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Physician Employment Contracts See Changes

Payment structures, non-competes, and contract duration among areas where shifts are occurring

By Bonnie Darves, a Seattle-area health care journalist.

Deciphering physician employment contracts is a perennially challenging task for young physicians. Now, myriad changes in health care, particularly the trend toward creating mega-systems and what industry observers call "super groups," are adding yet another level of complexity. What is new in the employment contract arena reflects what is happening in the employment market itself: Physicians are increasingly opting for employed positions — with hospitals, health systems, or large practices — and contracts that govern those employment arrangements are changing accordingly.

On one level, health lawyers point out, employment contracts are becoming more uniform. On another, areas such as restrictive covenants are becoming more complex. In themselves, these trends are neither positive nor negative, because it's the actual terms of the contract that matter, regardless of the organization offering the opportunity. At the same time, as medical practices and health care organizations grow, physicians who join large organizations might encounter less flexibility in contract terms than they once did.

There is one positive to the uniform-contract approach that might comfort young physicians: They're less likely to see an egregiously unfair contract, by virtue of the fact that the agreement is probably the same one that their colleagues before them signed, said Andrew Knoll, MD, JD, a Syracuse, New York, health lawyer. "It's the safety-in-numbers doctrine — you have a contract that treats all physicians the same regardless of their specialty. If you're the new physician and there's something particularly unfair, you can be sure that the other 300 doctors will complain before you do," said Mr. Knoll, who advises physicians and health care organizations on contract matters.

Health lawyer Bruce Armon, a partner with the law firm Saul Ewing, LLP who is based in Philadelphia, said that health care organizations' rapid growth in recent years is driving the trend toward contract uniformity. "As organizations grow, they may develop more robust employment agreements and be inclined to offer less flexibility," he said. "They're essentially

saying, 'We have several hundred physicians signing this agreement, Dr. Smith, and, respectfully, you will be treated in the same manner as everybody else."

That doesn't mean that contract provisions should not, or cannot be negotiated, according to Kyle Claussen, JD, vice president of Resolve Physician Agency in Columbia, Missouri, which advises physicians on contract issues. "We're definitely seeing more uniformity in employment contracts at larger organizations, which are trying to take the stance that things are not negotiable," he said. "But we're not finding that to be the case." Physicians in high-demand specialties might still succeed in negotiating more favorable terms in compensation, schedule, or working conditions than a boilerplate contract indicates, Mr. Claussen said.

Non-competes: new issues arising

Restrictive covenants, also called non-compete clauses, which stipulate what physicians are not permitted to do after they leave an organization, continue to be a key issue in employment contracts. Mr. Claussen and other health lawyers point out what while such clauses, generally speaking, have changed little in recent years, there are emerging areas for concern in how the restrictions are drawn.

An especially problematic area are covenants' geographical boundaries — clauses that prohibit the departing physician from practicing within a certain distance of the employer for a certain time period. A typical covenant might state that the physician may not practice within, for example, 20 miles of any location of the practice or hospital. That distance "might have been reasonable in the past," Mr. Knoll said, "when typical practices operated a single satellite location," or when hospitals and health systems were relatively "contained" geographically. Today, with the trend toward consolidation in the health-services marketplace, the picture is more complex.

"Now, when large hospital systems are gobbling up facilities and practices over a 60- or 80-mile radius around an urban area, or developing clinic networks that stretch across an entire region, the geographic-distance issue has become more complicated," Mr. Knoll said. To avoid unreasonable geographic restrictions, physicians should narrow the distance scope by drawing the radius from a single, or two principal practice locations. "Ideally, the contract should limit the distance to the locations where the physician will spend most of his or her time, and draw the line from there," he said.

If the position will require the physician to travel among locations, as in the case of a surgeon who performs procedures at two or three hospitals, the radius should be drawn from a single location, Mr. Knoll advised.

Young physicians should keep in mind that restrictive covenants are common not just in health care but in many industries, and that geographic-distance non-compete clauses can serve a legitimate purpose, Mr. Armon explained. "Employers want to protect their business interests, and you, the physician, want to ensure that there is enough flexibility that you won't need to uproot yourself and family should there be a change of circumstances. And that can be a fine balancing line," he said.

The merger trend in health care services is posing another geography challenge in a different aspect of the employment contract: locations where physicians are required to practice. "Where you provide services is very important because, as practices expand or become 'super groups,' they could have locations 80 miles apart," said Michael F. Schaff, a health lawyer with Wilentz, Goldman & Spitzer in Woodbridge, New Jersey.

Many contracts state that the physician "will perform services at the company's office and other locations as the company requires," Mr. Schaff observed. If the company is based in San Diego County, for example, but after the physician is hired, the company merges with an organization that operates clinics in Los Angeles County, that clause could become problematic for the physician who doesn't want to spend many hours commuting to distant practice locations. To avoid that scenario, Mr. Schaff counsels physicians to have the contract specify a principal place of service, and require the physician's consent if the company asks the physician to practice anywhere beyond a certain distance from that location. "I try to build this into young physicians' contracts – that providing services anywhere outside 25 miles, for example, of that principal location will require consent," he said.

Contract length, benefits shrinking

One notable change in physician contracts is that the terms are getting shorter, some sources observed. While three-year agreements were once standard, many practices and health care organizations are moving toward one-year, renewable contracts, Mr. Claussen noted. "I see this as an attempt on the part of employers to treat physicians like any other employee – and say, we can let you go whenever it's convenient for us or when the economics of the situation change," he said.

Whether shorter employment contracts are a downside or a plus depends on numerous factors, such as the physician's specialty, career stage, and family considerations. "I think it's largely a matter of preference," Mr. Claussen said. "If you're an emergency medicine physician or a hospitalist, physicians who tend to hop around more, it might be attractive to have a one-year vs. a three-year commitment." A dermatologist or ophthalmologist, on the other hand, might not be comfortable with a shorter term, given the logistics of and timeline for building a practice.

A shorter contract might also be preferable to physicians whose family or professional lives are somewhat in flux, such as when a physician spouse or partner is in training, or the physician is contemplating going on to fellowship in the relatively near term.

In another general trend, benefits are being pared back, some sources noted, and this likely reflects the general uncertainty in the health care economy and the reimbursement arena. Justin Nabity, a certified financial planner with the Omaha, Nebraska, firm Physician Advisors, observed that the loan forgiveness offers have become less common and less generous, and that CME allowances are being squeezed. On a potentially more pressing note, organizations are increasingly requiring physicians to carry a larger portion of the health benefits tab.

"We're seeing organizations pay the premiums for the physician but not for dependents, and far fewer organizations are offering short-term disability coverage than in the past," said Mr. Nabity, who frequently speaks to physicians in residency and fellowship programs about contract financial issues and negotiation. In any event, candidates should carefully review the benefits package for any position they're considering. "Physicians should keep in mind that the value of benefits can range from $20,000 to $50,000, so it's important to compare offerings," he said. He also urges physicians to ask to review benefits when leaving an interview during which both parties expressed an intent to move ahead with an offer.

Payment structures becoming more important

The way physicians and their practices are reimbursed for services is shifting away from volume and toward value or quality structures, through the Medicare Quality Payment programs and shared-risk arrangements, for example. Employment contracts are changing accordingly to reflect those changes. The challenge is that relatively few practices have deep experience with these programs. As such, many organizations are struggling to figure out how best to incorporate potential bonus and at-risk compensation in employment contracts, several sources concurred.

What this means is that physicians seeking a new practice opportunity should be aware of the incentive and risk programs their prospective organization is involved in, and should ask for specifics on how individual and group performance might affect compensation. "If the entity is part of a shared-savings program, physicians need to ask what happens if the group performs well or, alternatively, is penalized for poor performance," said Mr. Schaff. He urged physicians to ask to see concrete examples of how these structures have affected their prospective colleagues' compensation. "The point is to make sure that you receive any income you're entitled to, and that you understand the practice's compensation model and how any incentives or penalties are structured," he said.

If the practice is new to quality-based payment or bonus structures, it might be hard to tease out potential effects on income. In such cases, the more important consideration is probably the percentage of total compensation that derives from the structure, Mr. Claussen suggested. "I think physicians should be careful about how much of their compensation is weighted for that [quality] bucket," he said. "If it's five percent of your total compensation, it's probably something you can live with being a gray area. But if it's 30 percent, you need to understand the model and make sure they show you data on what has been paid out in the past."

Although value-pegged reimbursement structures are starting to affect compensation models, productivity-based compensation or bonus structures are still common in employment contracts, and physicians should understand how these components work. The most important issue is how productivity is measured for the purposes of both expected physician performance and the threshold for earning bonus compensation.

"It's very important for young physicians to understand these thresholds — usually measured in work RVUs — and make sure that they're actually attainable based on MGMA or other compensation survey data," Mr. Claussen cautioned. "We have encountered physicians who say they were told they would make all of this money, and then they can't actually get there [above the threshold] once they see what average production looks like."

To avoid such situations, physician candidates should find out how their colleagues have fared under the system in recent years, Mr. Knoll said, and should request that such information be provided in actual examples.

He also points to a productivity clause that should be a red flag: a provision that calls for a productivity bonus when the physician exceeds the cited RVU or other threshold but doesn't guarantee that the bonus will actually be paid out.

"I have seen practice contracts that say the physician will receive a bonus for any earnings over X, but states that the bonus will be paid out 'at the practice's discretion,'" Mr. Knoll said. "That's just unfair." Such one-sided clauses are more likely to show up in private practice agreements than in large organizations' contracts, he said, and might be included primarily to enable owner-partners to control the flow of payments and protect partners' income. "In a big health system, you're not taking that bonus money out of someone's pocket, but that's not the case in the small practice," he said.

Other trends and pitfalls

Even though employment contracts in general haven't seen major changes in the last five years, physicians should be aware of minor factors and trends that might make some contracts less favorable than others. Physicians should also avoid or attempt to negotiate patently physician-unfriendly provisions. Following are other contract issues and areas that physicians should consider.

Tail coverage responsibility shifting. Employers, through employment contracts, are increasingly shifting the financial burden of malpractice tail coverage to the physician. That might be in order for some situations, such as if a physician leaves without providing proper notice. Health lawyers interviewed for this article advise physicians to seek an approach based on reasons for termination: If the physician is terminated without cause or the contract isn't renewed, the employer pays. If the physician breaches the contract or leaves without cause, she or he picks up the cost. In any event, physicians should be aware of the cost of tail insurance for their specialty in the geographical area(s) under consideration, in the event that the coverage responsibility becomes a sticking point.

Academic medical center (AMC) contracts becoming more complex. As AMCs expand and affiliate with non-academic entities, their physician employment contracts have become shorter in duration and more complicated, and the contracts' provisions more numerous, sources noted. Although the key considerations are unchanged — physicians should closely evaluate balance of time (and responsibility) for clinical and non-clinical activities, and the opportunities and avenues for promotion — physicians should also look beyond the body of the contract.

AMC contracts tend to have many more attachments than private-sector contracts do, presumably to address the myriad policies and procedures. Termination policies, for example, might be in an addendum, not the actual contract.

Signing too early could be costly. It's not uncommon for organizations to offer residents a contract up to a year before they finish training. Although that is flattering and especially positive if the physician has her heart set on joining the organization, there can be downsides to signing early. Besides the possibility that the physician might change her mind and the problems that decision might cause, there might be financial penalties associated with walking away, Mr. Claussen cautioned.

"There could be a real issue about whether a non-compete should apply to you. Even if you haven't started working, you have gained access to information, and the organization might have stopped recruiting for your specialty. So some provisions might be enforced against you," he said. At the least, physicians inclined to commit early should ensure that non-compete provisions don't apply until the start date, not the date that the parties executed the contract.

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Primary Care Physician Compensation Update

By Bonnie Darves, a Seattle-area health care journalist.

Compensation for U.S. primary care physicians continues to rise steadily, even if the increases haven't been particularly impressive. Three leading physician compensation surveys all reported compensation upticks in family medicine, internal medicine, and pediatrics over the last 18 months, with the annual increases over the previous year ranging from approximately 1% to 4%, depending on the specialty and the survey.

Here is a quick look at the compensation surveys' big-picture findings in primary care compensation:

American Medical Group Association (AMGA) 2016 Medical Group Compensation and Productivity Survey

Specialty	Median compensation
Family medicine	$234,706
Internal medicine	$249,588
Pediatrics	$235,257

Medical Group Management Association (MGMA) 2016 Physician Compensation and Production Report

Specialty	Median compensation
Family medicine (no OB)	$230,456
Internal medicine	$247,319
Pediatrics	$231,637

Sullivan, Cotter and Associates 2016 Physician Compensation Survey

Specialty	Median total cash compensation
Family medicine	$226,000
Internal medicine	$233,715
Pediatrics-general	$225,121

Primary care physicians remain in demand throughout many areas of the country, even if the year-to-year compensation changes don't reflect a high-demand environment, according to Tom Dobosenski, president of the American Medical Group Association consulting practice and the AMGA's survey lead author. "Primary care compensation is going up, but not as fast as we expected in the last few years," Mr. Dobosenski said. "We thought that given the increasing focus on primary care in coordinating overall care delivery, compensation would go up at a faster rate. But we're just not seeing that."

That is not to suggest that need for primary care physicians (PCPs) is declining, Mr. Dobosenski pointed out. Residents leaving training can expect to find competitively compensated positions in most regions, and those willing to practice in less-desirable areas will find opportunities plentiful. As a point of reference, the Association of American Medical Colleges' latest forecast shows a persisting PCP shortage of between 14,900 and 35,600 physicians by the year 2025. Despite the AAMC's prediction and the recognition that the aging population will strain the primary care delivery system, PCP compensation likely will increase steadily but not dramatically, all sources agreed.

"I think we can expect primary care compensation to continue increasing by 3% to 4% annually over the next few years," said Kim Mobley, a managing principal with Sullivan, Cotter and Associates. "It's hard to predict beyond that because of MACRA," she added, referring to the Medicare Access and CHIP Reauthorization Act. That legislation, which moves into high gear this year, calls for increasing payments to physicians who meet government-set performance-improvement targets and penalizing those who don't.

David Gans, a senior fellow for industry affairs at the MGMA, predicts that although PCP compensation will continue to rise, demand might start leveling off as practices reconfigure their care-delivery models. "There is still a substantial need for primary care physicians, but at the same time, we're seeing practices develop more effective ways to utilize nurse practitioners and physician assistants," he said. "That's starting to reduce demand for PCPs in some markets."

Mr. Gans noted that practices are also eyeing ways to support closer collaboration between physician specialists treating chronic disease, and general internists or family physicians who focus on the elderly. As health care moves toward value-based payment structures, PCPs who are experienced or interested in such emerging care models will find opportunities plentiful, he said. Overall, primary care specialties collectively continue to

garner higher compensation increases than many other specialties, Mr. Gans noted, because of their pivotal role in care-delivery innovation.

Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians, concurred. "We're seeing steady growth in family physician income, because there is increasing recognition of the value of primary care," he said. Mr. Moore cited the MGMA-reported 18% cumulative compensation increase in primary care specialties over the last five survey years — compared with 11% for the physician specialties collectively — as evidence of this recognition. "The MGMA 2016 survey report showed primary care physicians' median income was more than $250,000. That's still woefully below subspecialty income, but it does show improvement," he said.

On a regional level, primary care compensation variation followed the same basic pattern it has for the last decade, sources noted. PCPs in the South, Midwest, and North Central regions are still the highest earners, followed by those in the West. PCPs in the Northeast tend to have the lowest compensation overall. In a noticeable departure, however, the AMGA survey found that pediatricians in the Northeast had the highest median compensation in the country, at $245,861, followed by $239,612 in the West.

At the upper end of the earnings spectrum, the MGMA reported that primary care physician compensation was highest in Alaska, Wisconsin, and Arkansas in 2015. Those in Nevada, Maine, and Maryland earned the least. In the Sullivan Cotter survey, PCPs in Nebraska had the highest compensation. Interestingly, the MGMA survey found PCP compensation generally higher in private practices than in hospital systems, while the AMGA reported that in family medicine and internal medicine, large groups — those with more than 300 providers, per the survey's categories — paid more than smaller groups.

It's important to keep in mind that PCPs new to practice likely will not be compensated at the median level. Many practices, on principle, set starting compensation for new graduates substantially below the surveys' reported median levels. Ms. Mobley said that primary care physicians new to practice generally earn between the 10th and 25th percentile. The Sullivan Cotter survey reported the following 25th percentile compensation: $191,683 in family medicine, $198,751 in internal medicine, and $181,914 in pediatrics.

On a positive note, signing bonuses in the realm of $15,000 are still common for new primary care graduates, sources noted, and some employers provide assistance with education loans. "We're seeing a lot of hospitals help new primary care physicians with education debt by providing access to lower-interest loans," Ms. Mobley said.

Productivity levels off

Trends in PCP productivity — how much physicians work based on the RVUs (relative value units) they generate — are showing significant shifts in recent years. With the exception of pediatrics, the surveys found that productivity, still a key component in compensation structures despite rapid movement toward quality-based methodologies, is leveling off. The AMGA survey reported flat productivity in family medicine and internal medicine last year compared to 2015, at a median of roughly 4,900 RVUs annually for both specialties. The AMGA also reported an unusual decline in pediatrics RVUs, from a 5,411 median in 2015 to 5,299 in 2016.

As with previous AMGA surveys' findings, family physician productivity in the Southern region far outpaced other regions, at a median of 6,855 RVUs, compared to 4,784 in the lowest-productivity Western region. The internal medicine regional productivity spread between those two regions was less pronounced, at 4,548 and 5,211 median RVUs (Western and Southern, respectively).

Over the past five years, the Sullivan Cotter surveys show flattening productivity in family medicine and internal medicine, with essentially no increase from 2011 to 2016 in median RVUs. The surveys report a steady productivity increase in pediatrics, from 4,971 median RVUs in 2011 to 5,309 in 2016.

The MGMA survey reported national median RVUs of 4,928 in family medicine, 4,698 in internal medicine, and 4,902 in pediatrics. Pediatrics was the only primary care specialty in which productivity measurably increased from 2015 to 2016 in that survey.

Compensation components shifting

Physician practices and employers still use RVUs to gauge PCP productivity and determine incentive compensation, but to a lesser extent than in the

past. With the growing use of care quality-based and patient-experience metrics, and the pronounced trend toward direct physician employment, predominantly productivity-based compensation is declining. In primary care, more than half of groups use base salary as a mainstay in setting compensation, survey data suggested, and most use performance and quality measures to set incentive compensation.

The Sullivan Cotter survey found that for PCPs, base salary accounted for 76% (mean) of total cash compensation, and performance and patient-experience combined, 18%. In the AMGA survey, the most common incentive-compensation determinants not tied to direct productivity were patient satisfaction and clinical outcomes.

In a relatively new development, practices are incorporating patient-panel size as a component of PCP incentive payment, as an alternative to encounter or services volumes. Ms. Mobley said that she expects panel size will become an increasingly important component of compensation, as practices try to move toward population-based care models. In the Sullivan Cotter survey, 14% of practices now use panel size as a compensation component, and in the groups that measure panel size, the component accounted for 9% of total cash compensation.

The AMGA 2016 survey reported a median panel size of 1,823 patients in family medicine, 1,808 in internal medicine, and 1,926 in pediatrics. Even with the now prevalent use of performance measures in determining primary care compensation, primary care practices are struggling to figure out how to reward quality without negatively affecting productivity, Mr. Dobosenski observed. “Everyone is trying to find the magic pill in terms of compensation package structure, to align with a future reimbursement scenario that will be more about value and less about volume,” he said. “In general, practices know that volume needs to be less important in primary care, and that panel size and patient access need to be more important. But they’re not sure how to structure compensation to support that.”

Interestingly, in a recent AAFP member survey about value-based payments, one third of respondents indicated that they “did not know where these payments were sent,” Mr. Moore said, and one-third indicated that the payments “were sent to their employers, not directly to the practicing physician.”

Questions to ask about compensation

When they evaluate practice opportunities and create a short list to pursue further, most young physicians focus primarily on total compensation and their geographic preferences. Both are important — and the latter may be crucially important for physicians who have families and working spouses/partners. However, it is short-sighted not to look at compensation package components in both a broader and longer-term perspective, all sources agreed, and to ask questions accordingly.

One key question, particularly in the current environment, is how the physician’s compensation — and the related expectations of the physician — will evolve. “Young physicians starting out should avoid getting fixated on the compensation amount they’ll receive under the salary guarantee. It’s more important to know what will happen with the compensation structure when that guarantee stops, typically in year three,” said Mr. Dobosenski. He added that physicians should also ask if compensation plan changes are expected.

Ms. Mobley said that PCPs should explore not just which performance metrics will determine their compensation beyond the guarantee but also how well equipped the organization is to help physicians achieve target metrics — in care quality, patient experience or satisfaction, panel size, RVU-based productivity, or any other measure that will affect income. “When they evaluate practice opportunities and go on interviews, physicians should ask what kind of support they will receive to meet those metrics after the guarantee stops,” she said, regardless of whether the practice is private- or hospital-owned.

For example, if neither the practice infrastructure nor the local market supports patient volume growth, or inadequate staffing levels or other factors compromise patient access or satisfaction, even PCPs who work hard to meet the targets might be unable to do so.

It also behooves PCPs to obtain at least a basic picture of the practice’s revenue sources and the reimbursement environment in which it operates, Ms. Mobley said, and to ask whether that picture is likely to change in the coming years.

To gauge how well an organization’s compensation structure aligns with the physician’s personal needs or objectives, it’s important to ask about compensation philosophy, Mr. Dobosenski noted. “It’s completely appropriate to ask what the practice’s guiding principles are in setting compensation,”

he said. "If that statement says, 'We try to be market competitive' vs. 'We expect to pay at the 40th percentile,' or 'We will move toward compensating PCPs based on patient panel size,' physicians need to know these things before they sign on."

Mr. Dobosenski further advised physicians to ask if the organization places a total cap on compensation, and if so, what that cap is based on. Some organizations might set the cap at the 75th or 90th percentile of national surveys, for example. "If you want to produce at a high level and get paid at a high level, it's very important to know if there is a cap in place," he said.

Finally, PCPs should carefully consider the value of the value of the benefits plan when they evaluate or compare opportunities, Ms. Mobley said. "The benefits, including retirement plans, which vary significantly based on the type of physician employer, can have a tremendous impact on the overall value of the total compensation, but younger physicians often overlook that."

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CLINICAL PRACTICE

Caren G. Solomon, M.D., M.P.H., *Editor*

Social Anxiety Disorder

Falk Leichsenring, D.Sc., and Frank Leweke, Dr.Med.

This Journal *feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the authors' clinical recommendations.*

A 26-year-old student reports feeling very anxious when giving a presentation, taking an examination, or meeting an authority figure. In these situations, he has palpitations, tremors, blushing, and sweating, and he is fearful that he will embarrass himself. He reports having few social contacts and avoids going to parties and making phone calls, but he feels lonely. His anxieties started during his teenage years and have increased considerably since he started attending a university. How should this case be managed?

THE CLINICAL PROBLEM

Social anxiety disorder is characterized by an intense fear of social situations in which the person may be scrutinized by others. The person fears being negatively evaluated — for example, being judged as anxious, weak, stupid, boring, or unlikable. Table 1 summarizes the diagnostic criteria for social anxiety disorder given in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5).[1] Only minor changes have been made since the publication of DSM-4 (Table 1). Social anxiety disorder represents a continuum of a number of feared social situations.[2,3] However, there is a distinct subtype of social anxiety that applies to patients who have performance-related fears that are often related to their professional lives (e.g., giving a public speech, a musical performance, or a presentation in meetings or classes) (Table 1).[1,3] The characteristics of persons with this subtype of the disorder seem to be qualitatively different from those of other persons with social anxiety disorder in several respects, including having a lower heritability of the disorder, a later onset, less impairment, stronger psychophysiological responses to performance situations, and a positive response to treatment with beta-blockers.[3,4]

Social anxiety disorder is one of the most prevalent mental disorders, with a lifetime prevalence of 13% and a 12-month prevalence of 8% among adults and similar prevalences among adolescents in the United States.[5] The disorder has an early onset (mean age, 13 years) and is often chronic.[6,7] Common coexisting conditions include other anxiety disorders, major depressive disorder, substance-use disorder, and avoidant personality disorder.[2,3] Social anxiety disorder is associated with an increased risk of depressive disorders, substance-use disorders, and cardiovascular disease.[2,8] The condition can also have adverse effects on the course of other mental disorders; for example, it is associated with a higher likelihood of persistence of substance abuse[8] and a more malignant course of depression, including suicidality, impaired functioning in social roles (e.g., productivity at work and

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An audio version of this article is available at NEJM.org

KEY CLINICAL POINTS

SOCIAL ANXIETY DISORDER

- Social anxiety disorder affects up to 13% of the U.S. population and is characterized by an intense fear of social situations in which the person anticipates being evaluated negatively.
- Social anxiety is associated with an increased risk of other mental disorders, such as depression and substance-use disorder.
- Patients frequently avoid consulting a physician for social anxiety disorder. A coexisting condition is often what leads people with social anxiety disorder to seek medical help.
- Cognitive behavioral therapy is usually considered to be the first-line treatment.
- For patients who are not interested in psychotherapy or for whom psychotherapy is not accessible, selective serotonin-reuptake inhibitors are the first-line pharmacotherapy.

Table 1. Diagnostic Criteria for Social Anxiety Disorder.*

Marked fear or anxiety related to one or more social situations in which scrutiny by others is anticipated; examples include engaging in social interactions (e.g., having a conversation or meeting unfamiliar people), being observed (e.g., when eating or drinking), and performing in front of others (e.g., giving a speech)†
Fear of acting in a way (e.g., showing symptoms of anxiety) that will be negatively evaluated by others (i.e., will be humiliating or embarrassing or will lead to causing offense or being rejected by others)
Fear or anxiety is almost always provoked by social situations
Social situations are avoided or endured with intense fear or anxiety
Fear or anxiety is out of proportion to actual threat posed by social situation and to sociocultural context‡
Fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more
Fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
Fear, anxiety, or avoidance is not attributable to physiological effects of substance use (e.g., drug abuse or medication) or another medical condition
Fear, anxiety, or avoidance is not better explained by symptoms of another mental disorder (e.g., panic disorder, body dysmorphic disorder, or autism spectrum disorder)
If patient has another medical condition (e.g., Parkinson's disease, obesity, or disfigurement from burns or injury), the patient's fear, anxiety, or avoidance is clearly unrelated to that condition or is excessive
If fear or anxiety is restricted to speaking or performing in public, social anxiety disorder should be specified as performance anxiety only§

* The diagnostic criteria listed are adapted from the *Diagnostic and Statistical Manual of Mental Disorders,* fifth edition (DSM-5).[1] All criteria must be met for diagnosis.

† In children, the anxiety must occur in situations involving peers and not only during interactions with adults. The fear or anxiety may be expressed by crying, tantrums, "freezing" in place, clinging, or shrinking from or failing to speak in social situations.

‡ The description of social anxiety disorder in the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, text revision (DSM-4-TR), has been changed from "the person recognizes that the fear is excessive or unreasonable" to "the fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context," since the clinician may be able to better identify this behavior than a patient with social anxiety disorder.

§ The subtype of social anxiety disorder referred to as "generalized" in DSM-4 has been removed in DSM-5.

impaired functioning in social and romantic relationships), and a reduced tendency to seek help.[2,8-11]

Social anxiety disorder has high socioeconomic costs. More than 90% of persons with the disorder report psychosocial impairments (e.g., increased risk of dropping out of school, reduced workplace productivity, and reduced socioeconomic status and quality of life), and more than one third report severe impairments.[2,3,5,8,9,11] However, according to a nationally representative household survey, only 35% of persons with a lifelong social anxiety disorder receive treatment specifically for this disorder.[2] Social anxiety disorder is often mistaken for shyness (Table 2) and remains both underrecognized and undertreated.[2,9,12]

Table 2. Differential Diagnosis.*

Shyness: Social anxiety disorder is often mistaken as shyness. Shyness by itself is not pathological. In the United States, only a minority people who identify themselves as shy meet the criteria for social anxiety disorder. Thus, it is only when there are significant adverse effects in important areas of functioning (e.g., social or occupational) that a diagnosis of social anxiety disorder should be considered.[1]

Agoraphobia: Persons with agoraphobia may be afraid of social situations (e.g., attending a concert) because escape may be difficult. However, persons with agoraphobia are not afraid of being scrutinized by others, as is the case in persons with social anxiety disorder.

Panic disorder: Patients with social anxiety disorder may have panic attacks. However, in contrast with patients with panic disorder, those with social anxiety disorder have panic attacks only when they have a fear of being negatively evaluated by others.

Generalized anxiety disorder: Patients with generalized anxiety disorder often worry about interpersonal relationships, but in generalized anxiety disorder, anxiety has a broad focus and is not predominantly related to a fear of negative social evaluation.

Separation anxiety disorder: Persons with separation anxiety disorder may avoid social situations, including school, because of concerns about separation from attachment figures.[1] They are not afraid when the attachment figure is present, whereas patients with social anxiety disorder may be afraid of being negatively evaluated in the presence of attachment figures. Persons with separation anxiety disorder are not afraid of being negatively evaluated.

Body dysmorphic disorder: In patients with body dysmorphic disorder, avoidance and social anxiety, if present, are related only to aspects of their physical appearance.

Major depressive disorder: Patients with major depressive disorder may be concerned about being negatively evaluated by others, but this concern is related to feelings that they are "bad" or not worthy of being liked.

Selective mutism: Patients with selective mutism are not afraid of negative evaluation if they are not required to speak.[1]

Autism spectrum disorder: In contrast with patients with autism spectrum disorder, patients with social anxiety disorder have an adequate capacity for social communication.

Delusional disorder: Persons with social anxiety disorder can be distinguished from patients with delusional disorder by their insight that their fears are out of proportion to the actual threat posed by the social situation.

Oppositional defiant disorder: In oppositional defiant disorder, people refuse to speak owing to opposition to authority figures, whereas those with social anxiety disorder are afraid of being negatively evaluated by authority figures.

Avoidant personality disorder: In avoidant personality disorder, the pattern of avoidance is broader than in social anxiety disorder. However, these disorders often coexist.[3]

Other medical conditions: In other medical conditions, symptoms may occur that are embarrassing (e.g., incontinence or trembling in Parkinson's disease). A diagnosis of social anxiety disorder should be considered if the fear of negative evaluation is excessive.

* Conditions and mental disorders other than social anxiety disorder involve patients' capacity to function in social situations. These conditions can be clinically differentiated from social anxiety disorder, as described below.

Recent data from studies involving twins suggest that genetic and environmental factors (e.g., illness and relationships with peers) explain most of the individual differences among persons with social anxiety disorder.[13] In children, the contribution of genetic factors is approximately twice as high as that in adults (53% vs. 27%).[13] Several candidate genes have been suggested, but larger samples are required for their identification and validation.[6] A plausible theoretical model assumes that genetic factors affect vulnerability to social anxiety disorder, but additional factors are required for its development.[14] These factors may include conditioning, observational learning (e.g., learning by watching a parent), and parenting behavior.[3,14] With regard to the latter, paternal but not maternal challenging behavior (e.g., playfully encouraging risky behavior) was found to be associated with a decreased risk of social anxiety disorder.[15] Furthermore, parental social anxiety disorder was found to be predictive of fear and avoidance in toddlers[16] and of autonomic hyperarousal in children,[17] with the latter being a marker for genetic vulnerability to anxiety disorders. Behavioral inhibition (i.e., wariness when exposed to novel situations) is another reported risk factor.[3] Neurobiologic research on social anxiety disorder has suggested dysfunction in distributed circuits involving the amygdala, insula, hippocampus, and orbital frontal regions of the

brain[18] and in serotonin regulation,[19] but these proposals require further study.

STRATEGIES AND EVIDENCE

ASSESSMENT

Persons with social anxiety disorder visit their primary care physician less frequently than do patients with other mental disorders.[20] They also avoid consulting a physician for psychological problems.[11] Among persons who do seek care, most avoid talking about their social anxiety.[21] Often it is a coexisting condition that leads persons with social anxiety disorder to seek medical help.[22] To screen for the disorder, two questions can be asked[12]: First, "Do you find yourself avoiding social situations or activities?" Second, "Are you fearful or embarrassed in social situations?" Clinical experience suggests that these questions are very useful in screening, although their sensitivity and specificity for social anxiety disorder are not known.

Although some features of social anxiety overlap with those of other conditions, these conditions, as well as normal shyness, can be clinically differentiated from social anxiety disorder (Table 2). Patients should be asked about potential coexisting conditions (e.g., alcohol and substance abuse), mood disorders, and other anxiety disorders frequently associated with social anxiety disorder.[12] Coexisting depression may mask the presence of social anxiety disorder.[11] Alcohol may be used as a means of self-medication to reduce social anxiety, but patients with social anxiety disorder avoid groups such as Alcoholics Anonymous.[23] Coexisting substance abuse does not preclude treatment of social anxiety disorder, but each disorder needs to be addressed individually.[12]

TREATMENT

Social anxiety disorder can be treated with psychotherapy, pharmacotherapy, or both.[6,23] The choice of treatment depends on the patient's preferences and on clinical judgment.[6] For patients who have previously been treated for social anxiety disorder, a previous positive or negative response to a given approach is useful in guiding treatment decisions. Among patients for whom psychotherapy is too frightening (because of being exposed to a feared situation), pharmacotherapy may be preferred initially, at least until anxiety has been reduced and psychotherapy becomes a more acceptable option. Patients whose social anxiety disorder is related to another medical condition, such as stuttering, obesity, or Parkinson's disease, may benefit from the established psychotherapeutic and pharmacologic treatments described below.[23,24]

Psychotherapy

Several methods of psychotherapy are available for the treatment of social anxiety disorder (Table 3). Cognitive behavioral therapy (CBT) is currently regarded as the first-line treatment.[12] Several randomized, controlled trials (RCTs) have shown that CBT can be a beneficial treatment for social anxiety disorder. Stable treatment effects have been reported at follow-up, typically at 1 month and 6 months after treatment.[26] However, a recent meta-analysis classified only a few trials of CBT for social anxiety disorder as being of high quality[28]; these trials showed large effect sizes in comparison with wait-list groups but only small-to-moderate effect sizes in comparison with treatment as usual or placebo.[28] Similar findings were reported for the use of CBT in treating depressive disorders and anxiety disorders other than social anxiety disorder.[28] In high-quality studies of CBT for the treatment of social anxiety disorder, response rates were between 50% and 65%,[25,29,30,34] an outcome that was superior to placebo (32%) and wait-list control groups, for which response rates were between 7% and 15%.[25,29,30,34] Remission rates with CBT were between 8.8% and 36%.[29,35] For adults who do not have access to face-to-face CBT, guided Web-based CBT may be an alternative. The efficacy of Web-based CBT has been reported to be similar to that of face-to-face CBT and is applicable in primary care settings.[36,37]

Other types of psychotherapy are also used to treat social anxiety disorder, but there have been fewer studies of these treatments. In head-to-head comparisons, a group receiving interpersonal therapy had a higher response rate than a wait-list group (42% vs. 7%),[25] a rate of response that was similar to that for supportive therapy (47%)[32] but lower than that for CBT (66%).[25] Mindfulness-based stress reduction carried out in the form of group therapy was likewise reported to result in lower response rates than CBT (39% vs. 67%).[33] In three randomized trials, response rates in groups receiving manual-guided, short-

Table 3. Psychotherapies for Social Anxiety Disorder.

Type of Therapy	Core Elements	Examples of Interventions	No. of Sessions and Duration of Therapy Recommended*
Cognitive behavioral therapy[25,27]	Involves education about nature of disorder and its treatment Centers on "self-focused attention" (i.e., focusing one's attention on oneself) and "safety behaviors" (i.e., coping behaviors used to reduce anxiety and fear when patient feels threatened) Focuses on problematic processing of events May include video feedback on performance May involve behavioral experiments (e.g., exposure to social situations) Addresses negative beliefs Involves homework Involves relapse prevention	Helping patient address self-focused attention and safety behavior by asking patient to read text as fast as possible and be aware of his or her voice. Patient is then asked to speak freely while looking at audience during presentation. Identifying and testing problematic event processing and negative beliefs (e.g., when patient might say, "This time I was just lucky when nobody laughed at me" or "I am a loser").	14–16 Sessions over 4 mo
Short-term psychodynamic therapy[29,31]	Informs patient about both social anxiety disorder and its treatment Involves setting goals Fosters a therapeutic alliance Identifies core, internalized conflict related to social anxiety disorder Relates symptoms to core, internalized conflict Uses confrontation, clarification, and interpretation of conflicts Focuses on establishing an encouraging inner dialogue Focuses on termination of therapy Focuses on relapse prevention	Identifying core underlying conflict (e.g. "I wish to be the center of attention, but others will humiliate me. Thus, I am afraid of social situations and avoid being exposed to such situations"). Relating patient's symptoms to core conflict: "Maybe you are afraid of being the center of attention but you also wish to be there [unconscious component of conflict of which patient is not aware]. But you are afraid of being humiliated by others." Supporting patient effort to develop an encouraging inner dialogue: "Last time, my presentation was successful. So it will be successful today as well."	25 Sessions over 6 mo
Interpersonal therapy[32]	Involves review of symptoms Involves assessment of current and past relationships Explains symptoms as part of a disorder Links symptoms to interpersonal problem Encourages expression of feelings about relationships Maintains focus on problem area identified Links changes in interpersonal problem to changes in symptoms Prepares patient for termination by reviewing progress, consolidating gains, helping patient prepare for challenging situations	Linking symptoms to an interpersonal problem, such as a role transition (e.g. marriage, divorce, graduation, or retirement) or a role-related dispute (e.g., conflict in an important relationship).	14 Sessions over 14 wk
Mindfulness-based stress reduction[33]	Involves orientation interview Provides psychoeducation about stress and meditation techniques Involves patient practice of meditation for 30 min/day with use of audiotapes Involves patient practice of sitting while meditating without audiotapes for 10–15 min/day Provides patient with reading material on practice of mindfulness	Using meditation techniques (e.g., mindful yoga, sitting meditation, or "body scanning"). In facilitating body scanning, practitioner might say: "Sit or lie comfortably, close your eyes, and start to breathe deeply. Start the scan at your feet. Be aware of how they touch the ground. Then move on. Be aware of your lower legs, your calves, your knees, your thighs, your stomach . . . your back, your face, your arms, and your fingers. Finally, open your eyes and breathe deeply several times. Then get up."	8 Group sessions, 2.5 hr each, over 8 wk

* The number of sessions shown is the typical number conducted in randomized, controlled trials of these treatments.

term psychodynamic therapy were superior to those in wait-list or placebo groups[29,31,38] and similar to those in CBT groups, both in the short term (52% to 63% for psychodynamic therapy vs. 60% to 64% for CBT) and at follow-up at 1 year and 2 years.[29,31,39] Remission rates were also similar for short-term psychodynamic therapy and CBT,[31,39] although in one study the rates of short-term remission were higher with CBT than with short-term psychodynamic therapy (36% vs. 26%)[29]; the difference was small and no longer significant at follow-ups of 6, 12, and 24 months.[39] More studies are needed to further assess the efficacy of short-term psychodynamic therapy, interpersonal therapy, and mindfulness-based stress reduction.

Pharmacotherapy

Pharmacotherapy and CBT appear to have a similar efficacy for the short-term treatment of social anxiety disorder.[44] The available head-to-head comparisons suggest that more immediate improvements are achieved with pharmacotherapy[30] but that the effects of CBT are more enduring.[48-50] Randomized trials comparing the combination of psychotherapy and pharmacotherapy with either alone have yielded inconsistent results.[6,41,44,50,51]

Several medications have been used for the treatment of social anxiety disorder (Table 4).[4,40,41] Selective serotonin-reuptake inhibitors (SSRIs) are considered to be the first-line pharmacologic treatment. Response rates reported for the serotonin–norepinephrine reuptake inhibitor (SNRI) venlafaxine have been similar to those reported for SSRIs.[4,43,44] These and other medications that are used to treat social anxiety disorder are discussed below.

SSRIs and SNRIs

SSRIs have become the first-line pharmacologic treatment for social anxiety disorder owing to their superiority to placebo in multiple RCTs. There is a low risk of side effects with SSRIs, and they offer the additional beneficial effects of being useful in the treatment of coexisting depression and other disorders related to anxiety.[4,6,12,40-43] Meta-analyses of the results of RCTs have shown a mean short-term response rate of 55% for SSRIs versus 32% for placebo.[43,44] The quality of many RCTs that are focused on the use of pharmacotherapy for social anxiety disorder is limited[45]; however, one recent meta-analysis suggested that the response rates reported in studies judged to be of high quality (according to examination with the Cochrane risk-of-bias instrument) were similar to those reported in studies of lesser quality.[45] Most trials in which different SSRIs have been compared did not show significant differences in the effects of treatment,[4,43] but only one of three trials of fluoxetine showed efficacy with regard to social anxiety.[4,43] As mentioned above, treatment with the SNRI venlafaxine has also been successful.[4,43,44]

The recommended doses and common adverse effects of these and other agents used to treat social anxiety disorder are listed in Table 4. The dose ranges used in most clinical trials are similar to those used for the treatment of major depressive disorder.[4] Doses are commonly increased in patients who have not had a response after 4 weeks as long as side effects are minimal.[23] However, in an analysis that included three randomized trials of the SSRI paroxetine, more than 25% of patients who did not have a response after 4 weeks did have a response after 8 weeks of treatment at the same dose.[6,46] Continued use of pharmacotherapy after short-term treatment (14 weeks or less) has been associated with greater improvement in maintenance trials and with lower relapse rates.[43] The appropriate duration of treatment is not clear,[4,40] but the available evidence suggests that treatment should be maintained for at least 3 to 6 months after the patient has had a response, after which the drug can be tapered gradually.[4]

If a patient does not have a response, nonadherence to treatment and the effects of coexisting conditions should be considered.[4] Although there are limited data on how to treat patients who do not have a response to initial treatment with an SSRI, clinical experience supports the strategy of trying an alternative SSRI or the SNRI venlafaxine.[12]

Anticonvulsants and Benzodiazepines

The anticonvulsant pregabalin was shown to be superior to placebo in two RCTs and is recommended as a first-line treatment in Canadian practice guidelines.[4,42] However, response rates in these trials were only between 30% and 43% as compared with 20% and 22%, respectively, for placebo.[4] Similar response rates were shown for gabapentin in one RCT (38% for gabapentin vs. 14% for placebo).[4] Tricyclic antidepressants are

Table 4. Pharmacotherapies for Social Anxiety Disorder and Performance Anxiety.

Medication*	Dosage	Common Side Effects†
Social anxiety disorder		
SSRIs		Headache, nausea, sedation, sexual dysfunction, insomnia, sweating, withdrawal syndrome In children and adolescents, suicidal ideation may occur
Sertraline‡	Initial: 25 mg/day Target: 50–200 mg/ day	
Paroxetine‡	Initial: 10 mg/day Target: 20–60 mg/day	
Paroxetine CR‡	Initial: 12.5 mg/day Target: 12.5–37.5 mg/day	
Fluvoxamine XR‡	Initial: 100 mg/day Target: 100–300 mg/day	
Escitalopram	Initial: 5 mg/day Target: 5–20 mg/day	
SNRI		Same as for SSRIs, plus hypertension
Venlafaxine XR‡	Initial: 37.5 mg/day Target: 75–225 mg/day	
Benzodiazepine		
Clonazepam	Initial: 0.25 mg once daily Target: 0.50–4.0 mg once daily or divided in 2 doses	Sedation, cognitive impairment, ataxia, withdrawal syndrome
Anticonvulsant		
Pregabalin	Initial: 150 mg/day Target: 600 mg/day Usually divided in 2 or 3 doses	Dry mouth, sedation, ataxia, nausea, dizziness, asthenia, flatulence, decreased libido
MAOIs§		
Phenelzine	Initial: 15 mg/day Target: 15–90 mg/day Usually divided in 3 doses	Hypotension, weight gain, sedation, insomnia, low-tyramine diet required to prevent hypertensive reaction Combining SSRI or SNRI with MAOI is contraindicated (risk of the serotonin syndrome)
Moclobemide¶	Initial: 150 mg/day Target: 300–600 mg/day Usually divided in 2 doses	Dry mouth, constipation, nausea, diarrhea, insomnia, dizziness, anxiety, restlessness
Performance anxiety‖		
Beta-blocker		
Propranolol	Initial: 10 mg/day as needed Target: 10–40 mg/day as needed	Hypotension, bradycardia
Benzodiazepines		Sedation, cognitive impairment, ataxia
Alprazolam**	Initial: 0.25 mg/day as needed Target: 0.25–1.00 mg per day as needed	
Lorazepam**	Initial: 0.5 mg/day as needed Target: 0.5–2.0 mg/day as needed	

* This list is not exhaustive. It includes all medications approved by the Food and Drug Administration (FDA) for the treatment of social anxiety disorder or performance anxiety and selected others for which there is evidence of efficacy in the treatment of social anxiety disorder or other anxiety disorders. CR denotes controlled release, MAOI monoamine oxidase inhibitor, SNRI serotonin–norepinephrine reuptake inhibitor, SSRI selective serotonin-reuptake inhibitor, and XR extended release.

† For each medication, the risks in case of pregnancy or lactation are specified by the FDA and need to be taken into account.

‡ These medications have been approved by the FDA for social anxiety disorder.

§ The use of MAOIs is limited by dietary restrictions and the risk of serious adverse events. MAOIs are reserved for refractory disorders.[12,23]

¶ Moclobemide is a reversible inhibitor of monoamine oxidase A, for which there are no dietary restrictions and fewer adverse effects than with MAOIs, but the outcome has not been consistently superior to placebo.[4] Moclobemide is not available in the United States.

‖ Evidence of efficacy for performance anxiety is inferred from randomized, controlled trials that included persons without a formal diagnosis of performance anxiety.

** These medications have been approved by the FDA for anxiety disorders.

not considered to be useful in the treatment of social anxiety disorder.[4]

Randomized trials have also supported the efficacy of benzodiazepines for social anxiety disorder (specifically, clonazepam and bromazepam, although the latter is not available in the United States).[4] However, benzodiazepines carry a risk of physiological dependency and withdrawal symptoms[40] and are not recommended for patients with coexisting depression or a history of substance abuse.[4,23] Benzodiazepines may be used as an initial or adjunctive therapy in patients with disabling symptoms that require rapid relief.[40,47] For patients who do not have a response to an SSRI or SNRI, augmentation with a benzodiazepine (clonazepam) or pregabalin is an option,[4,23,47] although more data are needed to inform treatment decisions. In a recent trial involving patients who did not have a response to sertraline and were then randomly assigned to augmentation with clonazepam or placebo or to a switch to venlafaxine, remission rates did not differ significantly among groups (27%, 17%, and 19%, respectively).[47]

Medications for Performance Anxiety

Beta-blockers such as propranolol are often used in patients with performance anxiety (e.g., musicians, actors, or persons doing public speaking). When taken approximately 1 hour before a performance, beta-blockers reduce autonomic symptoms such as tremor, sweating, and tachycardia.[3,4,23,40] Benzodiazepines are also used for performance anxiety on an as-needed basis, but they may cause sedation.[4] The data supporting the use of these agents are from randomized trials that have included persons (e.g., musicians and actors) without a formal diagnosis of performance anxiety.[4] Patients may benefit from a trial dose of a beta-blocker or benzodiazepine that is administered before they are exposed to a feared situation to check for side effects.[23]

AREAS OF UNCERTAINTY

The quality of many RCTs on the use of both psychotherapy and pharmacotherapy for the treatment of social anxiety disorder is limited. Additional well-conducted RCTs are needed to assess the effects of various treatments.[28,45] Furthermore, most trials of pharmacotherapeutic agents are short term and do not include long-term follow-up after treatment has been discontinued. Studies are needed to determine the most efficacious duration of treatment and to provide information on longer-term effects. In addition, more head-to-head trials that compare the long-term outcomes of pharmacotherapy and psychotherapy are required. Studies are needed to assess whether early treatment of social anxiety disorder may prevent a chronic course and more severe impairment. RCTs that assess the effects of beta-blockers and benzodiazepines on performance anxiety are also needed.[4,43]

GUIDELINES

Both the National Institute for Health and Care Excellence (NICE) and the Canadian Psychiatric Association have published guidelines for the treatment of social anxiety disorder.[12,42] The NICE guidelines recommend CBT over pharmacotherapy, whereas the Canadian guidelines consider both to be first-line treatments. The recommendations in this article are generally consistent with existing guidelines.

CONCLUSIONS AND RECOMMENDATIONS

The patient described in the vignette reported having social fears when giving a presentation, taking an examination, or meeting an authority figure. These fears were associated with palpitations, tremors, blushing, and sweating. He also reported avoidance of social contact. These symptoms are consistent with a diagnosis of social anxiety disorder. He should be asked about depression, other situations in which he becomes anxious, and substance abuse. For patients such as this young man, CBT (typically involving 14 to 16 sessions over approximately 4 months) or pharmacotherapy (typically with an SSRI) is likely to be effective. Pharmacotherapy tends to work more quickly, but CBT may have longer-lasting effects. Thus, if CBT is available, we generally recommend it in lieu of pharmacotherapy. However, if the patient prefers pharmacotherapy or does not have access to psychotherapy, we would initiate an SSRI at a low dose to minimize side effects and then increase the dose gradually as needed. Pharmacotherapy should be continued for at least 3 to 6 months after the patient has had a response. In addition, patients should be encouraged to reduce social avoidance and to increase social activities.[23]

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The NEW ENGLAND JOURNAL of MEDICINE

Classified Advertising Section

Sequence of Classifications

Classified Advertising Rates

We charge $8.22 per word per insertion. A 2- to 4-time frequency discount rate of $6.58 per word per insertion is available. A 5-time frequency discount rate of $6.37 per word per insertion is also available. In order to earn the 2- to 4-time or 5-time discounted word rate, the request for an ad to run in multiple issues must be made upon initial placement. The issues do not need to be consecutive. **Web fee:** Classified line advertisers may choose to have their ads placed on NEJM CareerCenter for a fee of $$90.00 per issue per advertisement. The web fee must be purchased for all dates of the print schedule. The choice to place your ad online must be made at the same time the print ad is scheduled. **Note:** The minimum charge for all types of line advertising is equivalent to 25 words per ad. Confidential reply boxes are an extra $75.00 per insertion plus 4 words (Reply Box 0000, NEJM). We will send the responses directly to you every Tuesday and Thursday. Purchase orders will be accepted subject to credit approval. For orders requiring prepayment, we accept payment via Visa, MasterCard, and American Express for your convenience, or a check. All classified line ads are subject to the consistency guidelines of NEJM.

How to Advertise

All orders, cancellations, and changes must be received in writing. E-mail your advertisement to us at ads@nejmcareercenter.org, or fax it to 1-781-895-1045 or 1-781-893-5003. We will contact you to confirm your order. Our closing date is typically the Friday 20 days prior to publication date; however, please consult the rate card online at **nejmcareercenter.org** or contact the Classified Advertising Department at 1-800-635-6991. Be sure to tell us the classification heading you would like your ad to appear under (see listings above). If no classification is offered, we will determine the most appropriate classification. Cancellations must be made 20 days prior to publication date. Send all advertisements to the address listed below.

Contact Information

Classified Advertising
The New England Journal of Medicine
860 Winter Street, Waltham, MA 02451-1412

E-mail: ads@nejmcareercenter.org
Fax: 1-781-895-1045
Fax: 1-781-893-5003
Phone: 1-800-635-6991
Phone: 1-781-893-3800
Website: **nejmcareercenter.org**

How to Calculate the Cost of Your Ad

We define a word as one or more letters bound by spaces. Following are some typical examples:

Bradley S. Smith III, MD.....	= 5 words
Send CV	= 2 words
December 10, 2007	= 3 words
617-555-1234	= 1 word
Obstetrician/Gynecologist ...	= 1 word
A	= 1 word
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 home 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 $8.22 per word, it equals $476.76. Because a reply box was requested, there is an additional charge of $75.00 for each insertion. The price is then $551.76 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 $90.00 per issue per advertisement and $160.00 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 nejmcareercenter.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.

Classified Ad Deadlines

Issue	Closing Date
August 3	July 14
August 10	July 21
August 17	July 28
August 24	August 4

Cardiology

NEW ENGLAND, MASSACHUSETTS BERKSHIRES, SPRINGFIELD — Exceptional opportunity for a Noninvasive Cardiologist with Heart Failure training/expertise. Join highly regarded, well-established, full spectrum 15-physician, 11-APP cardiology group. Affiliated with tertiary academic medical center with cardiac surgery service and Fellowship training program. Clinical teaching opportunities with Tufts-Baystate. Partnership position. Generous vacation/benefit package. "Five College Region" known for outstanding cultural venues, recreational options, educational resources. Easy access to Boston and NYC. Contact: Administrator, Pioneer Valley Cardiology. Phone: 413-781-5735; MDrecruitment@pvcardiology.com

PRESTIGIOUS, FULL-SERVICE, TEN-PHYSICIAN CARDIOLOGY GROUP — Seeking noninvasive or invasive university-trained cardiologist. Practice located in affluent Morris County, NJ. One hospital. Full partnership track. Forty-five minutes to NYC. Practice information at: www.morristowncardiology.com. E-mail CV to: Robert.mierzejewski@atlantichealth.org

CARDIOLOGY GROUP, LOCATED ON THE JERSEY SHORE — Close to New York City, is looking for a cardiologist. This is an excellent opportunity to join a busy Cardiology practice. Top salary and benefits offered. Collegial work environment, possible partnership track, and much more. Please e-mail: cardiologyresumehr@gmail.com

ASSISTANT/ASSOCIATE PROFESSOR — The Division of Cardiology at Columbia University Medical Center/NewYork-Presbyterian Hospital seeks a BC/BE cardiologist for a clinical faculty position at the rank of Assistant or Associate Professor. Candidates should have strong clinical and teaching qualifications and be Level III certified in echocardiography. Responsibilities will include attending in the echocardiography lab, supervision and teaching of fellows and medical students, and active participation in Departmental activities. Please send CV to: Marco Di Tullio, MD, md42@cumc.columbia.edu. Columbia University is an Affirmative Action/Equal Opportunity employer.

CARDIOLOGY — Great work/life balance. Excellent compensation. Low cost of living. Up to 12 weeks of vacation. Thriving/growing private physician run practice. 26 Cardiologists and nine mid-levels. Structural heart, vascular, CT, complex PCI, and Afib/VT ablations. Busy CT surgery program. Full EMR. Close to skiing and Adirondack lakes. Cardiology Associates of Schenectady, PC. Contact: dmeyers@heartdocs.com

A BUSY FIVE-PERSON CARDIOLOGY GROUP IS SEEKING A NON-INVASIVE CARDIOLOGIST — To join their practice in a highly desirable Philadelphia suburb. The responsibilities will be split between a busy office practice in two locations and hospital work at a single local high quality suburban hospital, offering the full spectrum of clinical non-invasive and invasive cardiology services. Call schedule would be one in six with an efficient work schedule at a single hospital. The position offers a competitive salary and benefits package. The philosophy of the practice is dedicated to providing the highest quality of care with an aim towards balancing work schedule and lifestyle schedule. For immediate consideration, please e-mail CVs to: DoylestownHealthHR@dh.org

Gastroenterology

NORTHERN NEW JERSEY — Group seeks BC/BE Gastroenterologist to join well-established large volume practice. Advanced fellowship training in EUS and ERCP preferred. Position includes participation in multidisciplinary conferences in an academic medical center. Competitive salary and benefits with partnership track if desired. Practice includes both an active hospital and outpatient practice and a licensed multi-room endoscopy center close to New York City. If interested, please contact: frps140@gmail.com

Geriatrics

SEEKING BE/BC IM OR FM PHYSICIAN — For a one-year Geriatric Fellowship at Maimonides Medical Center in Brooklyn, NY. Excellent clinical exposures with high quality faculty. Contact Joey Li, Academic Program Coordinator, at: 718-283-7089; or e-mail to: joli@maimonidesmed.org

Hematology-Oncology

GROUP OF TWO ONCOLOGISTS — Looking for 3rd one to join busy well-established practice in Hudson Valley, New York. 60 miles from NY City. Excellent compensation package with partnership track. Good opportunity to become senior partner in the practice. Send CV: ccareny@gmail.com

EXCEPTIONAL AND RARE OPPORTUNITY — Deep rooted small private practice looking for a motivated Hematologist/Oncologist. Washington, DC, area, best schools, sophisticated living. E-mail: skmd69@yahoo.com

HEMATOLOGIST/ONCOLOGIST IN SE NEW MEXICO — J-1 welcome. Large friendly practice. Moderate four-season climate with exceptional outdoor recreational opportunities. Exceptional schools, private and public, a state university, and culturally diverse. Twelve providers with 100 support staff, four modern/new clinics in Roswell, Carlsbad, and Hobbs. Ancillary services include lab and radiology. Compensation above national average plus bonus structure, complete benefits package. Please e-mail: dave.southward@kymeramedical.com or visit our website: http://kymeramedical.com

HEMATOLOGY/ONCOLOGY, SOUTHERN CALIFORNIA (PALM SPRINGS) — Private Oncology group in Southern California resort city seeking BC/BE oncologist. Competitive salary and benefits. Must have active California License. Please Send CV to: oncposition@gmail.com

Hospitalist

HOSPITALIST, NOCTURNISTS — The Division of General Internal Medicine, Department of Medicine at the University of Pittsburgh has a large academic hospitalist program. Our positions provide exciting opportunities for long term careers in patient care or a combination of patient care, teaching, and research. We are interested in hiring Nocturnists with a special interest in Oncology for the UPMC Hillman Cancer Center. Competitive compensation commensurate on qualifications/experience. Send letter of interest and CV to: Wishwa Kapoor, MD, 200 Lothrop Street, 933 West MUH, Pittsburgh, PA 15213; fax: 412-692-4825 or e-mail: Noskoka@upmc.edu. EO/AA/M/F/Vets/Disabled.

HOSPITALIST — The Division of General Internal Medicine, Department of Medicine at the University of Pittsburgh is building a large academic hospitalist program. The positions provide exciting opportunities for long term careers in patient care or a combination of patient care, teaching, and research. Competitive compensation commensurate on qualifications/experience. Send letter of interest and CV to: Wishwa Kapoor, MD, 200 Lothrop Street, 933 West MUH, Pittsburgh, PA 15213; fax: 412-692-4825 or e-mail: Noskoka@upmc.edu. EO/AA/M/F/Vets/Disabled.

Infectious Disease

BC/BE INFECTIOUS DISEASE SPECIALIST — To join busy Group Practice in Orlando, Florida. Practice consists of 100% Infectious Disease with both Hospital and Outpatient consultation. Competitive salary, medical benefits, and bonus package. No H-1 or J-1 Visa. Fax resume to: 407-896-9661, or e-mail to: cpacha@jamesmcclellandmd.com

BC/BE INFECTIOUS DISEASE PHYSICIAN — Midway Specialty Care Center Inc. is seeking a BC/BE Infectious disease physician. Must have MD or equivalent, and completion of residency in Internal Medicine and fellowship in Infectious Diseases. Possess or eligible for Florida medical license. Location: St Lucie County, Florida. H-1 or J-1 Visa welcome. If interested, e-mail resume to: midwayspecialtycare@yahoo.com; or fax resume to: 772-464-9750.

Internal Medicine (see also FM and Primary Care)

INTERNAL MEDICINE POSITION — Lemuel Shattuck Hospital is seeking a half-time (20 hours/week) BC/BE IM physician with/without subspecialty to supervise one PA/NP and provide clinical coverage to a chronic subacute inpatient service including chronic vent patients. LSH is located in Boston, and serves as a Mass. DPH teaching hospital affiliate of Tufts University School of Medicine. Competitive salary, full benefit package, and academic appointment at Tufts University School of Medicine will be offered. Please e-mail cover letter and CV to: Salah.alrakawi@massmail.state.ma.us. This is not a J-1 opportunity.

OUTPATIENT-ONLY INTERNAL MEDICINE WITH LOAN REPAYMENT AND SIGN-ON BONUS — The Central Maine Medical Group seeks BE/BC Internal Medicine physician to join cohesive, well-established, hospital-employed practice in Lewiston, Maine. We offer: up to $200K in medical student loan repayment, $50K sign-on bonus, up to $12K moving allowance, four-day work week/generous outpatient call, healthy work/life balance. Central Maine affords easy access to the coast and mountains where you can enjoy four seasons of outdoor activities. We have a growing arts and restaurant scene in a very safe affordable area to live and raise a family. To join our growing team, contact: Gina Mallozzi, Central Maine Medical Center, 300 Main Street, Lewiston, ME 04240. E-mail: MallozGi@cmhc.org; Fax: 207-344-0696; Call: 800-445-7431; or visit our website: http://recruitment.cmmc.org

INTERNAL MEDICINE, HUDSON COUNTY, NJ — Well-established, busy multispecialty NCQA-PCMH practice is seeking full-time internist. Competitive salary and benefit package. Please e-mail CV to: Lourdes@medmagic.net

BC/BE INTERNAL MEDICINE OR FAMILY PRACTICE TO JOIN MEDICAL GROUP IN SOUTHERN CALIFORNIA — Competitive salary, liberal benefits, eligibility for H-1B Visa, if needed. Full-time position. We welcome NPs also! Please send your CV to: Julie Bash, Manager, QMG, Inc., 264 North Highland Springs Avenue, Suite 2A, Banning, CA 92220 or fax to: 951-845-7256; e-mail to: qazimed@airenetworks.com

Nephrology

FULL-TIME NEPHROLOGIST NEEDED IN CENTRAL CONNECTICUT — BC/BE IM and Nephrology, Connecticut license. E-mail CV to: rezartabejleri@gmail.com; or call for Rezarta, at: 203-758-1800.

FULL-TIME NEPHROLOGIST NEEDED IN CENTRAL NEW JERSEY — BC/BE IM and Nephrology, NJ license. E-mail resume to: Lincolnsc@gmail.com; or call: 732-241-1872 and ask for Lincoln.

NORTHERN NEW JERSEY — Looking for a Clinical Nephrologist and a Transplant Nephrologist to join well-established 100% nephrology practice. Spanish speaking is desirable. Send CV: melmdbbs@aol.com

COLUMBIADOCTORS IS LOOKING FOR A NEPHROLOGIST — To practice in Orange and Rockland County. Located in a bedroom community of NYC, the practice consists of a growing multispecialty academic practice focused on quality. This is a tremendous opportunity for professional development and teaching in a near private practice setting, the best of both worlds. Please e-mail CV to: sl3329@cumc.columbia.edu

NEPHROLOGIST — The Nephrology Division at the University of Rochester School of Medicine is recruiting additional faculty who have a strong background in clinical nephrology, have a desire to teach, and be involved in research. E-mail CV and cover letter to: David_Bushinsky@urmc.rochester.edu

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Neurology

NEUROLOGIST, PHOENIX, ARIZONA — Work locations (1) 9305 West Thomas Road, Phoenix, AZ 85037; (2) 9201 West Thomas Road, Phoenix, AZ 85037. Submit resumes to: Jamie Ross, Office Manager, Jeffrey S. Gitt, DO, P.C., d/b/a Center for Neurology & Spine, 3805 East Bell Road, Suite 2400, Phoenix, AZ 85032.

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URGENT CARE/PRIMARY CARE — Seeking full-time MD to join well-established hybrid practice in Springfield, Massachusetts. Partnership option. X-ray, lab, PT on site. Suboxone program and occupational medicine. Please e-mail resume to: pagpac@hotmail.com

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PRIMARY CARE PHYSICIAN NEEDED IN COLORADO SPRINGS CLINIC — Large metropolitan family oriented city. For Non-Profit primary care clinic. FP or Internist with or without subspecialty. H1-B, J-1, available. Salary w/benefits. Send resume: Anjujoshi50@yahoo.com

Rheumatology

MAINE — Central Maine Medical Center, a multispecialty regional referral center, is looking for a BC/BE Rheumatologist to join its well-established employed practice. We work collaboratively with a skilled network of medical specialists, receive referrals from a large base of primary care physicians, and have an active infusion center. Interest in diagnostic and procedural ultrasound is a plus! Central Maine's location is ideal as we are close to the ocean, lakes, and mountains, offering unlimited recreational possibilities. Interested candidates, send CV or call: Julia Lauver, Central Maine Medical Center, 300 Main Street, Lewiston, ME 04240. Fax: 207-795-5696; e-mail: JLauver@cmhc.org; or call: 800-445-7431. Not a J-1 opportunity.

Chiefs/Directors/Dept. Heads

THE DEPARTMENT OF MEDICINE AT UNIVERSITY OF PITTSBURGH AND UPMC — Is seeking an experienced physician as an overall director of its Academic Hospitalist Programs within five teaching hospitals. The individual will be responsible for development of the strategic, operational, clinical, and financial goals for Academic Hospital Medicine and will work closely with the Medical Directors of each the five Academic Hospitalist programs. We are seeking a candidate that combines academic and leadership experience. The faculty position is at the Associate or Professor level. Competitive compensation based on qualifications and experience. Requirements: Board Certified in Internal Medicine, significant experience managing a Hospitalist Program, and highly experienced as a practicing Hospitalist. Interested candidates should submit their curriculum vitae, a brief letter outlining their interests, and the names of three references to: Wishwa Kapoor, MD, c/o Kathy Nosko, 200 Lothrop Street, 933 West MUH, Pittsburgh, PA 15213; Noskoka@upmc.edu; fax: 412-692-4825. EO/AA/M/F/Vets/Disabled.

Faculty/Research

PART-TIME CLINICAL AND PART-TIME RESEARCH POSITION IN CENTRAL MAINE — Central Maine Medical Center and Maine Research Associates seek a physician to work 50% in your specialty and 50% as medical director of its clinical research company. Maine Research Associates, with offices located in both Lewiston and Auburn, is a full service clinical trial research center with certified coordinators, over 25 years of experience, and is physician led. Central Maine Medical Center, located in Lewiston, is a 250-bed, Level II trauma center and is part of a three-hospital system which serves the populations of western and central Maine. Qualified candidates will be BE/BC in your specialty. We have a variety of inpatient and outpatient clinical positions from which to choose. Candidates will also possess experience as a Principal Investigator on clinical trials and will understand the clinical research industry, institutional review boards (IRBs), and the general regulatory requirements of safe and responsible clinical research. The successful candidate will be able to promote research and foster development of a portfolio of clinical trials as well as advocate for our organization's continuing commitment to research. This will involve working with a large and diverse medical community and potential clinical research sponsors. Our current primary research interests include, but are not limited to, lipids, heart failure, oncology, diabetes, and Alzheimer's disease. Our vision is to expand our trial portfolio across a diverse range of clinical disciplines. Interested candidates should contact: Julia Lauver, Medical Staff Recruitment, Central Maine Medical Center, 300 Main Street, Lewiston, ME 04240. Call: 800-445-7431; fax: 207/755-5854; e-mail: LauverJu@cmhc.org. Visit our websites, too! http://www.maineresearchassociates.com/ https://www.cmmc.org

Graduate Training/ Residency Programs (see also Related Specialties)

BOSTON, MASSACHUSETTS — WikiDoc.org seeks applicants for a research fellowship in medical education/clinical research. No salary. Requires J-1 research Visa. Visa sponsorship offered. Contact Megan Merlo at: mmerlo@bidmc.harvard.edu

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Beebe Healthcare

Atrius Health

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Central Maine Heart and Vascular Institute
The Central Maine Medical Family

MASSACHUSETTS GENERAL HOSPITAL

Heart Failure Program Medical Director with an appointment to the Massachusetts General Hospital

Central Maine Heart and Vascular Institute (CMHVI) in Lewiston, Maine and Massachusetts General Hospital Heart Center are seeking an enthusiastic cardiologist with expertise in Heart Failure to serve as Medical Director to lead the development and expansion of CMHVI's Heart Failure Program. Successful candidates should possess a M.D. or M.D./Ph.D., board certified, excellent leadership skills, clinical expertise and a successful background in quality, performance improvement and program development. The CMHVI HF Program Medical Director will have dual reporting responsibilities to the Section Head of the Massachusetts General Hospital (MGH) Heart Failure Program and the Division Chief of Central Maine Heart and Vascular Institute.

CMHVI is a unique facility with a service line model offering innovative programs in minimally invasive valve surgery, transcatheter valve therapies, structural heart disease, population health with a particular focus on genetic lipoprotein disorders and contemporary diagnostic and therapeutic cardiac electrophysiology. This is an exceptional opportunity to conceive, lead and build an Institute-wide effort in contemporary heart failure management and mechanical circulatory support. Central Maine Healthcare includes a large number of Primary Care providers, which creates an abundant referral base. Sophisticated medical and surgical sub-specialty ancillary systems support the work of the Institute.

Established in 1811, MGH is a 1,000-bed facility in Boston, MA and is the original and largest teaching hospital of Harvard Medical School.

Central and Mid Coast Maine, including the Lewiston/Auburn community, provides an exceptional place in which to live and raise a family. The area offers a wide range of schooling and housing options and provides many cultural opportunities, all centrally located to both the mountains and coast.

To learn more about this exceptional opportunity, please contact:

Dr. Andrew Eisenhauer, Division Chief, CMHVI at: eisenhan@cmhc.org or 207/786-1647
and send CV to Julia Lauver, CMMC Physician Recruiter at: lauverju@cmhc.org or 800/445-7431

UFHealth CANCER CENTER | ORLANDO HEALTH®

Medical Oncologist – GYN Malignancy focus

The UF Health Cancer Center - Orlando Health is seeking a BC/BE **Medical Oncologist; with a focus on GYN Malignancies**, to join one of our Central Florida community based multi-disciplinary integrated facilities where sub specialization and Clinical Trial enrollment are encouraged. The candidate will join experienced practitioners at a fully equipped facility with newly designed and installed chemotherapy, radiation and laboratory capabilities. The UF Health Cancer Center - Orlando Health is part of an 8 hospital health system with over 500 employed physicians and a large primary care physician practice. It is the only cancer center in Central Florida to be recognized by the State of Florida as a Center of Excellence. This is an employed position in a desirable area with competitive salary and benefits and an emphasis on work-life balance.

Interested candidates should e-mail a letter of interest and resume to:
Lindsay.Jacques@orlandohealth.com.

Benefits of Practicing at UF Health Cancer Center-Orlando Health:

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- Multiple daily multidisciplinary meetings available either in person or by telemedicine
- Excellent lifestyle: Conveniently located in Orlando with access to world class restaurants and entertainment, excellent public and private schools, 3 medical schools, diverse neighborhoods, outdoors activities, Florida beaches, a thriving cultural scene and International Airport
- Academic Affiliations with the University of Florida
- Practice development opportunities
- Competitive applicants

UNIVERSITY of ROCHESTER

Infectious Diseases Division
Chief and Professor/Associate Professor

The Department of Medicine at the University of Rochester (UR) is recruiting a new **Chief of the Division of Infectious Diseases**. We seek an individual with an M.D. or M.D./Ph.D. degree and a track record of excellence in teaching, research, and mentoring of faculty to lead all division activities. The applicant should be clinically active in Infectious Diseases with ABIM certification or equivalent qualification preferred.

The successful applicant will lead a faculty group located in an 830-bed tertiary care teaching hospital, Strong Memorial Hospital providing the full spectrum of infectious diseases services in the in-patient and ambulatory environments. This includes general as well as transplant infectious diseases services.

The Division of Infectious Diseases is an international leader in patient care, education and research. The research portfolios include major well-funded research programs in Human Immunodeficiency Virus (HIV), Influenza, and Respiratory Syncytial Virus (RSV), and other bacterial and viral respiratory pathogens with a focus on vaccine development, clinical trials, and translational research. The Division is home to an ACGME accredited fellowship program in Infectious Diseases.

Appointment to the full-time faculty would be at the rank of Associate Professor or full Professor, with or without tenure, commensurate with qualifications. Applications will be accepted until the position is filled.

The University of Rochester is one of the nation's leading academic medical centers and is a leader in translational research and infectious diseases. The University maintains a strong and active program in faculty development. The Rochester area affords the best in stress-free living, including affordable housing; easy commutes; highly ranked public schools and varied cultural, recreational and outdoor activities.

Please Apply at: www.rochester.edu/JobOpp
Go to: Faculty Openings at School of Medicine and Dentistry
Go to: Medicine
Apply to Job Posting #200571
Send Questions to: Patricia_Sime@URMC.Rochester.edu

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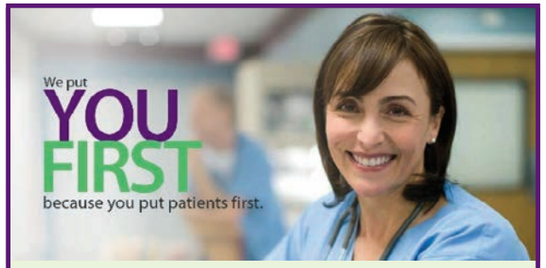

Saint Mary's Hospital in Waterbury, Connecticut – a member of Trinity Health New England, the nation's second-largest nonprofit health system is seeking the following BC/BE:

- Primary Care Physician – Internal Medicine & Family Medicine
- Inpatient Psychiatrist

We offer an extremely competitive base salary with incentives, an excellent benefits package and a comfortable work/life balance!

Saint Mary's Hospital is a Catholic teaching hospital that has been serving patients in Waterbury, CT and our surrounding communities since 1909.

The Waterbury area is home to some 300,000 residents and offers a tremendous selection of welcoming neighborhoods in which to live, with excellent public and private schools – plus great restaurants, shopping, music, museums and historical areas. You'll also enjoy an easy commute and access to dependable air and rail passenger services. Waterbury is also located near the coastline, in close proximity to both New York & Boston.

Interested candidates contact:

Elena Geanuracos
Physician & Advanced Practitioner Recruitment Specialist
***at:* elena.geanuracos@stmh.org**
***or:* 203.709.6223**

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Senior Director, Provider Recruitment and Engagement

Emerson.Moses@ReliantMedicalGroup.org

PRESBYTERIAN

New Mexico

Presbyterian Healthcare Services (PHS) is New Mexico's largest, private, nonprofit, healthcare system based in Albuquerque. Presbyterian Medical Group employs over 700 providers, representing over 50 specialties. We have openings in the following specialties for BE/BC physicians:

- Cardiovascular Surgery
- Emergency Medicine
- ENT
- Family Medicine
- Gynecologic Oncology
- Hematology/Oncology
- Hospitalist
- Internal Medicine
- Neurology
- OB/GYN
- Pediatric Pulmonary
- Pediatric Surgery
- Rheumatology
- Urology
- Vascular Surgery

Presbyterian Healthcare Services is based in Albuquerque with five rural locations in New Mexico. These opportunities offer a competitive salary; paid malpractice (occurrence-type); relocation; CME allowance; 403(b) w/match; 457(b); health, life, AD&D, disability insurance; dental; vision; pre-tax health and child care spending accounts. EOE.

For more information in Albuquerque contact: **Tammy Duran;** ***Tel:*** **505-923-5567** ***or e-mail:*** **tduran2@phs.org;** ***Fax:*** **505-923-5007**

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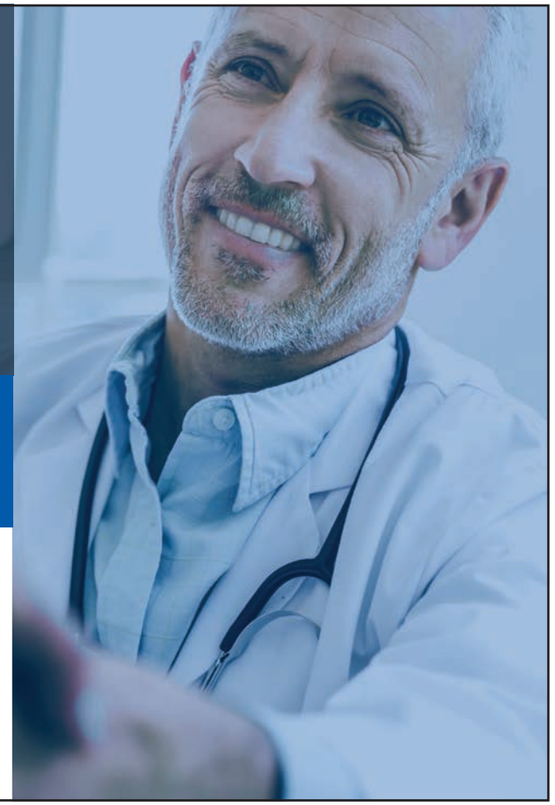

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David Geffen School of Medicine | UCLA Health

University of California, Los Angeles
Department of Medicine
Full-time faculty positions in Primary Care

The University of California, Los Angeles, Division of General Internal Medicine and Health Services Research has Full-time faculty openings in Primary Care. Positions are available in multiple practices in the Greater Los Angeles area. Minimum 36 hours/week of direct patient care and supervision of residents and medical students in inpatient and outpatient settings. Demonstrated skill in clinical teaching and practice required.

UCLA Health has provided high-quality health care and the most advanced treatment options to the people of the greater Los Angeles region and the world for more than 60 years. UCLA Health includes four hospitals on two campuses — Ronald Reagan UCLA Medical Center; UCLA Medical Center, Santa Monica; Mattel Children's Hospital UCLA; and Resnick Neuropsychiatric Hospital at UCLA — and more than 150 primary and specialty offices throughout Southern California, including the South Bay and North West Valley campuses. UCLA Health is consistently ranked as one of the top hospitals and the best in the Western United States in the national rankings by *U.S. News and World Report*. UCLA Health ranks Best in the West for 26 consecutive years and now No. 3 in the nation in *U.S. News & World Report*'s survey of "America's Best Hospitals." UCLA Medical Group was awarded the Gold Level Achievement for clinical quality by the California Department of Managed Health Care.

The University of California is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, age or protected veteran status. For the complete University of California non-discrimination and affirmative action policy see: UC Nondiscrimination and Affirmative Action Policy.

To apply, please visit:
https://recruit.apo.ucla.edu/apply/JPF02805

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tom_green@iasishealthcare.com

COLLEGE OF MEDICINE AND LIFE SCIENCES
THE UNIVERSITY OF TOLEDO

Assistant/Associate Professor – Hematology and Oncology

The Department of Medicine of the University of Toledo College of Medicine & Life Sciences has immediate opportunities, and invites applications and nominations for the position of Assistant or Associate Professor of Medicine in the Division of Hematology and Oncology. The recent Academic Affiliation between the College of Medicine and the ProMedica Health System has created remarkable growth opportunities in cancer research, education, and patient care. Substantial resources are available to expand the Division building on current strengths of the College, the Department and the Eleanor N. Dana Cancer Center.

The candidate must have the creativity, flexibility, and vision to support the goals and mission of the department and division, be committed to medical and graduate education, and be prepared to help the program grow.

The attractive 550-acre University of Toledo Health Science Campus includes the University of Toledo Medical Center and the Colleges of Medicine & Life Sciences, Nursing, Health Science, and Pharmacy & Pharmaceutical Sciences. Information about the University can be obtained on the website:

www.utoledo.edu

Candidates should send a curriculum vitae, a cover letter summarizing clinical, educational, and research background to:

Ms. Amber Rice
Amber.Rice@utoledo.edu

The University of Toledo is an Equal Access, Equal Opportunity, Affirmative Action Employer and Educator

UT Southwestern Medical Center

Chief, Division of Hematology & Oncology

The University of Texas Southwestern Medical Center, Department of Internal Medicine, is seeking an outstanding individual to serve as Chief of the Division of Hematology & Oncology. Candidates must have a distinguished record of scholarly achievement, a strong commitment to patient care and graduate medical education, and proven leadership skills. A demonstrated ability to maintain an externally funded research program will receive high priority in the selection process. Applicants must be board certified in hematology, oncology, or both, and eligible for Texas medical licensure. The position is available at a rank of Professor or Associate Professor depending on qualifications. Interested applicants should submit a letter of application, current curriculum vitae, and 3 letters of reference to:

David H. Johnson, M.D., MACP, FASCO
Donald W. Seldin Distinguished Chair in Internal Medicine
Professor & Chairman, Department of Internal Medicine
UT Southwestern School of Medicine
5323 Harry Hines Blvd.; Rm. G5.210A
Dallas, TX. 75390-9030
Email: David.Johnson@UTSouthwestern.edu

UTSW is an Affirmative Action/Equal Opportunity Employer. Women, minorities, veterans and individuals with disabilities are encouraged to apply.

Endocrinologist/Diabetogist:
If You're the Best, why not JOIN the Best?

The **Albany Stratton VA Medical Center** in **Albany, NY (135 miles North of New York City)** is actively recruiting for a full-time Physician – Endocrinology/Diabetology Specialist, Board Certified or Board Eligible, to join our Medical Department.

This is an amazing opportunity to provide excellent Endocrinology/Diabetology services to our veteran patients, in an Academic environment, working closely with leading Endocrine Specialist and helping to train a new generation of Endocrinology/Diabetology. The Endocrinology/Diabetology Specialist will perform indicated services for conditions in both in-patient and out-patient clinical settings, including telemedicine. This care must be delivered in accordance with hospital policy and meet community standards and pertains to outpatients as well as inpatients. The Endocrinology/Diabetology Specialist works within her or his privileges at all times. The Endocrinology/Diabetology Specialist is expected to maintain current knowledge and skills. She or he must be able to deliver interventions throughout the full spectrum of Endocrinology/Diabetology Care; i.e. s/he is expected to maintain good diagnostic and therapeutic acumen. Stratton VAMC is a tertiary care teaching facility affiliated with Albany Medical College (AMC), providing first class training to students, residents, and fellows. The successful candidate must be eligible for a faculty appointment at Albany Medical College and will collaborate with specialists from AMC Endocrine Group.

NOTE: VHA is an equal opportunity employer. Physicians will be paid commensurate with experience, using VA's market based physician pay system.

Albany is a cultural and historical center of the Capital district and offers: **great staff, family oriented environment, and close proximity to great secondary schools and colleges such as Rensselaer Polytechnic Institute, Russell Sage, and SUNY Albany!**

Interested candidates who wish to inquire about this opportunity may contact:

David Liddle at 518-626-7091 or david.liddle@va.gov
You may also apply online at www.usajobs.gov
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For more information, please contact Roberta Margolis directly at 203.663.9335 or email your CV and references to roberta.margolis@comphealth.com.

Quick Facts

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CHA Cambridge Health Alliance | AFFILIATED WITH Beth Israel Deaconess Medical Center | MassGeneral Hospital for Children | Harvard Medical School Teaching Hospital

Cambridge Health Alliance
Primary Care Opportunities

Cambridge Health Alliance (CHA), a **Harvard Medical School** and **Tufts University School of Medicine** teaching affiliate, is an award winning, academic public healthcare system which receives national recognition for innovation and community excellence. Our system includes three hospital campuses as well as an established network of primary and specialty practices in the Cambridge, Somerville and Boston's metro-north area. Our practices serve an ethnically and socio-economically diverse patient population.

- Opportunities available for physicians specializing in Family Medicine, Internal Medicine, Pediatrics, Med/Ped, and Family Medicine with Obstetrics
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Candidates should be BE/BC and passionate about working with our underserved, multicultural patient population. Our robust primary care department is expanding and incoming physicians will work with a collegial group of providers who share our mission and values.

Please send CVs to: Lauren Anastasia via email lanastasia@challiance.org or by fax at (617) 665-3553 www.challiance.org

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

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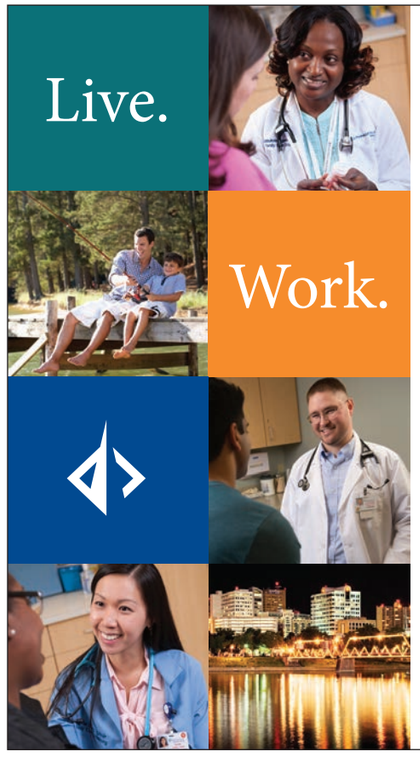
If interested, please email your CV to:
michelle.wimberly@cardio.com
You may learn more about CIS at **www.cardio.com**.



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Gina Mallozzi
Central Maine Medical Center
300 Main Street
Lewiston, Maine 04240
fax: 207-344-0696
E-mail: MallozGi@cmhc.org
call: 800/445-7431

or visit our website:
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Candidates must be U.S. citizens. Contact:

VANCHCS Physician Recruiter
10535 Hospital Way (05PRO)
Mather, CA 95655

or email: crystal.keeler@va.gov

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(Covering Consultative Services Only!)

Central Maine Heart & Vascular Institute (CMHVI) in Lewiston, Maine, seeks General Cardiology physicians to join our established program. We are a unique facility offering innovative programs in minimally invasive valve surgery, transcatheter valve therapies, structural heart disease, population health with a particular focus on genetic lipoprotein disorders and contemporary diagnostic and therapeutic cardiac electrophysiology. The Central Maine Medical Family includes a large number of Primary Care providers, which creates an abundant referral base as well as a sophisticated medical and surgical subspecialty support system to support the Institute.

Maine is a wonderful state in which to raise a family, with a broad range of schooling and housing options. We are centrally located both near the mountains and coast providing easy access to an abundance of activities, ideal for the outdoor enthusiast yet close enough to Boston to take advantage of all it has to offer.

Interested candidates should submit a letter of application and curriculum vitae to:

Dr. Andrew Eisenhauer
Medical Director of CMHVI
***at:* eisenhan@cmhc.org *or* 207/786-1647**
***or send CV to* Julia Lauver,**
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Interested physicians should send CV to:

JKCooper@bmcllp.net
or fax to 503-382-7706

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Professor of Pediatrics (Boston Children's Hospital) and Genetics (Harvard Medical School)

The Departments of Cardiology at Boston Children's Hospital (BCH) and Genetics at Harvard Medical School (HMS) are jointly recruiting for an investigator at the rank of Professor or Associate Professor of Pediatrics (BCH) and Genetics at HMS to serve as the Director of basic science research in Cardiology at BCH. Appointment as an Associate Member of the Broad Institute will also be considered for appropriate candidates. The successful candidate's research should align with both departments and focus on translating fundamental discoveries to the understanding, diagnosis and treatment of heart disease. Topics may be in, but not limited to, cardiac and musculoskeletal development and disorders, computational biology, stem cell biology, and/or developmental biology. This joint recruitment seeks to capitalize on the strengths of existing faculty and to enhance and expand the translational research opportunities embedded in both departments. The successful candidate is expected to direct innovative and independent research and to participate in the teaching and other activities of both departments. Suitable candidates will have an M.D., Ph.D. or M.D.-Ph.D. International applicants are welcome. For further information about department, please see web page:

http://genetics.med.harvard.edu
or **http://www.childrenshospital.org/cardiology**

Interested candidates should forward a cover letter, curriculum vitae and three referees to provide letters of recommendations by **August 15, 2017** to :

Christopher Walsh, M.D., Ph.D. c/o Suet Yip at:
suet.yip@childrens.harvard.edu

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

BOCA RATON REGIONAL HOSPITAL | CHRISTINE E. LYNN WOMEN'S HEALTH & WELLNESS INSTITUTE

Primary Care - Women's Health

The Christine E Lynn Women's Health and Wellness Institute, part of Boca Raton Regional Hospital, in idyllic Boca Raton, Florida, is seeking to recruit a physician leader to develop a comprehensive, sophisticated women's general medicine practice. The Institute provides women in South Florida with a continuum of care that addresses a woman's unique medical needs. The strikingly beautiful 46,000 square-foot facility offers the expertise of renowned clinicians, the most advanced imaging technology in the region and a myriad of holistic and educational programs, as well as support groups.

Boca Raton Regional Hospital is a 400-bed, advanced academic medical center with more than 800 primary and specialty physicians on staff. With a host of national and regional accolades for its quality of care, Boca Regional has been recognized by *U.S. News & World Report* as a Top Ranked Regional Hospital and is the highest ranked hospital in Palm Beach County.

The successful candidate must have a background in internal medicine and preventive cardiology, with a passion for women's health.

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- Access to an outstanding team through our integrated healthcare system
- Competitive compensation and benefits

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- Internal Medicine Faculty
- Internal Medicine
- Maternal-Fetal Medicine
- Medical Oncology
- Nephrology
- Neurology
- Neurohospitalist
- Neurosurgery
- Occupational Medicine
- Ophthalmology-Retina Specialist
- Pediatrics
- Pediatric Gastroenterology
- Physical Medicine & Rehabilitation
- Psychiatry
- Psych Hospitalist
- Pulmonary Critical Care
- SameDay Care
- Radiology

Billings Clinic is nationally recognized for clinical excellence and is a proud member of the **Mayo Clinic Care Network.** Located in Billings, Montana – this friendly college community is a great place to raise a family near the majestic Rocky Mountains. Exciting outdoor recreation close to home. 300 days of sunshine!

#1 Hospital in Montana – U.S.News & World Report

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PHYSICIAN OPPORTUNITIES NEAR BOSTON, MA

ONE TEAM. ONE FOCUS.

One thing sets North Shore Physicians Group apart–our team based model of care which is founded on the principle that physicians, nurses, care managers, and other providers working together will provide higher quality and a better patient experience. Today, that team focus drives our physicians to be leaders of quality of care, patient safety and process improvement initiatives throughout NSPG.

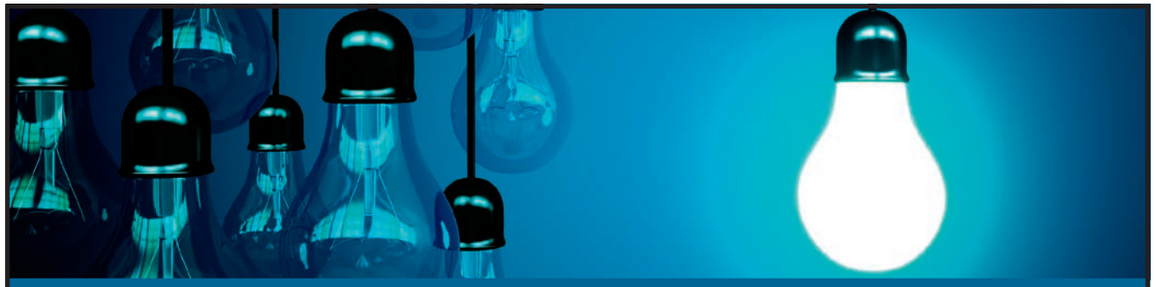
Current Opportunities Available Include:

- Primary Care – IM, FM, and Med/Peds
- Emergency Medicine
- Hospitalist – Day rounders, Nocturnists, and Admitters
- Adult Psychiatry – Inpatient and Outpatient
- Geriatrics

Do you share our philosophy?
It's time to join our team.

NSMC NORTH SHORE Physicians Group

To apply or learn more about our opportunities visit us at http://joinnspg.org/NEJM or email your CV and letter of interest to NSPGphysicianrecruiters@partners.org.



a bright future for your clinical career

DHproviders.org

The Dartmouth-Hitchcock health system stretches over New Hampshire and Vermont and offers the quintessential New England experience. With no income or sales tax, this beautiful area combines history, industry and business and has been ranked consistently as one of the best places in the U.S. to live and work. The D-H system includes our academic medical center in Lebanon, NH, 4 affiliated community hospitals and 30 ambulatory clinics across the region. With destinations like Boston, New York, Montreal, the seacoast and ski country within driving distance, the opportunities - both career and personal - truly make New Hampshire and Vermont the ideal place to work and play. Visit our Provider Career Site below to learn more about all we have to offer a Primary Care physician.

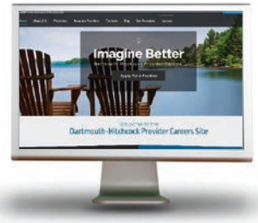



Dartmouth-Hitchcock

Dartmouth-Hitchcock is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, veteran status, gender identity or expression, or any other characteristic protected by law.

We have careers available in the following areas:

- **Primary Care** - FM, IM, Pediatrics
- **Psychiatry** - Adult, Adolescent, Addiction, Geriatrics
- **Neurology** - General, Headache Medicine
- **Medicine** - Endocrinology, Weight and Wellness, Infectious Disease, Pulmonary/CC, Nephrology, Cardiology, Hospital Medicine
- **Ophthalmology** - Retina, Glaucoma
- **Orthopaedics**
- **Urgent Care/Emergency**
- **Palliative Care**
- **Anesthesiology**
- **Occupational Medicine**
- **Dermatology**
- **Urology**
- **Otolaryngology – Otologist**
- **Radiology**



Learn more and apply at: DHproviders.org

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For 46 years, On Lok Lifeways has been making a difference in the lives of Bay Area seniors by delivering healthcare and long-term care services that enable them to live with dignity at home for as long as possible. The "Program of All-inclusive Care for the Elderly" (PACE) that we originated is globally recognized as an outstanding model of integrated geriatric care and services.

Join a collaborative, interdisciplinary team that includes nurses, social workers, nutritionists, occupational and physical therapists, specialty physicians and other care professionals. Your unique skills will enrich and help promote innovative care solutions, and you will enjoy a multitude of benefits, including:

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- 100% managed care – no billing or paperwork
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Please email your resume to careers@onlok.org

On Lok Lifeways is an EOE/AA/M/F/D/V employer.

University Hospitals

Rainbow Babies & Children's

Chair, Department of Pediatrics & Pediatrician-in-Chief
University Hospitals Rainbow Babies & Children's Hospital
University Hospitals, Cleveland, OH

University Hospitals Rainbow Babies & Children's Hospital and the UH system have initiated a national search to identify candidates to serve as Chair of the Department of Pediatrics and Pediatrician-in-Chief.

The organizations are seeking a transformational physician leader capable of establishing and implementing a vision for the creation of a nationally respected Pediatric Service Line across the $4.0 billion University Hospitals system.

The successful M.D. or M.D./Ph.D. candidate with a sustained record of leadership accomplishment, operational expertise, and scholarly activity will be qualified to be appointed at the rank of Associate or Full Professor and will be eligible for an unrestricted medical license in the state of Ohio.

For details, please contact:

Marcel Barbey at **(682) 223-5779**
or via email:
Marcel.Barbey@millicansolutions.com

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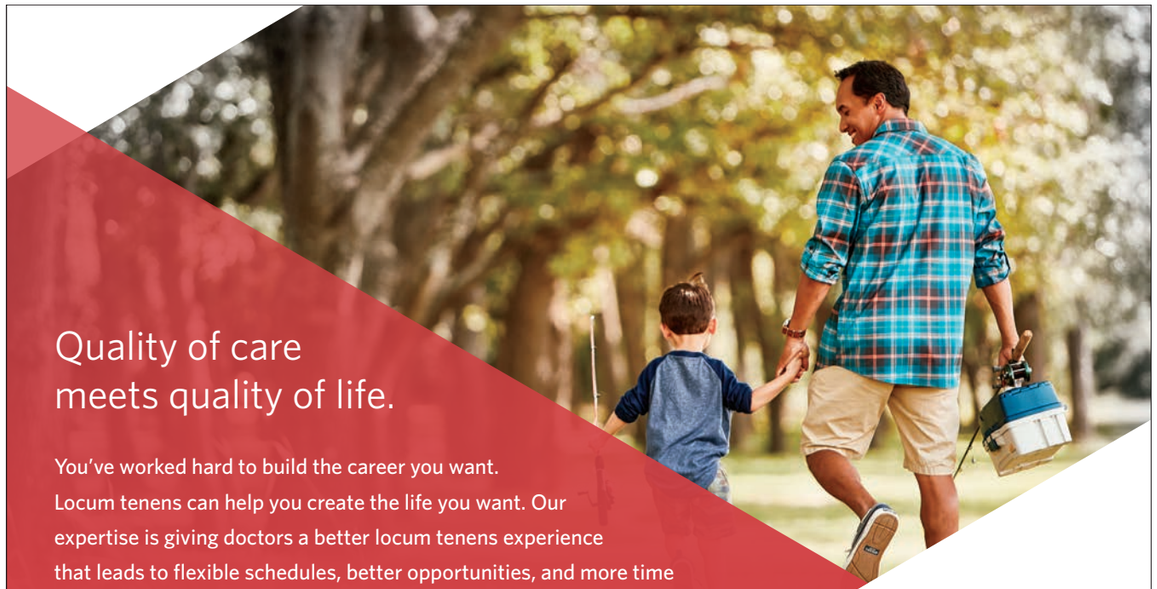

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U.S.ARMY

Northwestern Medicine Lake Forest Hospital

Join the thriving Hospitalist team at Northwestern Medicine Lake Forest Hospital. We seek a physician who is dedicated to exceptional clinical care, quality improvement and medical education.

ABOUT US

Northwestern Medicine Lake Forest Hospital is a community hospital with nearly 200 beds and is located approximately 30 miles north of downtown Chicago in scenic and charming Lake Forest, IL. Care is provided through the main hospital campus in Lake Forest and multiple outpatient facilities including one in Grayslake, IL, which also includes a free-standing emergency center. Lake Forest Hospital is served by a medical staff of more than 700 employed and affiliated physicians. It continues to be recognized by *U.S. News & World Report* as one of the top hospitals in Illinois and Chicago and also received Magnet® re-designation in 2016, the gold standard for nursing excellence and quality care. A new state-of-the-art hospital facility is scheduled to open in 2018.

Northwestern Medicine is a growing, nationally recognized health system that provides world-class care at seven hospitals and more than 100 locations in communities throughout Chicago and the north and west suburbs. Together with Northwestern University Feinberg School of Medicine, we are pushing boundaries in our research labs, training the next generation of physicians and scientists, and pursuing excellence in patient care.

Our vision and values are deeply rooted in the idea that patients come first in all we do. We value building relationships with our patients and their families, listening to their unique needs while providing individualized primary, specialty and hospital-based care. Our recent affiliations and ongoing growth make it possible for us to serve more patients, closer to where they live and work.

Northwestern Memorial HealthCare, a nonprofit organization, is the corporate parent of Northwestern Medicine and all of its entities, including Northwestern Medicine Lake Forest Hospital, Northwestern Memorial Hospital, Northwestern Medicine Central DuPage Hospital, Northwestern Medicine Delnor Hospital, Northwestern Medicine Kishwaukee Hospital, Northwestern Medicine Valley West Hospital and Marianjoy Rehabilitation Hospital, part of Northwestern Medicine.

If you are interested in advancing your career as a Hospitalist with Northwestern Medicine Lake Forest Hospital, please email your CV and cover letter to:

LFHMRecruitment@nm.org