly recommended if the patient has structural lung disease or severe COPD with productive cough</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>Health care–acquired pneumonia</td>
<td>Recommended</td>
<td>Strongly recommended if there is tracheal aspirate or bronchoalveolar-lavage aspirate in an intubated patient; strongly recommended if there is productive cough in a nonintubated patient</td>
<td>Strongly recommended if the patient has structural lung disease or severe COPD with productive cough</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td>Other condition or circumstance</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
</tbody>
</table>

* COPD denotes chronic obstructive pulmonary disease, and ICU intensive care unit.
† Severe community-acquired pneumonia is defined as community-acquired pneumonia for which admission to the intensive care unit is being considered.
after initial admission to a general medical service have higher mortality than those with an obvious need for ICU care (mechanical ventilation or hypotension requiring vasopressors) at the time of admission. However, no prospective studies have been performed to establish whether initial admission to the ICU of patients without these major criteria for ICU admission would prevent subsequent deterioration better than initial admission to a general unit.

The percentage of hospitalized patients with pneumonia who are admitted to the ICU also varies widely (ranging from 5 to 20%) depending on hospital and health-system characteristics. Because the PSI and CURB-65 scores have limited ability to identify patients whose condition is likely to deteriorate if they are admitted to a general ward, the IDSA–ATS guidelines suggest that the presence of three or more of nine minor criteria should warrant consideration of ICU admission (Table 5). Other scores for predicting clinical deterioration have also been developed and validated. For each of these scores, the probability of the need for invasive ventilatory or vasopressor therapy increases with higher numbers of criteria met or points tallied. These scores have many variables in common (Table 5) and use a similar threshold score (approximately 3) to consider ICU admission. If followed rigidly, all result in substantially more ICU admissions of patients who will never need ICU-level interventions.

The most appropriate use of these scores may be to focus attention on patients who have high scores while still in the emergency department. A quality-improvement study showed that increased attention in the emergency department to patients with three or more IDSA–ATS minor criteria resulted in a decrease in mortality (from 23 to 6%) and fewer floor-to-ICU transfers (from 32 to 15%) without substantially increasing direct ICU admissions. Potentially useful interventions include aggressive fluid resuscitation, prompt initiation of appropriate antibiotics, measurement of arterial blood gas in patients with borderline hypoxemia or lactate in those with borderline hypotension, and treatment of coexisting illnesses (e.g., administration of bronchodilators for asthma and COPD); reassessment after such interventions can clarify the trajectory of the patient’s illness.

**Areas of Uncertainty**

Concerns have been raised that the original definition of health care–associated pneumonia, with the associated recommendation for broad-spectrum antibiotic treatment, results in overuse of antibiotics. The group of risk factors included in the original definition of health care–associated pneumonia (Table 2) were extrapolated from studies of health care–associated bacteremia and may therefore not be entirely appropriate for pneumonia. As compared with early observational studies of culture-positive cases that suggested benefits of broad-spectrum antibiotic therapy in persons with these risk factors, subsequent prospective studies of patients with health care–associated pneumonia have shown markedly lower rates of antibiotic-resistant pathogens and high rates of culture-negative cases. The use of risk factors for health care–associated pneumonia as the basis for antibiotic choices results in broad-spectrum treatment of almost half the patients with community-acquired pneumonia in some centers.

Of particular concern are findings that suggest increased risks of adverse outcomes among persons who are treated with broad-spectrum antibiotics for health care–associated pneumonia, although selection bias cannot be ruled out as an explanation for these findings. A multicenter quality-improvement project showed increased mortality in association with broad-spectrum therapy in such patients. Similarly, an analysis that included patients with risk factors for health care–associated pneumonia who were treated at Veterans Affairs medical centers showed higher mortality among those who were given broad-spectrum therapy than among those who received standard treatment for community-acquired pneumonia.

The most appropriate criteria for identifying patients who should receive initial empirical broad-spectrum coverage are unclear. A recent prospective, multicenter study identified six risk factors (Table 2) for pneumonia caused by pathogens resistant to the usual inpatient antibiotic regimens recommended by IDSA–ATS guidelines. These pneumonia-specific risk factors are consistent with those cited in other reports that indicate that recent antibiotic use or hospitalization and poor functional status are more important.
predictors of resistant pathogens than nursing home residence alone.\textsuperscript{47} Availability data suggest that the incidence of MDR pathogens generally is not significantly increased unless three or more risk factors are present.\textsuperscript{29} However, MRSA is an exception: the presence of one MRSA-specific risk factor (prior MRSA infection or colonization, long-term hemodialysis, or heart failure) and another pneumonia-specific risk factor may warrant MRSA coverage (but not dual antipseudomonal antibiotics).\textsuperscript{29} The importance of distinguishing between health care–associated pneumonia and community-acquired pneumonia depends on the local prevalence of antibiotic-resistant pathogens, which varies markedly within the United States, highlighting the value of knowledge of local epidemiologic data. Data from randomized trials are lacking to guide treatment in patients with culture-negative health care–associated pneumonia.\textsuperscript{29,43} Whereas studies indicate that initially inappropriate empirical antibiotic therapy for health care–associated pneumonia is associated with increased mortality among patients with culture-negative cases,\textsuperscript{30,31} observational data suggest that a switch to traditional antibiotic regimens for community-acquired pneumonia is safe when cultures are negative,\textsuperscript{43} and such treatment may be associated with reduced mortality.\textsuperscript{29} Targeted diagnostic testing

### Table 5. Criteria for Consideration of ICU Admission for Patients without an Obvious Need.\textsuperscript{28}

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Definition</th>
<th>Other Scoring System or Strategy with Similar Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDSA–ATS minor criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confusion</td>
<td>None specified</td>
<td>SMART-COP,\textsuperscript{39} CURXO,\textsuperscript{41} and REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Elevated blood urea nitrogen</td>
<td>Blood urea nitrogen ≥20 mg/dl</td>
<td>CURXO\textsuperscript{41} and REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Tachypnea</td>
<td>Respiratory rate ≥30 breaths/min</td>
<td>SMART-COP,\textsuperscript{39} CURXO,\textsuperscript{41} and REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Multilobar infiltrates observed on radiograph</td>
<td>None specified</td>
<td>SMART-COP,\textsuperscript{39} CURXO,\textsuperscript{41} and REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Hypoxemia</td>
<td>Ratio of partial pressure of oxygen in arterial blood to fraction of inspired oxygen &lt;250 mm Hg</td>
<td>SMART-COP,\textsuperscript{39} CURXO,\textsuperscript{41} and REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>&lt;100,000 platelets/mm\textsuperscript{3}</td>
<td>—</td>
</tr>
<tr>
<td>Hypotension</td>
<td>Hypotension (systolic pressure &lt;90 mm Hg) requiring aggressive fluid resuscitation</td>
<td>SMART-COP\textsuperscript{39} and CURXO\textsuperscript{41}</td>
</tr>
<tr>
<td>Hypothermia</td>
<td>Core temperature of &lt;36°C</td>
<td>—</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>White-cell count &lt;4000/mm\textsuperscript{3}</td>
<td>REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Other criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactic acidosis</td>
<td>Lactic acid level ≥4 mmol/liter</td>
<td>Early goal-directed therapy\textsuperscript{42}</td>
</tr>
<tr>
<td>Low pH</td>
<td>&lt;7.30–7.35, depending on scoring system\textsuperscript{†}</td>
<td>SMART-COP,\textsuperscript{39} CURXO,\textsuperscript{41} and REA-ICU,\textsuperscript{40} depending on pH\textsuperscript{†}</td>
</tr>
<tr>
<td>Low albumin</td>
<td>&lt;3.5 g/dl</td>
<td>SMART-COP\textsuperscript{39}</td>
</tr>
<tr>
<td>Hyponatremia</td>
<td>Sodium level &lt;130 mmol/liter</td>
<td>REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Leukocytosis</td>
<td>Leukocyte count &gt;20,000/mm\textsuperscript{3}</td>
<td>REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>Heart rate ≥125 beats/min</td>
<td>SMART-COP\textsuperscript{39} and REA-ICU\textsuperscript{40}</td>
</tr>
<tr>
<td>Older age</td>
<td>&gt;80 yr</td>
<td>CURXO\textsuperscript{41} and REA-ICU\textsuperscript{40}</td>
</tr>
</tbody>
</table>

\* A patient without an obvious need was defined as one who did not require endotracheal intubation and mechanical ventilation or as one who did not have hypotension requiring vasopressors while in the emergency department. Risk increases proportionally with the presence of more than three criteria. IDSA–ATS denotes Infectious Diseases Society of America–American Thoracic Society, and REA-ICU Risk of Early Admission to ICU.

\† The criterion of a pH level of less than 7.30 is used in the calculation of the CURXO\textsuperscript{41} score. The criterion of a pH level of less than 7.35 is used in the calculation of the SMART-COP\textsuperscript{39} and REA-ICU\textsuperscript{40} scores.
allows the de-escalation of therapy if cultures are negative (or positive for typical community-acquired pneumonia pathogens).

GUIDELINES

The IDSA–ATS guidelines for community-acquired pneumonia were published 7 years ago, but little has changed regarding antibiotic treatment of community-acquired pneumonia, and the recommendations in this article are generally consistent with these guidelines. Criteria and antibiotic recommendations for health care–associated pneumonia from the older guidelines for hospital-acquired and ventilator-acquired pneumonia are outdated. The discussion of health care–associated pneumonia has been removed from the planned update of the guidelines for hospital-acquired and ventilator-acquired pneumonia and will be incorporated in a future guideline by these organizations.

The IDSA–ATS guidelines for community-acquired pneumonia differ only slightly from non-U.S. guidelines. European guidelines keep the option of beta-lactam monotherapy and de-emphasize the use of fluoroquinolones in hospitalized patients outside the ICU.

CONCLUSIONS AND RECOMMENDATIONS

The woman described in the vignette has a CURB-65 score of 4, suggesting that she would benefit from inpatient therapy. She has at least four minor criteria for severe community-acquired pneumonia (confusion, respiratory rate ≥30 breaths per minute, multilobar infiltrates, and uremia). Although ICU admission may be prudent, she would clearly benefit from further evaluation. We would measure the arterial blood gas and lactate levels, given the high respiratory rate and low saturation, and hydrate aggressively.

As a nursing home resident, the patient meets the current criteria for health care–associated pneumonia. However, since she has no pneumonia-specific MDR risk factors but does have risk factors for severe community-acquired pneumonia, we would initiate treatment with ceftriaxone and azithromycin. Influenza testing should be requested if she has presented during the appropriate season, and empirical oseltamivir started if the local influenza rate is high. We would not obtain blood cultures or attempt to obtain sputum cultures because of the low likelihood of the presence of pathogens resistant to usual treatment for community-acquired pneumonia.

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Dalton, MD 01622 .......... = 3 words

As a further example, here is a typical ad and how the pricing for each insertion is calculated:

MEDICAL DIRECTOR — A dynamic, growth-oriented hospital health care company is looking for a full-time Medical Director in greater New York. Ideal candidate should be board certified in internal medicine with subspecialties in oncology or gastroenterology. Willing to visit patients at home. Good verbal and written skills required. Attractive salary and benefits. Send CV to: Reply Box 0000, NEJM.

This advertisement is 58 words. At $7.60 per word, it equals $440.80. Because a reply box was requested, there is an additional charge of $75.00 for each insertion. The price is then $515.80 for each insertion of the ad. This ad would be placed under the Chiefs/Directors/Department Heads classification.

How to Respond to NEJM Box Numbers

When a reply box number is indicated in an ad, responses should be sent to the indicated box number at the address under “Contact Information.”

Classified Ads Online

Advertisers may choose to have their classified line and display advertisements placed on NEJM CareerCenter for a fee. The web fee for line ads is $70.00 per issue per advertisement and $140.00 per issue per advertisement for display ads. The ads will run online two weeks prior to their appearance in print and one week after. For online-only recruitment advertising, please visit nejmcarecenter.org for more information, or call 1-800-635-6991.

Policy on Recruitment Ads

All advertisements for employment must be non-discriminatory and comply with all applicable laws and regulations. Ads that discriminate against applicants based on sex, age, race, religion, marital status or physical handicap will not be accepted. Although the *New England Journal of Medicine* believes the classified advertisements published within these pages to be from reputable sources, NEJM does not investigate the offers made and assumes no responsibility concerning them. NEJM strives for complete accuracy when entering classified advertisements; however, NEJM cannot accept responsibility for typographical errors should they occur.

NEJM is unable to forward product and service solicitations directed to our advertisers through our reply box service.
Cardiology

MAINE — Join Central Maine Heart Associates, a well-established group of nine cardiologists in central Maine. Our team of Noninvasive, Interventional, and EP Cardiologists seek a Noninter- ventional Cardiologist to provide the full spectrum of inpatient and outpatient care to a service area of 400,000+. We are looking for someone who does ECHO and nuclear cardiology and TEE is preferred. The Central Maine Medical Family has a large number of Primary Care providers, which deliver an abundant referral base and our established Heart and Vascular Surgical team round out the services provided to our patients. Candidates can expect to also participate in clinical outreach programs in involvement in large clinical research programs is a plus! We offer a competitive compensation and benefits package, too! Lewiston/Auburn is a safe community in which to raise a family. Lewiston/Auburn is a wide range of schooling and housing options and cultural activities, and is centrally located to the both the mountains and coast. To learn more about this employed opportunity, please send CV to: Julia Lauver, Medical Staff Recruiter, Central Maine Medical Center, e-mail: J.Lauver@cmhc.org; call: 800-445-7431; or fax: 207-795-5696.

CARDIOLOGY, BC/BE CARDIOLOGIST — Noninvasive, nuclear cardiology certified preferred. Outstanding opportunity with rapidly expanding, full-service cardiology practice in Morris County, NJ. Excellent compensation package. Partnership potential. Send CV to: morrisheart@aol.com

CARDIOLOGY PRACTICE, ON THE BEAUTIFUL JERSEY SHORE — Close to New York City. This is an excellent opportunity to join a busy Cardiology practice. Top salary and benefits offered. Collegial work environment and much more. Partnership track for the right candidate. bhimazau@oceanheartgroup.com

SINGLE-SPECIALTY CARDIOLOGY GROUP LOCATED IN CENTRAL NJ — Looking for an Interventional Cardiologist. Candidate should be Board Certified/Eligible. Position effective immediately or 7/2014. Please send CV to Practice Manager at: Lisa.Leon718@gmail.com

INTERVENTIONAL CARDIOLOGIST — Looking for a second interventionist for a large cardiology group in Central NJ. Must be BE/BC in general cardiology. Competitive salary and benefits. Send CV to: njcardiologjob@gmail.com

ELECTROPHYSIOLOGIST — Looking for a second EP for a large cardiology group in Central NJ. Must be BE/BC in general cardiology and EP. Competitive salary and benefits. Send CV to: njcardiologjob@gmail.com

FULL-TIME CARDIOLOGIST — Private New York City multi-location cardiac diagnostic practice is in search of a full-time cardiologist boarded in Nuclear Cardiology. Please send letter of interest and CV to: physicians@resumes@gmail.com

Cardiology

MOUNT SINAI ST. LUKE’S ROOSEVELT HOSPITAL CENTER — Is accepting applications for a two-year fellowship in Clinical Cardiac Electrophysiology starting July 1st, 2015. Successful applicants will train in a fully equipped Arrhythmia Institute with state-of-the-art technology for the treatment of all electrophysiologic disorders including complex arrhythmias and will have opportunities for research. Faculty has a broad range of clinical and academic interests. For more information, please contact Israel Marmolejos at: imarmole@chpnet.org

NONINVASIVE CARDIOLOGY — New York Methodist Hospital, located in Park Slope Brooklyn, is offering an excellent staff noninvasive cardiology practice opportunity. The applicant must be fluent in Mandarin or Cantonese. Join our rapidly-growing faculty of seven noninvasive, three electrophysiology, and two interventional cardiologists. The newly joined cardiologist will have the opportunity to develop outreach practice serving a diverse population of Brooklyn. We offer excellent compensation and benefits. Interested applicants should send their CV to Ericka Ayala; eha9004@nyp.org

HEART FAILURE/LVAD — New York Methodist Hospital, located in Park Slope Brooklyn, is offering an excellent CHF opportunity. We are looking for a candidate who is board certified/cardiologist certified in Advanced Heart Failure and Transplant to develop and lead a new CHF/LVAD program at our institution. We offer excellent compensation and benefits. Interested applicants should send their CV to Ericka Ayala; eha9004@nyp.org

Endocrinology

THE ENDOCRINE SECTION — In the Department of Internal Medicine at Yale University seeks two physician-scientists and a clinician at the Assistant Professor level. Three or more years of experience are required for the positions. The two physician-scientist positions should have experience in diabetes, obesity, and fuel metabolism and should have a history of external peer-reviewed funding. Training should be fully trained in internal medicine and endocrinology; with a focus in the areas of diabetes, obesity, and osteoporosis. Interested candidates should forward their curriculum vitae and three letters of reference; Review of the applications will begin on April 27, 2014 and will continue until the positions are filled. Robert S. Sherwin, MD, Chief, Section of Endocrinology, Department of Internal Medicine, PO Box 208020, New Haven, CT 06520-8020; or via e-mail to: Brittain.Harris@yale.edu. Yale is an Affirmative Action/Equal Opportunity Employer and welcomes applications from women, persons with disabilities, covered veterans, and members of minority groups. Please reference this number: 42714, when writing to:

NEW YORK CITY — Large/growing, multispecialty group affiliated with prestigious academic medical center, seeking Board Certified Endocrinologist with primary focus on Diabetes for superb opportunity for full-time clinical practice, turn-key set up in midtown Manhattan. Partner-track position, with incentives, excellent benefits and 401K. Please forward CV via fax: 212-253-9631; or e-mail: cmrgmdcareers@gmail.com

ENDOCRINE, NEW YORK — Hudson Valley, expanding multispecialty group of 120 providers. Practice 100% Endocrine along with other Endocrinologists. Partnership track. Also: Endocrine Massachusetts, Boston area; adding 10-20 providers adding Five office locations, 300 providers. Join two Endocrinologists. Practice 100% Endocrine. lorileo@neprc.com

Family Medicine

FAMILY MEDICINE, MASSACHUSETTS — Suburbs southwest of Boston. $320K-$380K Earning potential! Great suburban location, 10K Sign-on bonus, productivity bonuses. Well-established practice with excellent retention rate. H-1 Compatib. lorileo@neprc.com

MAINE — Bridgton Hospital, part of the Central Maine Medical family, seeks BE/BC Family Medicine physicians to join practices in either Naples or Fryeburg. The opportunities include both inpatient and outpatient responsibilities with OB. Located 45 miles west of Portland, Bridgton Hospital is located in the beautiful Lakes Region of Maine and boasts a wide array of outdoor activities including boating, kayaking, fishing, and skiing. Benefits include medical student loan assistance, attractive call schedule, competitive salary, highly qualified colleagues, and excellent quality of life. For more information, visit their website at: www.bridgtonhospital.org. Interested candidates should contact: Julia Lauver, Central Maine Medical Center, 300 Main Street, Lewiston, ME 04240; call: 800-445-7431; e-mail: j.lauver@cmhc.org; or fax: 207-795-5696. Not a J-1 opportunity.

MAINE, CENTRAL MAINE MEDICAL CENTER — A growing regional referral center in Lewiston, is looking for a BE/BC Family Practitioner to join their expanding practice. The outpatient-only position offers a very attractive call schedule, medical school student loan assistance, competitive salary, and the opportunity to practice in a physician-friendly Maine! Please forward your CV to: Julia Lauver, Central Maine Medical Center, 300 Main Street, Lewiston, ME 04240; call: 800-445-7431; e-mail: j.lauver@cmhc.org; or fax: 207-795-5696. Not a J-1 opportunity.

FAMILY MEDICINE PHYSICIAN, SUBURBAN ATLANTA — WellStar Medical Group is seeking full-time BC/BE Family Medicine Physicians for well-established practice locations covering a five-county service area. Practices are located approxi- mately 25 miles northwest of downtown Atlanta, Georgia. Competitive salary. Comprehensive benefits package to include; malpractice coverage, medical/dental/vision insurance, disability/life insurance, 403b plus defined pension plan, and vacation/sick/CME allowance. WellStar is a non-profit system of five premier hospitals in the North- west suburbs of Atlanta. WellStar Medical Group is the largest non-academic medical group in Georgia with more than 135 locations employing 700+ medical providers in more than 35 specialties. Also, more than 1,100 affiliated physicians practice within WellStar Health System. To apply to this job, please go to: www.wellstar.org; or contact WellStar Provider Services at: 470-644-0090, for additional information.

PRIMARY CARE OPPORTUNITY IN BEAUTIFUL CALIFORNIA — Employed position in a secure and stable hospital. All outpatient medicine. Generous salary and benefits. Paid malpractice with tail coverage. Nearly six weeks PTO first year. Visa candidates welcome. Contact Roberta Margolis at: 203-663-9355; or e-mail: roberta.margolis@comphc.com. Ref#:214807.
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GASTROENTEROLOGY WITH ONE OF BOSTON’S FINEST GROUPS — With or without ERCP/EUS training. Top living suburb in Boston. Affiliations with Massachusetts General and Brigham and Women’s Hospitals. Successful financially stable group. Accredited outpatient endoscopy center. High reimbursement rate. Massachusetts@physician-openings.com

MAINE — Looking for a better lifestyle and a professional culture that values your clinical skills? Consider moving to physician friendly Maine! Central Maine Medical Center is seeking a BC/BE gastroenterologist (ERCP not necessary) to join our established team of eight dedicated physicians. Located in South Central Maine, this exceptional 100% GI position offers candidates a competitive salary and generous benefits package and 1-9 weekend call. Close to the ocean, lakes, and mountains, this opportunity offers the outdoor enthusiast unlimited recreational possibilities. Enjoy the professional challenge offered in a sophisticated medical community along with the wonderful recreational opportunities and quality of life in Maine. Please forward CV and cover letter to: Babette Irwin, CMMC, 300 Main Street, Lewiston, ME 04240; e-mail: birwin@cmmc.org; fax: 207-773-5855; or call: 800-445-7431.

THREE-MEMBER GASTROENTEROLOGY PRACTICE — With an in-house Medicare approved Endoscopy Center in Cary, NC looking for interested applicant. Females highly encouraged to apply. E-mail CV to: bmnoroe@centerfordigestivediseases.com

Geriatrics
GERIATRICS, MASSACHUSETTS — Physician. Coastal community. $75k Loan repayment. Bonuses and Relocation allowance. Outpatient Geriatrics. Established group practice. Base salary plus productivity bonus every six months, 10 Miles to Boston. Visa compatible. lorie@nemr.com

RAPIDLY EXPANDING MULTISPECIALTY MEDICAL GROUP — Affiliated with a major medical center looking for a BC/BE Geriatrician. Participation in a Geriatric Fellowship program available with academic appointment. Extensive mid-level support. Excellent salary and benefits. Easy access to New York City. Send your CV to: egold@hackensackumc.org; or fax to: 201-666-3919, Attn: Susan F.

GERIATRICIAN — BC/BE to join busy and growing hospital-based practice in Sleepy Hollow, Westchester County, NY, 40 minutes to NYC. Experience and/or interest in Palliative Care ideal. Inpatient work covered by hospitalist service. Strong referral base with state-of-the-art diagnostic imaging. Located minutes from academic medical center and medical school. Active involvement with Family Practice residents. Strong ancillary support for these complex patients. Competitive salary and generous compensation package. We seek to balance a quality, evidence-based medical practice with a rewarding full lifestyle. Apply to: Joe Amaruto, Physician Recruiter, Phelps Memorial Hospital; 914-566-1179; jamaruto@pmhc.us

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Sign up for Job Alerts at NEJM CareerCenter.org.

Hospitalist
HOSPITALIST OPPORTUNITIES FOR DAY SHIFT AND NOCTURNIST HOSPITAL MEDICINE. — Flexible scheduling, 8-14 shifts per month. Competitive salary and full benefits. Premium pay for nights. Hospital based CPOE system. One-year candidates welcome! Located 30 minutes from Boston. Premier 170-bed community hospital. Family friendly culture, good collaboration with specialists, PCBs, and administration. Please send your CV to Diane Forte at: dforte@emersonhosph.org. Not a J-1 or H-1B opportunity. www.emersonhospital.org

HOSPITALISTS — (Multiple openings for FT day and night positions at Lowell General Hospital, 295 Varnum Avenue, Lowell, MA). Under the supervision of managing partner will provide coverage to an acute care hospital; examine, diagnose, and treat patients, prescribe medication, and utilize medical equipment as needed. Minimum Requirements: MD (foreign equivalent degree accepted) and eligible for Massachusetts Medical Licensure. E-mail your CV to: New England Inpatient Specialists, LLC, c/o Judy Hanson, NEIS, Administrative Assistant, 120 Water Street, Suite 404, North Andover, MA 01845, or to Job Code: NEO5. No calls please.

HOSPITALIST, MASSACHUSETTS — Physician needed, Boston region. $300k Potential. Boston region, minutes south of the City. Most desired regions of Boston with excellent schools. Full benefits package. ICU covered 24/7 by Intensivists. Strong leadership and experience. Full EMA. One of the best Hospitalist programs in Massachusetts. Boston@physician-openings.com

HOSPITALIST, MASSACHUSETTS PHYSICIAN — Hospitalist physician needed, southern Massachusetts, Coastal region. Minutes to Providence. 200k Plus plus. Outstanding salary plus high bonus structure. Fantastic team! Balanced lifestyle. Exceptional compensation and full benefits. Friendly and enjoyable atmosphere. Massachusetts@physician-openings.com


HOSPITALIST JOBS IN MAINE — Why not live and work in your favorite vacation destination? We have a dozen different locations throughout Maine looking for BC/BE Hospitalists to join their team. All offering versatile schedules with competitive compensation and benefits. Call Jane Ham, Maine Recruitment Center, at: 800-546-4090, for further details.

MAINE COAST HOSPITALIST — Located directly on the ocean in Rockport, Pen Bay Medical Center seeks a Hospitalist to join our employed group. Block scheduling, broad subspecialty support, excellent salary and benefits, relocation, and outstanding loan repayment. Nocturnist differential available. Superb location with fabulous natural beauty, safe communities, good schools, and four-season outdoor recreation. Forward CV to: physicianrecruitment@penbayhealthcare.org; or call: 207-596-8214.


INPATIENT MEDICINE, CENTRAL NEW JERSEY — Summit Medical Group (SMG), a 200+ physician multispecialty medical group, seeks a board certified/board eligible physician to provide inpatient services. SMG physicians refer their patients to the SMG Hospitalist Service which ensures collaborative and integrated care for SMG patients that are hospitalized. Our Hospitalist Service attains some of the nation’s highest clinical and quality outcomes through this unique design. In this position, you will join an existing group of five Hospitalists working in a continuity of care model specializing in caring for the hospitalized patient. Each physician participates in 24-hour call rotation. They supervise residents who work with admissions, discharge, and rounding. Participation in electronic medical record access, two PAs, a discharge coordinator, and a dedicated patient advocate. The selected candidate must be able to work as both a team and possess excellent communication skills. Position offers a highly competitive salary and comprehensive benefits. To learn more, visit: www.summitmedicalgroup.com. To learn more, contact Beth Briggs at: 800-678-7858; or e-mail: ebiggs@cejkasearch.com. ID#149900NJ.

HOSPITALIST POSITION, SYRACUSE, NY — Crouse Hospital (500 acute-care beds) located in Syracuse, NY is seeking a Hospitalist to join its dynamic Hospitalist team who has the passion to deliver high-quality patient care in a collegial and teamwork oriented environment. 7 Days on/7 off, 10-hour shifts with full sub-specialist support, and no call. Crouse is one of Central New York’s largest employers with over 3,000 employees and a medical staff of more than 800 physicians. It serves more than 25,000 inpatients, 65,000 emergency medicine visits, and more than 150,000 outpatients a year from a 16-county area in Central and Northern New York. An excellent compensation package includes a very competitive salary, bonus, paid malpractice, CME stipend, and a complete personal benefits schedule. A signing/retenion bonus is also offered. Contact Ken Sammut at: 888-372-9415; ksammut@cejkasearch.com; or visit: www.cejkasearch.com. ID#152243NJ.

HOSPITALIST, FAMILY PRACTICE, NEW YORK AREA — Internist and Family Practitioners needed. Join established group looking to expand. Flexible scheduling. Sign-on and relocation. Located just short drive to NYC, the scenic Adirondacks, Berkshire, and Catskill Mountains. Excellent year-round outdoor recreation. Excellent schools, affordable homes. newyork@physician-openings.com

EXPERIENCED HOSPITALIST OPPORTUNITI- — For new Hospitalist Service in Meadville, Pennsylvania. Meadville Medical Center is a 235-bed community hospital in north-west Pennsylvania. Schedule will be 7 days on, 7 days off. Daytime shifts at first. Anticipated average patient load no more than 15 patients/day with two hospitalists working each day. Most support specialties available. www.mchcs.org. Contact Danielle Fettig, at: dfettig@mmchs.org; or: 814-333-5701.

SEE THE FIRST PAGE OF THE CLASSIFIEDS FOR ADVERTISING RATES.
ICU nephrologist to join WellStar. 36 Patient care hours/wk. Great opportunity to practice in expanding practice in northwest Indiana. Sphere of practice is approximately 30 minutes from downtown Chicago. Guaranteed excellent starting salary with progressive growth leading to partnership. Enclose CV to: Medical Management & Data Services, Attn: Infectious Disease, 9201 Calumet Avenue, Munster, IN 46321.

INFECTION DISEASE SPECIALIST — To join 5-physician ID group, Westchester/ Putnam Counties, NY. Inpatient and outpatient ID and HIV care. Community and Tertiary Care Hospital, Office Infusion, and Travel Medicine. Send CV to: idlo@optonline.net

ACADEMIC INFECTION DISEASES PHYSICIAN — Medical University of South Carolina-Charleston — Candidates sought for Assistant or Associate Professor positions in a rapidly growing ID program (Clinical Educator or Academic Clinician tracks). Experience in HIV, Transplantation, Antimicrobial Stewardship/Nosocomial Infections particularly desirable. Potential duties include ID consult service, outpatient clinics, expanding research opportunities in teaching, and practice settings. Send inquiries and CVs to: J. Michael Kilby, MD; 135 Rutledge Avenue, #1201, MSC752, Charleston, SC 29425; or: mkilby@msuc.edu. MUSC is an Equal Opportunity/Affirmative Action Employer.

INFECTION DISEASE — BC/BE Internist specializing in infectious disease to establish a practice. 36 Patient care hours. An established practice expanding practice in northwest Indiana. Sphere of practice is approximately 30 minutes from downtown Chicago. Guaranteed excellent starting salary with progressive growth leading to partnership. Enclose CV to: Medical Management & Data Services, Attn: Infectious Disease, 9201 Calumet Avenue, Munster, IN 46321.

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BUSY CENTRAL FLORIDA PRACTICE NEAR BEACHES — Seeks long term employees to fill internal medicine positions for inpatient and outpatient duties. J-1 welcome. Respond to: janetecody@ado.com.

NORTH CENTRAL FLORIDA (OCALA, VILLAGE AREA) — Rural Health Centers/Hospital, Outpatient, BC/BE Internal/Family/Emergency Medicine. J-1/H-1B visa. Competitive salary, bonuses, benefits. E-mail: providers@fmshealth.com; fax: 800-985-9108.

IM/FP — Geriatric fellowship trained preferred. Southern Indiana/greater Louisville area. Walking distance from downtown Louisville. J-1 waiver permission. Contact: mim@mountainmedgroup.com

INTERNAL MEDICINE — Practice big medicine in a vibrant, small community nestled in the heart of Iowa. This physician owned and governed hospital is part of a large, established referral network and enjoys state-of-the-art facilities and equipment with extensive subspecialty support. Marshalltown is close to several major metropolitan cities, which means you can enjoy the idyllic, small town lifestyle with all the benefits of a big city. Family friendly, with one of the highest-rated public school systems in the nation, with McFarland Clinic you can practice unparalleled medicine in the Heartland. Contact Doug Kenner: 866-670-0334; or: dkenner@mountainmed.net.


WANTED BC/BE IM/FP DOCTOR — For a busy practice in Kingwood, Texas. Texas license required. H-1/J-1 Visas welcome. Contact: 832-213-6055; and send your CV to: Nephrorecruit@renaltouchllc.com.

OUTPATIENT INTERNAL MEDICINE OPPORTUNITIES — Stipend and generous Loan Repayment. Flexible practice styles, full-time/part-time. Consensus-based, team-oriented group. Modern facilities equipped with EMR. Innovative approach to health care delivery. Teaching and research opportunities available. Billings Clinic is a multispecialty, physician-led organization and a partner of the Mayo Clinic Care Network. Located in the magnificent Rocky Mountains in Billings, Montana, this friendly college community has great schools, safe neighborhoods, and family activities. Exciting outdoor recreation minutes from home. 360 Days of sunshine! “Our internists give top-quality care along side excellent colleagues. Billings Clinic has the best of big-city medicine with a Montana feeling.” Eric J. Saber, MD, Burton, DO, at: jburton@springfieldmed.com.

SAN FRANCISCO BAY AREA, INTERNAL MEDICINE — North East Medical Services (NEMS) has an excellent opportunity for a board eligible/certified full-time Internal, Med-Peds, Pediatricians, or Family Practitioner. Bilingual in Chinese preferred. NEMS, a comprehensive, multispecialty practice, has served the SF community for over 40 years. NEMS offers a competitive salary, malpractice coverage, and an excellent benefits package. Located in San Francisco, NEMS is close to major medical and cultural institutions. Please visit our website at: www.nems.org; or e-mail your CV to: Diana.Liang@nems.org

PRIMARY CARE PHYSICIAN SEEKING QUALITY OF LIFE. CARMICHAEL, CALIFORNIA — FT/PT, BC/BE Family Practice, Internal medicine, Pediatrics, or GP. Monday thru Friday from 8am to 5pm. No nights or weekends. Competitive salary and benefits. Send resume to: 9700621@gmail.com or fax: 866-826-0090.

Nephrology

WANTED NEPHROLOGIST, GREATEST BOSTON AREA, MASSACHUSETTS — Long term commitment needed. Only individuals need to apply, no agencies please. Salary and benefits moderate. But future is secure. Apply: yahweh08@yahoo.com.

NORTHERN NEW JERSEY — Looking for Nephrologists to join well-established 100% nephrology practice. Send CV: melneds@aol.com.

TRANSPLANT NEPHROLOGIST — The Division of Nephrology at The Johns Hopkins University School of Medicine is seeking a transplant nephrologist. The candidate should be an MD, MD/PhD who is BE/BC in Nephrology and who is either practicing or completing nephrology fellowship, or who has recently completed a transplant nephrology fellowship. Applicants should mail or e-mail his/her curriculum vitae and letter of interest to: Dr. Harald Rabbi, 720 Rutland Ave, Room 905, Baltimore, MD 21287; or: HRabbi@jhmi.edu.

Nephrology opportunities NATION-WIDE — Excellent compensation, benefits with partnerships. For additional information, call: Martin Osimi, NephrologyUSA, 800-367-3218. E-mail: m@nephrologyusa.com; website: www.NephrologyUSA.com.


IMMEDIATE OPENING IN SUNNY TUCSON ARIZONA — For a BC/BE/ASIDN Certified Interventional Nephrologist to join a well-established seven-physician, very busy, nephrology practice with Vascular Center. Candidate with J-1 Visa status will be considered. Competitive salary and benefits leading to partnership. E-mail CV to: clunecford@renalcareaz.com

Neurology

THE BERKSHIRES, WESTERN MASSACHUSETTS — Berkshire Health Systems is currently seeking BC/BE Neurologists, both General Neurology as well as fellowship training in Epilepsy, to join our growing four-physician, patient focused practice. Shared call arrangement allows for a perfect balance of both professional interests and personal commitments. Competitive salary/benefits package, including productivity option and relocation. Excellent opportunity to live and work in an area known for its diverse cultural and recreational activities, just 2-3 hours from both Boston and New York City. Please contact: Antoinette Lobb, Etown Pediatrics, at: aaby2631@yahoo.com.

NEUROLOGY OPPORTUNITIES NATION-WIDE — Excellent compensation, benefits with partnerships. For additional information, call: Martin Osimi, NephrologyUSA, 800-367-3218. E-mail: m@nephrologyusa.com; website: www.NephrologyUSA.com.

IMMEDIATE OPENING IN SUNNY TUCSON ARIZONA — For a BC/BE/ASIDN Certified Interventional Nephrologist to join a well-established seven-physician, very busy, nephrology practice with Vascular Center. Candidate with J-1 Visa status will be considered. Competitive salary and benefits leading to partnership. E-mail CV to: clunecford@renalcareaz.com.

Are you a cancer survivor (or, would like to care for cancer survivors)?

Seeking a rewarding position in a primary care practice? Unique opportunity for a primary care physician. Our practice is expanding to create the first primary care cancer survivorship program in the region. Join a new kind of practice designed for cancer survivors, led by a cancer survivor who has practiced quality primary care for 25 years. This well-established multispecialty group is located in Springfield, Massachusetts and Enfield, Connecticut. Part or full-time. Outpatient call by telephone only, shared among 12 primary care providers. Independent practitioners provide inpatient care. Excellent benefits package. Early partnership is the goal. Relocation consideration available. Dr. Jay Burton, DO, at: jburton@springlemd.com

LOWER WESTCHESTER COUNTY, NY — Unique opportunity with a large, prestigious, Mount Sinai affiliated multispecialty multisite practice. 25 minutes north of Manhattan. The position is office based with minimal hospital or call responsibility. Offers excellent compensation and lifestyle. E-mail resume to: contact@doctorsmedical.com or fax: 914-725-0908.

GHPMA, A MULTISPECIALTY GROUP (19 PHYSICIANS) — Offering a wide variety of diagnostic services is seeking Primary Care Physicians. GHPMA centers/offices are located in pleasant suburban areas of North Houston. Interested candidates please contact Kendyl Parker at: 713-249-4294; kendylparker@yahoo.com

LINKING PHYSICIANS WITH POSITIONS.

NEJM RECRUITMENT ADS WORK.

NEJM CareerCenter
PULMONARY CRITICAL CARE AND CRITI-
CAL CARE PHYSICIANS, BOSTON REGION—
Admitted Academic Faculty in the region. Exce-
llent earnings potential and comprehensive ben-
efits package. Two openings: one Critical Care
only. 300-Bed hospital. Also: Pulmonary/Critical
Care opening join two others. Excellent earnings
potential and comprehensive benefits package.
lori.lee@nprcp.com

PULMONARY/Critical Care Sleep, Con-
necticut — Largest multispecialty group in the
state. Two-year employed position plus pro-
ductivity incentives leading to partnership. Subur-
ban, family friendly community southwest of
Hartford. Very competitive salary and compre-
prehensive benefits. lori.lee@nprcp.com

PULMONARY PHYSICIAN NEEDED — For ex-
panding pulmonary group in Suffolk County,
Long Island. Traditional pulmonary practice in-
cluding inpatient, outpatient, critical care, and
sleep if desired. Base hospital is a Magnet Hospi-
tal with excellent support services. Hospitalist and
critical care physicians available in the hospital at
times. Partnership track, three years. E-mail let-
ter of interest and resume to dkt501@yahoo.com

PULMONARY/Critical Care Physician — McAllen, Texas. Fantastic opportunity for BC/BE
PCCM. Sleep available. We look for candidates highly motivated to practice CCM. Presently four
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St. Peter’s Health Partners, via its affiliated member hospitals (St. Mary’s, Albany Memorial, and Samaritan hospitals) is seeking applicants for several new, full-time, Hospitalist positions that became available on January 1, 2014. We are excited to offer these new, directly-employed positions with flexible scheduling, and have needs for all shifts and schedules. These are exciting opportunities to join existing practices as they transition from third party employment to direct employment with our expanding health system.

Candidates should be Board Certified in IM or FP. 1-5 years experience as a Hospitalist is preferred. Must possess excellent clinical, communication, and time management skills, along with a strong commitment to providing excellent care that is team oriented. We offer competitive base and premium hourly rates, with production and quality bonuses. Excellent benefits are offered, including health/vision/dental, paid malpractice, CME allowance & expense, and retirement savings programs. Relocation assistance is available. Sign on and retention bonuses are also available.

Albany, located at the heart of NY’s Capital Region, is a medium-sized area offering all the amenities of a larger urban area in a beautiful, scenic, and affordable setting. The region has excellent year-round outdoor recreation, including golf, water sports, camping, hiking, and skiing. It offers a wealth of cultural offerings and activities, including several renowned museums and theaters, fine dining, and a year-round events calendar of music and sporting events. Excellent public and private schools are available, as are affordable homes and reasonable taxes. Higher education opportunities abound in our region and we are part of NY’s Tech Valley. The Capital District is a short drive from beautiful Saratoga Springs, and the scenic Adirondack, Berkshire, and Catskill mountains.

Winchester Hospital is the northwest suburban Boston area’s leading provider of comprehensive health care services. It was named a top hospital by both U.S. News and World Report and Beckers Hospital Review in 2012-2013.

We are seeking talented physicians to join our award-winning team in the specialties of:

- OB-Gyn
- Primary Care:
  - Internal Medicine
  - Family Medicine
  - Pediatrics
- Neurology
- Rheumatology
- Hospitalist

For information, contact Kate Lane, CMSR
Physician Recruitment Manager at klane@winhosp.org (email) 781.756.2116 (Phone) 781.756.7274 (Fax)
1021 Main St., 2nd Floor, Winchester, MA 01890

Greenville Health System (GHS), the largest healthcare provider in South Carolina, seeks BC/BE Internal Medicine Physicians interested in opportunities as Hospitalists. Details include:

- 12 hour shifts, 7 days on/7 days off
- No outside call or outpatient work
- Salary (2 levels) based on experience
- Incentive bonus based on process improvement, patient satisfaction, billing compliance and citizenship
- Additional shifts above base paid at a premium based on location and shift
- Comfort managing critically ill patients
- IM procedures highly recommended, simulation center training available as needed (placement of central lines, etc.)
- IM residency supervision a plus
- Engagement in hospital functions, including committees, required
- Must be a team player with a strong work ethic
- Vertical advancement available

GHS employs over 11,000 people, including 700 physicians on staff. Our system includes clinically excellent facilities with 1,358 beds on 6 campuses. We offer 14 residency and fellowship programs and a new 4-year medical education program. We are a designated Level 1 Emergency Trauma Center and also have a separate research facility.

Greenville, South Carolina is a beautiful place to live and work and the GHS catchment area is 1.3 million people.

Please submit letter of interest and current CV to: Kendra Hall, Senior Physician Recruiter, khall@ghs.org. Ph: 800-772-6987.
No sponsorship available at this time. GHS is an equal opportunity employer.
Lahey Hospital & Medical Center

careers.lahey.org

Internal Medicine Opportunities

Primary Care

Lahey Hospital & Medical Center’s division of Primary Care is recruiting for BC/BE Internist for their site in Lexington. Consisting of 6 physicians and one advanced nurse practitioner, the practice has been delivering care to patients of Lexington and surrounding communities since 1972. Providing 100% outpatient care to their patients, the physicians admit to Lahey Hospital & Medical Center in Burlington utilizing the Hospitalist model.

Call is shared among the 6 physicians in the group. The Lexington practice provides care in conjunction with the physicians of Lahey Hospital & Medical Center in Burlington as well as the many sub-specialists located on site in Lexington.

Our physicians provide top-quality primary care working within local communities throughout northeastern Massachusetts, while having access to Lahey’s world-renowned medical centers and physicians in Burlington, Lexington and Peabody. Lahey Clinic is a physician-led, nonprofit group practice providing quality health care in virtually every specialty and subspecialty, from primary care to cancer diagnosis and treatment to kidney and liver transplantation. The Lahey Clinic health care system is comprised of medical centers in Burlington, Lexington, and Peabody, Mass., as well as more than a dozen community primary care and satellite specialty care locations throughout northeastern Massachusetts and southern New Hampshire.

For more information or to apply, please send your letter of intent and CV to:

Joan Patriakeas
138 Conant Street
Beverly, MA 01984
Joan.E.Patriakeas@Lahey.org

We are an Equal Opportunity Employer proud to reflect the diverse communities that we serve.

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Wake Forest Baptist Medical Center

Baptist Medical Center

Chair, Department of Internal Medicine

Wake Forest Baptist Medical Center (WFBMC) is seeking an outstanding physician-scientist to serve as the Tinsley R. Harrison Chair of the Department of Internal Medicine. As the academic, administrative and research leader for the department, he/she is responsible for the department’s fiscal affairs and efficient resource utilization, faculty recruitment and development, and strategic growth of quality research services.

Candidates must have the following qualifications:

- Certification (and ideally subspecialty) by the American Board of Internal Medicine (ABIM)
- M.D. or M.D./Ph.D.
- Eligible for NC license
- Have demonstrated record of research funding in Internal Medicine
- Substantial administrative expertise

The Department consists of twelve Sections and totals over 260 faculty members in the Sections on Cardiology; Endocrinology and Metabolism; Gastroenterology; General Internal Medicine; Gerontology and Geriatric Medicine; Hematology and Oncology; Hospital Medicine; Infectious Diseases; Molecular Medicine; Nephrology; Pulmonary, Critical Care, Allergy and Immunology; and Rheumatology.

The outstanding reputation of the Department of Internal Medicine continues to be sustained by substantive extramural funding from agencies, such as the National Institutes of Health (NIH). In the last available rank of U.S. Departments of Medicine by NIH funding, our Department was ranked 42nd.

Winston-Salem, North Carolina, with a population of approximately 225,000, is home to WFBMC. The city is nestled in the northwestern region of North Carolina, within easy driving distance to the beautiful Blue Ridge Mountains and the pristine beaches of North Carolina.

Wake Forest Baptist Medical Center is an affirmative action and equal opportunity employer with a strong commitment to achieving diversity among its faculty and staff.

Interested candidates should submit their CV and letter of interest to:

J. Wayne Meredith, M.D.

c/o Cindy Warlick
cwarlick@wakehealth.edu

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Community Health Network is seeking exceptional physicians interested in practicing in a progressive, integrated, community-minded setting. We are pleased to offer a number of primary and specialty opportunities within our expanding network. Community Health Network’s full continuum of care integrates over 550 physicians, 8 specialty and acute care hospitals, 9 surgery centers, home care services, urgent care clinics, behavioral health and employer health services throughout Central Indiana.

Learn More & Join Us:

- Physician-led organization
- Multi-disciplinary collaborative relationships, including MD Anderson Cancer Network (MD Anderson certified oncologists on staff)
- Patient-Centered Medical Home (PCMH) model
- Built-in referral network via robust EMR (EPIC)
- Largest network of primary care physicians in the state
- Competitive compensation and benefits package, including incentives
- Board certification or board eligibility required

Founded in 1956, we are a physician-led, non-profit health system ranked among the nation’s most integrated healthcare systems; our physicians are well supported not only by each other, but also by facilities, technologies and a culture that addresses their patients’ needs at every step.

For more information about our opportunities and network, visit: www.ecommunity.com/physicianrecruitment
Interested physicians should email their CV to
interests, and world-renowned live entertainment and music.
schools and academic centers, professional sports teams, world-class dining and cultural
Ochsner Medical Center Kenner, a suburb of New Orleans, Louisiana.
New Orleans is a cosmopolitan, historic city with unique architecture, multiple medical
The Ochsner Health System's Department of Cardiology is seeking a Board Certified/Board
candidate will have the opportunity to join three other interventional cardiologists in an established
for review by Christopher J. White, M.D., FSCAI, FACC, FAHA, FESC, Director,
The newly recruited cardiologist will also have the opportunity to develop and grow an outreach
opportunity to expand this established subspecialty practice with the support and encourage-
and outcomes. We are perennially recognized as one of the top Heart and Heart Surgery programs
vascular physicians working together to achieve the best possible patient access, satisfaction,
庭 and medical students. The individual will
also be expected to provide care to patients with a broad range of hematologic and oncologic conditions.
Candidates should be qualified for the Assistant Professor rank, and must be board eligible or certified in Hematology and Oncology. Applicants should have evidence of academic excellence, including evidence of contemporary peer-reviewed publication, and presentation of research at national meetings.
Position will be 8/8ths full-time VAMC. Thriving opportunities for collaborative interdepartmental clinical research activities create a superb academic environment.
Interested candidates should submit their curriculum vitae to the Federal Government’s Official Jobs Site at http://www.usajobs.gov Referencing
Vacancy Identification Number: 1061868
EOE.
The University of Michigan, Division of General Medicine seeks BC/BE internists to join our expanding Academic Hospitalist Group. Duties include teaching, providing direct patient care, and involvement in quality improvement and patient safety initiatives. Unique inpatient specialty practice concentrations available. Prior training or clinical experience at a major academic medical center is preferred. Research opportunities and hospitalist investigator positions are also available for qualified candidates. Successful candidates will receive a faculty appointment at the University of Michigan Medical School. Excellent benefits and compensation package with guaranteed salary plus incentive bonuses. Relocation support provided.

LOAN FORGIVENESS PROGRAM: An educational loan forgiveness program provides up to $50,000 in loan forgiveness for qualifying educational loans.

The University of Michigan is an equal opportunity/affirmative action employer and encourages applications from women and members of minority groups.

Send cover letter and CV to:
Laurence McMahon, M.D., MPH
Chief, Division of General Medicine
2800 Plymouth Rd, B16, Rm 430W
Ann Arbor, MI 48109-2800
_flanders@umich.edu

To inquire please contact:
Scott Flanders, M.D.
Director, Hospitalist Program
Department of Internal Medicine
734-647-2892
flanders@umich.edu

Visit our website:
http://www.med.umich.edu/intmed/hospitalist/index.html

Dartmouth-Hitchcock's Section of Rheumatology is seeking up to 2 Rheumatologists to work at Dartmouth-Hitchcock Medical Center in Lebanon, NH. Candidates must be Board Certified in Rheumatology and experienced in clinical care and have evidence of achievement, training and interest in clinical or translational research. Candidates who have the potential for establishing an independent research program are desirable.

The Rheumatology Section has a long history of clinical and research excellence, as well as fellowship training at both Dartmouth-Hitchcock Clinic and the White River Junction VA Hospital in VT. These positions include benefits commensurate with FTE and a faculty appointment at the Geisel School of Medicine at Dartmouth at a rank of Assistant or Associate Professor. Full-time and part-time will be considered.

Dartmouth-Hitchcock Medical Center is a state of the art facility located in the Upper Valley of New Hampshire. This is a vibrant community offering excellent schools and an outstanding quality of life in a beautiful, rural environment. Candidates should submit a cover letter and curriculum vitae electronically to the Search Chair:

Richard I. Enelow, MD
Professor of Medicine and Microbiology/Immunology
Dartmouth-Hitchcock Medical Center
One Medical Center Drive, Lebanon, NH 03756
rheumatologist@dhphysicians.org

Dartmouth-Hitchcock Clinic is an Equal Opportunity/Affirmative Action employer and encourages applications from women and members of minority groups.

www.dartmouth-hitchcock.org

The Albany VA Medical Center located in Albany, New York is seeking Hospitalists for full-time, part-time and intermittent staff positions for overnight, weekend and holiday shifts. We are seeking candidates with excellent clinical, leadership and communication skills and experience in the full range of general post-operative surgical care.

Duties include care of surgical patients to include ICU and patients on the inpatient wards in close communication and consultation with the on-call attending surgery staff, as well as evaluation and admission of patients from the ED. The Albany VAMC ED does not see trauma patients.

The Albany VA offers competitive salaries, pay for performance and an excellent federal benefits package. A recruitment incentive may be authorized for highly qualified candidates. The Albany VA is located near the pristine Adirondack Mountains and situated between New York City, Boston and Montreal. Albany New York offers the versatility of a big-city and outdoor enthusiast's dream.

Requirements:
- Board Certified or Board Eligible in Internal Medicine or Surgery, U.S. Citizenship, current, full, unrestricted license to practice medicine or surgery, and proficient in written and spoken English.

Interested candidates who wish to inquire about this opportunity may contact:
Bobbie Kirsch at 518-626-7091 or bobbie.kirsch@va.gov
You may also apply online at www.usajobs.gov, Vacancy ID 1041169
Aspirus is a nationally recognized health system based in Wausau which is located in the center of Wisconsin. Our system and service area extends from beautiful central and northern Wisconsin into the majestic lake shore regions of the Upper Peninsula of Michigan. With more than 6,000 employees and a world-class consortium of more than 500 providers, we provide a higher level of care to some of the most wholesome, family-focused communities you will find.

**Seeking Employed Hospitalists:**
- Opportunities to practice hospitalist medicine in Antigo and Wausau, Wisconsin.
- Competitive Salary and benefit package
- Other benefits include potential for residency stipend, loan repayment and sign-on bonus.
- Low cost of living, low crime rate and minimal traffic congestion
- Enjoy top-notch school systems

North Central Wisconsin is a great place to raise a family and make it easy to get the most out of your life outside of a clinical setting.

Details at AspirusProviderOpps.org.
Contact Amanda Krueger at Amanda.Krueger@aspirus.org or 800-792-8728

The Rockefeller University seeks an outstanding physician scientist to lead a molecular medicine program that includes patient-oriented research protocols in the NIH CTSA-supported Center for Clinical and Translational Research at the University’s research hospital. We encourage applications in all areas of patient-based research; current areas include human genetics, cancer biology, vascular biology, dermatology, metabolic disease, substance abuse, infectious disease, digestive disease, immunology, physiology and pharmacology.

Applications are being accepted electronically through our Online Application System at http://oas.rockefeller.edu. Applicants should follow the online application procedure and select Medical Sciences, Systems Physiology and Human Genetics as the field of study in the Professional Information section.

The deadline for application submission is April 18, 2014.

If you have questions regarding submitting an application, please contact our Administrator at facultysearch@rockefeller.edu. More specific information regarding our current search can be found at www.rockefeller.edu/facultysearch.

The Rockefeller University is an Affirmative Action/Equal Opportunity/VEVRAA Employer and solicits applications from women and underrepresented minorities.

We are looking for:
• Pulmonary and Critical Care Physicians in Hampton and Williamsburg, VA.
• Outpatient Primary Care and Specialty Physicians:
  - Family Medicine
  - Urgent Care
  - Dermatology
  - Endocrinology
  - Rheumatology
• Neurosurgery In Virginia Beach, VA.

Additional benefits include:
• Competitive Compensation & Benefits
• Administrative Support
• Reduced Individual Risks
• Access to Innovative Tools & Technologies
• The Support and Resources of a Broad-Based, Fiscally Sound, Nationally Recognized System

Your future is waiting. Contact Us Today.
Lisa Waterfield, Physician Recruiter Specialist
lmwaterf@sentara.com | (757) 252-3025
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Practice in Beautiful Upstate New York

Opportunities at Over 40 Hospitals

Visit the Upstate NY Physician Recruiters website to easily search and apply for positions throughout Upstate NY.

Learn directly from in-house recruiters about all specialties and practice models. Enjoy an excellent quality of life in one of many cities and towns. Our diverse communities offer rich family lifestyles, with abundant cultural opportunities and outdoor activities.

www.NYPhysicianCareers.org
info@unypr.org

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Saint Francis Care, an innovative leader and integrated healthcare delivery system in Hartford, Connecticut, is seeking a BC Internal Medicine physician with extensive clinical, administrative, and supervisory experience to serve as Medical Director for Ambulatory Services.

As Director, you will lead a multi-disciplinary team dedicated to the health and wellbeing of over 7,000 patients and oversee over 18,000 annual visits. Recognized by NCQA as a PCMH, this practice is a major part of our population health management and accountable care strategies. A faculty appointment with the University of Connecticut School of Medicine is available to the qualified candidate.

If you are ready to for a new and exciting leadership opportunity, we can make that happen.

Call Christine Bourbeau, Director of Physician Recruitment, today at 855-894-5590, or email your CV and letter of interest to CBourbea@stfranciscare.org.

To learn more about this opportunity, visit:
www.JoinSaintFrancisCare.com/GSC/NEJMP

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Hospitalist

Full-time, Part-time & Per Diem Opportunities

South Shore Hospital/Coastal Medical Associates offers an outstanding program for hospitalists who enjoy practicing medicine in a collegial environment.

Enjoy:
• excellent consultant staff
• support of Magnet level nursing department
• opportunity to teach Tufts medical students
• research opportunities through IRB
• named to the Top 100 Places to Work/Boston Globe past 3 years
• flexible schedules to balance home and work life

Our Hospitalist program offers a highly competitive salary and benefits package including an incentive program that includes bonuses for teamwork, quality, and productivity.

• 24/7 Hospitalist program with 40 employees including 6 midlevel providers
• Full-time 72 10-hour shifts per month
• Night duty minimal with coverage supplemented by 3 Nocturnists and per diem Physicians
• Average Census 165 with 11 Rounders and co-Management with midlevel providers
• Regional Care with our Cardiovascular Center with 3 EP Physicians, DFCI Cancer Center, Bone and Joint Center, 3 ED Observation Units, Level 2 Trauma Program, and 80 new private beds

South Shore Hospital
southshorehospital.org

An equal opportunity employer

To apply for a Hospitalist position, or to learn more about us, please visit www.southshorehospital.org

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Medical Director Ambulatory Services

If you're an accomplished leader and clinician seeking an exciting opportunity to oversee a multi-site ambulatory service within a nationally recognized healthcare system, we can make that happen.

Saint Francis Care, an innovative leader and integrated healthcare delivery system in Hartford, Connecticut, is seeking a BC Internal Medicine physician with extensive clinical, administrative, and supervisory experience to serve as Medical Director for Ambulatory Services.

As Director, you will lead a multi-disciplinary team dedicated to the health and wellbeing of over 7,000 patients and oversee over 18,000 annual visits. Recognized by NCQA as a PCMH, this practice is a major part of our population health management and accountable care strategies. A faculty appointment with the University of Connecticut School of Medicine is available to the qualified candidate.

If you are ready to for a new and exciting leadership opportunity, we can make that happen.

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To learn more about this opportunity, visit:
www.JoinSaintFrancisCare.com/GSC/NEJMP

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University of Pittsburgh
School of Medicine
Chair, Department of Obstetrics, Gynecology, and Reproductive Sciences
Magee-Womens Hospital of UPMC

The University of Pittsburgh School of Medicine and Magee-Womens Hospital of the University of Pittsburgh Medical Center (UPMC) are seeking applications for the position of Professor and Chair of the Department of Obstetrics, Gynecology and Reproductive Sciences. The department is dedicated to providing high-quality health care for women and the newborn while developing and maintaining innovative basic and clinical research programs aimed at advancing clinical practice. The department is the nation’s leading recipient of NIH research funding in the field with approximately $38 million per year of federal funding and $49 million of total extramural funding. It runs a large residency and 9 fellowship programs with an NIH T32 for postdoctoral research training and two K12 training grants for junior faculty researchers.

Competitive candidates must be board certified in Obstetrics and Gynecology with academic accomplishments meeting criteria for appointment at the tenured and professor level, including a distinguished record of research, clinical, teaching and service activities. Other key characteristics include a broad visionary approach to major issues in the field, ability to foster collaborations, capability to manage an active group of community and academic specialty practices, as well as significant administrative and leadership experience.

The University of Pittsburgh School of Medicine is one of the nation’s leading medical schools, renowned for its curriculum that emphasizes both the science and humanity of medicine and its remarkable growth in NIH funding. With more than $400 million of NIH funding, the University ranks fifth among more than 3,000 entities that receive NIH support. As one of the University’s six Schools of the Health Sciences, the School of Medicine is the academic partner to UPMC. The combined mission is to train tomorrow’s health care specialists and biomedical scientists, engage in groundbreaking research that will advance understanding of the causes and treatments of disease, and participate in delivery of outstanding patient care. UPMC is a global health system with 23 hospitals, more than 60,000 employees and close to $11 billion of annual revenue.

The University of Pittsburgh and UPMC are Affirmative Action, Equal Opportunity Employers.

Please send curriculum vitae and bibliography to the Chair of the Search Committee:
David H. Perlmutter MD
Attention: Margaret Lyle
Children’s Hospital of Pittsburgh of UPMC
Administrative Office Building
4401 Penn Avenue, Suite 5300
Pittsburgh, PA 15224
412-692-8071
Email: Margaret.Lyle@chp.edu

Internist/Family Practice Physician

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We are seeking an internist/family practice physician to join a team of fourteen other primary care physicians and five nurse practitioners in an environment where emphasis is placed on working with patients from diverse cultural backgrounds. There is shared on-call (1 in 10) but no inpatient responsibilities.

Qualifications and skills include:
- board certified in internal medicine or family medicine and certification must be maintained
- experience in adult primary care
- minimum five years’ post-residency clinical experience preferred
- experience using an EMR
- excellent clinical skills and ability to work as part of a multidisciplinary team
- ability to work with patients from diverse cultural backgrounds

MIT is an equal opportunity/affirmative action employer. Applications from women, minorities, veterans, older workers, and individuals with disabilities are strongly encouraged.

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The Department of Medicine invites nominations and applications for the position of:

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Contact:
Clay F. Semenkovich, M.D.
Renal Search Committee
Washington University School of Medicine
Campus Box 8127
660 South Euclid Ave.
St. Louis, MO 63110
csemenko@wustl.edu

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https://aprecruit.ucsf.edu/apply/JPF00082

The University is an “Equal Opportunity/Affirmative Action Employer.” All qualified applicants are encouraged to apply including minorities and women. UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to the diversity and excellence of our faculty.

Ochsner Medical Center New Orleans is searching for a Chair of the Department of Hematology & Oncology. Applicants must be board certified in Hematology/Medical Oncology. Prior experience in a physician leadership role is required. This position will include 20% protected administrative time with the majority of Chairman’s time spent engaged in clinical activities. Prior productivity in clinical research and excellence in educational activities are highly valued. The salary offer will be commensurate with the candidate’s experience and training.

The Hematology / Oncology Department is housed in the newly constructed Gayle and Tom Benson Cancer Center. The Chairman’s role will be to lead 12 faculty members with a broad variety of clinical and research interests including a growing hematopoietic stem-cell transplant program.

Teaching opportunities include the Medical Oncology Fellowship Training Program as well as resident teaching for a large training program in Internal Medicine and involvement with 3rd and 4th year medical students of the Ochsner Clinical School of the University of Queensland. Clinical research activities are supported through the Ochsner Cancer Institute which houses the Ochsner Health System is a physician-led, non-profit, academic, multi-specialty healthcare delivery system dedicated to patient care, research, and education. Our mission is to serve, heal, lead, educate, and innovate. The system includes 10 hospitals and over 45 health centers throughout Southeast Louisiana. Ochsner employs over 900 physicians representing all major medical specialties and sub-specialties. For additional information, please visit our website, www.ochsner.org.

New Orleans amenities include multiple medical schools and academic centers, professional sports teams, world-class dining and cultural interests, and world-renowned live entertainment and music. Interested physicians should email CV to:
profrecruit@ochsner.org
for review by Christopher J. White, M.D., Chair of the Department of Medicine

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