In Demand Specialties:
Primary Care, Psychiatry, and Neurology

INSIDE

Career: Medscape Physician Compensation Report 2019: Earnings Up, but Satisfaction with Compensation Is a Mixed Bag. Pg. 1

Career: Targeting Physician Burnout. Pg. 5


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Jeffrey M. Drazen, MD

Medscape Physician Compensation Report 2019: Earnings Up, but Satisfaction with Compensation Is a Mixed Bag

The annual Medscape physician compensation report delivered a mix of good news and not-so-good news. In the first category, despite the generally tumultuous economic and policy environment in health care this year, compensation is stable or increasing. Across all physicians, the average compensation is now $313,000 — solidly above $300,000 for the first time. Notably, primary care physicians (PCPs) continue to see substantial incremental annual gains: PCPs now earn $237,000 on average, Medscape reports, up 21.5 percent from the $195,000 average in 2015. Within the primary care specialties, gaps are lessening. Internists’ annual compensation averaged $234,000, family medicine physicians earned $231,000, and pediatricians $225,000.

The top flyers on the compensation chart include several specialties that have long been in the highest earners, along with a few newcomers. Orthopedics took the first spot, at $482,000, followed by plastic surgery at $471,000 and otolaryngology at $461,000. Cardiology took the fourth spot at $430,000, and dermatology and radiology shared the fifth, at $419,000. Cardiology took the fourth spot at $430,000, and dermatology and radiology shared the fifth, at $419,000.

Public health and preventive medicine was the lowest-earning specialty, at $209,000, substantially below pediatrics, which had the second lowest compensation.

Gender gap — still a big issue

For female physicians awaiting the closing of the longstanding pay disparity between men and women in medicine, the news from the Medscape report, which surveyed 19,328 physicians in more than 30 specialties, is not good. Across the spectrum, male physicians earned 25 percent more than their female counterparts, a marked downturn from last year’s survey, which found an 18 percent difference; the gap was 16 percent in 2017 and 17 percent in 2016. For all survey years, the figures include only physicians

Medscape.org
who work full time. In this year’s sample, 64 percent of respondents were men and 34 percent were women.

Not surprisingly, the pay gap is more pronounced in the specialties. Average compensation for male specialists was $372,000, compared to $280,000 for female specialists — a 33 percent difference. One factor contributing to the overall pay disparity is that more women than men tend to choose lower-paying specialties. For example, women make up less than one-fifth of the following specialties: plastic surgery, orthopedics, cardiology, and urology. That reality, however, doesn’t alter the fact that the gender pay gap remains pronounced within those specialists — and all specialties.

The Medscape report also found compensation disparities among ethnicities. Overall, Caucasian physicians (who accounted for 75 percent of all specialist respondents) had an average income of $319,000 across all specialties, and mixed-race physicians earned $303,000. Average compensation for Hispanic/Latino physicians was $303,000. Average compensation was $300,000 for Asian physicians and $281,000 for African American/Black physicians.

**Employment model affects earnings**

Despite the continued trend toward physician employment by hospitals and health systems and the decline in doctors choosing private group practice or solo employment, self-employed physicians still outstrip their employed counterparts in the earnings department. The Medscape report cited average compensation of $399,000 for self-employed physicians, compared to $298,000 for employed physicians. Notably, 64 percent of self-employed physicians are over age 50.

There is some indication that young physicians in training or just out of residency are becoming more open to considering models other than straight employment. In last year’s Medscape Residents Salary & Debt Report, although only 20 percent of respondents expressed interest in practice ownership, 21 percent said that they might consider the option at some point.

**Geography matters — a lot**

There are numerous factors that affect how much physicians earn in different regions of the country. Those range from local payer mix, to physician supply and demand, and from the state malpractice environment to the prevalence of managed care. Overall, however, the Medscape compensation report found that physicians who practice in regions that lie between the two historically desirable East and West Coasts of the country tend to out-earn their counterparts in the states with the most popular urban areas, such as San Francisco, Seattle, New York, and Boston.

The following are the top five top states for physician compensation, along with average earnings:

1. Oklahoma — $337,000
2. Alabama — $330,000
3. Nevada — $329,000
4. Arkansas — $326,00
5. Florida — $325,000

Others in the top 10 include Kentucky at $324,000, Tennessee and Connecticut at $323,000, and Georgia and Indiana at $322,000.

**Compensation and practice satisfaction, by the numbers**

Although compensation has always been an important factor in how satisfied physicians feel with their practice lives, it’s not the only key determinant, based on numerous surveys’ results in recent years. This year’s Medscape survey findings illustrate how that disconnect plays out sometimes: the specialties most satisfied with their earnings were not necessarily those with the highest compensation.

For example, even though orthopedic surgeons out-earned all other specialties, only 52 percent reported being satisfied with their compensation. Similarly, only 52 percent of plastic surgeons and 49 percent of urologists consider their compensation satisfactory. Both infectious disease physicians and endocrinologists were in the low-satisfaction group, with only 42 percent feeling adequately compensated for their work.

The specialists who reported the highest satisfaction with their compensation included the following: public health and preventive medicine (73 percent), emergency medicine (68 percent), dermatology and radiology (66 percent), psychiatry (64 percent), and critical care (61 percent).

Medscape also asked physicians to rate how they view their own performance. To the extent that respondents answered honestly, 42 percent claimed that
they’re very satisfied with their performance and 49 percent said that they’re satisfied. Only 2 percent were dissatisfied.

On the plus side, the majority of physicians reported that if they had the chance to start over again, they’d choose medicine. More than 80 percent of respondents in the following fields are satisfied with their career choice: infectious diseases, cardiology, nephrology, dermatology, orthopedics, oncology, general surgery, critical care, and psychiatry.

Similarly, most physicians reported that they would choose the same specialty given the chance. Overwhelmingly (more than 90 percent) of ophthalmologists, orthopedic surgeons, dermatologists, gastroenterologists, urologists, and radiologists would choose their specialty again. However, about one-third of internists and family medicine physicians said that they would choose a different specialty.

Payment models shifting

As physicians and their employing entities are increasingly on the hook for measuring and reporting both quality and care-cost-associated financial performance, it stands to reason that payment models are shifting. In the 2019 Medscape survey, 28 percent of physicians reported accountable care organization (ACO) participation, up from only 3 percent in 2011 but down significantly from 36 percent in 2017. It’s worth noting that the number of ACOs increased from 480 in 2017 to 561 in 2018, according to national data. At the same time, Medscape survey respondents are reporting increasing concerns about ACO programs’ designs and risks, which might explain the recent participation drop.

The health care economists who predicted a decade ago that we’d see the end of fee-for-service medicine before this decade is out are being proved wrong. Medscape reports that 44 percent of physicians are still involved in fee-for-service payment models. In terms of alternative payment models, only 11 percent of respondents reported involvement in direct primary care (membership-fee care models), only 6 percent in cash-only practices, and a mere 2 percent in the concierge medicine practices that were once expected to take hold more broadly.

What is taking hold, however, is the Merit-Based Incentive Payment System, called MIPS. Forty-two percent of PCPs and 37 percent of specialists are either participating in MIPS or planning to do so soon.

With the problem now at epidemic levels, the medicine and graduate medical education communities are undertaking major mitigation initiatives

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

Physician researchers and scientists who study physician burnout and the attendant decline in professional satisfaction have pointed to a worsening problem for more than a decade. Until recently, however, efforts to address the issue have been mostly sporadic and largely unorganized. When studies in the past few years started calling a spade a spade — identifying physician burnout as a serious condition that’s reached epidemic levels and now affects more than 40 percent of US physicians — organized medicine and the graduate medical education community began addressing the problem.

The American Medical Association, the Accreditation Council for Graduate Medical Education (ACGME), and the National Academy of Medicine, among other organizations, have launched programs targeting physician burnout. These endeavors initially focused on increasing awareness of what formal research and surveys clearly show: Burnout is increasing among physicians regardless of where they are on their career horizon. The epidemic is affecting residents and fellows; it’s depleting satisfaction among mid-career physicians; and it’s a chief reason cited by physicians who choose to retire early or leave medicine altogether.

The increasing awareness of physician burnout has spawned several recent efforts to mitigate the problem. Many early initiatives set their sights too narrowly, some experts claim, by failing to recognize that the chief causes of physician burnout today are not individual factors and inadequate coping mechanisms, but rather system and organizational issues. Tait Shanafelt, MD, a leading researcher on physician satisfaction and burnout who directs the Mayo Clinic Program on Physician Well-Being, thinks the focus needs to shift.

“Awareness of physician burnout and its potential impact on quality of care has increased dramatically, and most organizations now recognize this problem,” Dr. Shanafelt said. “Unfortunately, to date, most organizational efforts to address the issue have focused on individual-level solutions, such as resilience training, rather than addressing the system issues that are the primary drivers of this problem.” Those issues, while wide ranging,
fall into several basic categories, based on Mayo Clinic's research. Dr. Shanafelt cites the following: work-load, efficiency, flexibility and control, work-life integration, and organizational culture and values. Other key dimensions are finding meaning in work, and social support and community at work.

“System interventions targeting these domains need to be developed and evaluated with robust outcome measures, as well as assessment of cost and return on investment,” Dr. Shanafelt said, “so that effective approaches can be scaled and disseminated.”

**Burnout-mitigation initiatives taking hold**

The ACGME and the AMA are among the organizations heeding that call, with initiatives that target the burnout factors Dr. Shanafelt cites. The ACGME added a new section on physician well-being to its Common Program Requirements (Section VI) that gives residents more flexibility in their schedules and more control in managing their time. Effective July 1, 2017, residents may choose to stay beyond their shift to remain with a patient whose care is at a critical juncture, in their view; or to continue in an educational opportunity that’s important to the resident — observing or participating in a procedure, for example. “One thing we have heard from residents in recent years is that they feel there is a genuine loss of choice,” said Rowen Zetterman, MD, co-chair of the ACGME Common Program Requirements task force. “And we know that one factor that contributes to burnout is being in a situation in which you have no choice.”

Residents have cited circumstances in which they’ve had to leave the bedside of a critically ill or dying patient because they’ve reached the end of a 16-hour shift, Dr. Zetterman noted, or have been forced to leave the hospital before their patient comes out of recovery after surgery. The new requirements attempt to address such dilemmas. Those "overtime" hours still count in the 80-hour work week, but the greater individual flexibility might help alleviate an often-cited stressor: lack of schedule control.

Anai Kothari, MD, a surgery resident who serves on the Common Program Requirements task force, expects that these changes will be well received. “This requirement is a huge change. It dramatically increases the amount of flexibility residents have to conduct their time in the hospital, because there’s this sense that you’re constantly competing against the clock in terms of how the [duty-hour] standards were written,” said Dr. Kothari, who is training at Loyola University Medical Center in Chicago. “One major piece of this is that there’s now a standard for resident well-being in the requirements. That’s a huge transformation from when I started my training five years ago.”

In addition, the Section VI requirements include a new policy that permits residents to take time off for personal health care needs, whether that is a dental appointment or a counseling session, or simply because the resident is too sick or fatigued to continue that day. The training program must put in place a policy to accommodate such absences. “I think that residents have sometimes felt that they didn’t dare ask for the time off,” Dr. Zetterman said, noting that programs will have a year starting July 1 to operationalize the required changes. The ACGME also recently revised its Clinical Learning Environment Review (CLER) program to strengthen its focus on resident well-being.

**ACGME launches resident-led initiative**

A new ACGME resident-developed initiative called “Back to Bedside” targets another burnout cause: the mounting reporting, electronic health record (EHR) and computer time, and administrative burdens that reduce the time trainees have available to engage with patients. The initiative provides a competitive funding opportunity for residents and fellows to develop innovative ways to enable physicians to spend more time with patients, to improve resident well-being and patient satisfaction. Physicians spend two hours or more on these activities for every hour they spend in direct patient contact, a recent AMA-Dartmouth-Hitchcock study found. “People [physicians in-training] are quoting up to 3:1 computer versus patient time,” Dr. Kothari said, “and we’re seeing this nationally, regardless of the specialty.”

Through Back to Bedside, the ACGME will fund up to five $10,000 awards annually, for up to a two-year period. “The goal is to generate actionable recommendations for improving the clinical learning environment to combat resident burnout,” said Dink Jardine, MD, an otolaryngologist who chairs of ACGME’s Council of Review Committee Residents. She added that the initiative’s objective is to amass a toolbox of processes, curricula, and projects, and then disseminate those throughout the GME community. (See Resources.)

The Alliance for Academic Internal Medicine (AAIM) is also seeking burnout-reduction remedies. The alliance formed a wellness committee last year, and has expanded its Collaborative on Healing and Renewal in Medicine (CHARM) outside internal medicine. CHARM convenes medical educators...
and leaders, and burnout experts to investigate the impact of trainee burnout, and develop tools and best practices to foster and support resident well-being. The collaborative encourages residents to join the effort by submitting and presenting papers on wellness issues at national meetings.

“We no longer have to sell people on the idea that burnout is a big deal, but we’re not sure what to do about it — and that’s what we’re working on now,” said Gopal Yadavalli, MD, chair of AAIM’s wellness committee and director of Boston University’s internal medicine residency program. Dr. Yadavalli cites increasing EHR documentation requirements and work compression as key contributors to resident burnout. “Residents are not just working fewer hours because of duty-hour restrictions; they’re also required to do the same amount of work in fewer hours. And that’s a big issue for everyone,” he said.

In tandem with the national efforts occurring, Boston University is pursuing in-house burnout-reduction strategies in its internal medicine residency program. Dr. Yadavalli said. A relatively new resident-led wellness committee has developed several initiatives, and program faculty is working to ensure that mental health counselors can be available to residents after a particularly difficult event, such as a patient death or a bad outcome in the ICU. The BU residents also started a program to support a local family at Thanksgiving, and organized a major holiday party that featured residents in musical performances and an art show.

“Residents respond better to things that their fellow residents come up with. That’s much better than me sitting in my office making up things,” Dr. Yadavalli said. The program also has begun devoting its December academic half-days to wellness activities, which start with a faculty member sharing her or his own struggles with work-life balance and burnout issues. Those presentations have been very well received, Dr. Yadavalli said, and frequently generates thank-you notes from residents. “We need to role model this for trainees, and I think most of us aren’t very good at that,” he said.

**Causes and stressors see shifts**

Some contributors to dissatisfaction or burnout among both trainees and practicing physicians are age-old — work load, exhaustion, and work-life imbalance, to name a few. Others are either new or are new manifestations of existing stressors. EHRs, particularly the ever-increasing work required to keep the EHR updated and comply with documentation requirements, is a stressor that keeps showing up on the list. A recent RAND study also pointed to the cumulative burden of externally imposed regulations and rules as a chief cause of professional dissatisfaction.

The AMA, acknowledging that burnout is a major issue throughout the physician-career continuum, launched a multifaceted initiative to seek national-level solutions to both organizational and individual burnout drivers. The AMA’s STEPS Forward program, started in 2015, offers interactive practice transformation strategies intended to reduce the administrative burdens that can lead to physician burnout.

“My observation is that about 80 percent of burnout is driven by systems and organizational practices rather than individual factors. We are targeting most of our efforts at the AMA to those systems issues, but we’re addressing individual burnout factors as well,” said Christine Sinsky, MD, AMA’s vice president of professional satisfaction.

STEPS Forward is organized around online educational modules that feature physician-developed strategies for addressing common practice challenges that reduce physicians’ face time with patients. The modules focus on practice efficiency, technology and innovation, with an emphasis on work flow; and on patient health and physician health. Since the STEPS Forward program began, the dedicated website has tallied more than 250,000 visits, Dr. Sinsky reported, an indication that physician practices are actively seeking burnout remedies. (See Resources.)

“I often tell physicians and others that practices could save three to five hours a day by reengineering the way work is done and redistributing the work according to ability,” Dr. Sinsky said. “Right now, a lot of work landing on the physician’s plate is work that doesn’t require a medical education.”

Two STEPS Forward modules, one on preventing trainee burnout and a second on improving resiliency, provide strategies for individual physicians. Toyin Okanlawon, MD, MPH, a senior health care project leader at Harvard Business School who authored the module on preventing resident and fellow burnout, thinks it’s imperative that physicians learn self-care skills during residency.

“Just as physicians don’t learn about anatomy when they’re done with medical school, physicians need to learn to take care of themselves at the beginning of training,” said Dr. Okanlawon, whose interest in physician wellness evolved from his own experience and the recognition, while he was public health chair of the AMA Resident and Fellow Section, that
burnout “was plaguing” the training environment. “Burnout is a huge disease right now [in training programs], and there’s a huge demand for ways to address what has become a very serious problem.”

Call for comprehensive, physician-led response

Dr. Okanlawon said that while it’s gratifying to see physician burnout get the attention it warrants from the medical education community, he thinks that a national-level response has been overdue based on what the data have shown consistently. “I think this [focus] should have started a few years ago, because once something like this pops up, you don’t really need more red flags,” he said, “to tell you it’s time to do something.”

Physicians should “take charge of their own epidemic now,” in Dr. Okanlawon’s view, and not take a haphazard approach to an issue that deserves our full attention. This is not a task force or quality-meeting issue,” he said.

A longtime proponent of proactive approaches to burnout mitigation, Ralph Greco, MD, at Stanford University, echoes Dr. Okanlawon’s view about the delayed collective response; and both agree that residency programs must also work to reduce the stigma associated with residents seeking help for possible burnout. Dr. Greco, who founded Stanford’s Balance in Life program for surgical residents following the suicide of a much-admired resident who had just gone on to fellowship, points to a 2008 American College of Surgeons survey that found a burnout rate of 40 percent. “That was a scathing report, and nine years later, we’re not exactly setting the world on fire,” he said. “Seven or eight academic articles came out of that data, but I think the [burnout] issue was largely ignored until recently.”

The Stanford Balance in Life program — Dr. Greco admits the name is not “universally liked” — seeks to support surgery trainees’ physical, psychological, social, and professional well-being though various activities and resources. Components range from mandatory weekly meetings with a clinical psychologist, to organized physical and social activities, to dedicated professional well-being mentorship. The program, which also features an annual resident retreat, has been well received since it started in 2011. “It is slowly being replicated by other programs,” Dr. Greco said.

Dr. Greco applauds the efforts national organizations and individual programs have undertaken to address burnout. At the same time, he worries that some initiatives might not be robust enough to address the systemic scope of the problem. “My concern is that some of these programs are not well enough resourced to deal with the magnitude of this issue,” said Dr. Greco, who is the Johnson & Johnson Distinguished Professor, Emeritus at the Stanford University School of Medicine. He is also concerned that the great variability among training programs in how they address burnout — if at all — leave many trainees without the support they need.

Timothy Brigham, MDiv, PhD, chief of staff at ACGME and co-chair of its Physician Well-Being Task Force, thinks that the important next step is ensuring that there is a collective, continual effort to combat physician burnout. “The ACGME and the entire house of medicine are working very hard to turn this Titanic around a bit,” Dr. Brigham said. “But it’s clear that we’re not going to ‘resilience’ our way out of this.” He proposes convening all the organizations that are trying to address physician burnout to ensure that successful strategies and best practices are shared as those emerge.

“We need to make sure that we’re all reading from the same page,” Dr. Brigham said, “while recognizing that this is not one disease, one cure. What works for one program or organization might not work for another. We’re trying to identify the constellation of things that work so people can pick and try them — and then as we gather more research from Mayo Clinic and others, find out empirically what works.”

Resources

The following lists several organizations and initiatives targeting physician-burnout reduction; most offer avenues for resident and/or practicing-physician involvement.

ACGME Back to Bedside initiative: www.acgme.org/backtobedside

Alliance for Academic Internal Medicine CHARM (Collaborative for Healing and Renewal in Medicine): http://www.im.org/page/charm

American Medical Association STEPS Forward initiative: https://www.stepsforward.org/

Mayo Clinic Physician Well-Being Program: http://www.mayo.edu/research/centers-programs/physician-well-being-program/overview
National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience:  
https://nam.edu/initiatives/clinician-resilience-and-well-being/

Stanford Balance in Life program:  
https://med.stanford.edu/gensurg/education/BIL.html

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Helicobacter pylori Infection
Sheila E. Crowe, M.D.

A 32-year-old woman who emigrated from Eastern Europe is evaluated for persistent epigastric pain and bloating. Previous assessments showed a normal complete blood count and metabolic profile, and a negative result on serologic testing for celiac disease. Serum testing for Helicobacter pylori IgG was positive. She was treated with 20 mg of omeprazole, 1 g of amoxicillin, and 500 mg of clarithromycin, each taken twice daily for 10 days, but her symptoms persisted. How would you further evaluate and treat this patient?

THE CLINICAL PROBLEM

Helicobacter pylori infection is a common, usually lifelong, infection that is found worldwide. Studies suggest that infection rates vary according to geographic region, but the number of infected people has persisted or even increased over the past three decades because of population growth and because of reinfection and recrudescence due to unsuccessful eradication. A less advantaged socioeconomic status is a risk factor for Helicobacter pylori infection because it is associated with more crowded living conditions that favor intrafamilial transmission. Farrogenic infection by means of endoscopes also occurs. Although the majority of infected persons remain asymptomatic, infection has been directly linked to several conditions—in particular, peptic ulcer disease and nonulcer dyspepsia. Evidence (reviewed below) has shown that treatment to eradicate H. pylori can reduce the risks of both conditions, although the data are less consistent regarding nonulcer dyspepsia. Gastric cancer has also been closely associated with the presence of H. pylori. In a study conducted in Japan, gastric cancer developed (over a mean follow-up of 7.8 years) in 2.9% of patients with peptic ulcer, dyspepsia, or gastric hyperplasia who had H. pylori infection, whereas no cases were detected in uninfected patients with these conditions. On the basis of compelling evidence, the World Health Organization (WHO) has classified H. pylori as a group 1 carcinogen leading to gastric adenocarcinoma. In addition to Japan, areas with an increased incidence of gastric carcinoma attributable to this infection include the Middle East, South-east Asia, the Mediterranean, Eastern Europe, Central America, and South America. Immigrants who grew up in regions of the world with a high incidence of H. pylori infection (e.g., Eastern Europe and East Asia) and who now reside in the United States or Western Europe are also at increased risk for gastric cancer. Another neoplastic disease that is caused by chronic H. pylori infection is gastric mucosa-associated lymphoid tissue lymphoma (MALToma)—a condition that is much less common than peptic ulcer disease or gastric adenocarcinoma. Conditions outside the gastrointestinal tract have also been associated with H. pylori infection. An observed association with coronary artery disease probably reflects shared risk factors, such as poverty and suboptimal nutrition. Unexplained iron-deficiency anemia and immune thrombocytopenia have been associated with H. pylori infection; although the pathogenesis is not well understood, reports of successful treatment of H. pylori infection leading to an increased hemoglobin level or higher platelet count suggest causal relationships (see below).

STRATEGIES AND EVIDENCE

Screening and Diagnosis
Indications for screening for H. pylori (and for treatment if screening is positive) are reviewed in Table 1. Direct (invasive) histologic testing of gastric mucosal biopsy samples is used for the diagnosis of H. pylori infection in patients with indications for endoscopy, such as epigastric pain, weight loss, iron-deficiency anemia, and dyspepsia with alarm symptoms (e.g., weight loss, severe abdominal pain, dysphagia, vomiting, gastrointestinal bleeding, and others), or in patients 60 years of age or older. If a person is from a region with a greater incidence of infection and gastric cancer, this testing should be done at a younger age as guided by local recommendations (e.g., <35 years of age in China). Direct testing is also recommended in patients with long-term use of aspirin or nonsteroidal antiinflammatory drugs (NSAIDs) for whom endoscopy is indicated; this ensures that the management of NSAID-induced peptic ulcer disease is not complicated by the infection. Histologic detection of H. pylori in gastric tissues has a sensitivity and specificity that can exceed 95%; however, proper sampling and interpretation are required. Endoscopy is also used to determine eradication of infection but is usually repeated only in the context of persistent ulcers, to confirm healing of a gastric ulcer, or after the removal of early gastric cancer or MALToma. Noninvasive testing is recommended in patients for whom endoscopy is not indicated but who have conditions associated with the infection (e.g., history of peptic ulcer disease, unexplained iron-deficiency anemia, or immune thrombocytopenia) or who are considered to be at increased risk for infection or complications of infection (e.g., patients with long-term use of NSAIDs or aspirin) (Table 1). In the United States, prevalence varies regionally and according to ethnic group or socioeconomic status.

Noninvasive tests for active infection include the stool antigen test and urea breath test. Stool antigen testing, which involves a mixture of antibodies against H. pylori, is used for initial diagnosis and for confirming eradication of the infection; the sensitivity and specificity of stool antigen tests typically exceed 90%. Urea breath tests involve the ingestion of either 13C-labeled or 14C-labeled urea; if H. pylori...
Active peptic ulcer disease or a history of peptic ulcer disease, unless H. pylori has been eradicated
Low-grade gastric mucosa-associated lymphoid tissue lymphoma (MALToma) or a history of endoscopic resection of early gastric cancer
Uninvestigated dyspepsia, with noninvasive testing in patients ≤60 yr of age who do not have alarm symptoms (e.g., weight loss, severe abdominal pain, dysphagia, hematemesis, melaena, bleeding, and others), but esophagogastroduodenoscopy is recommended in patients ≥60 yr of age if alarm symptoms are present

Long-term aspirin use

Long-term NSAID use

Unexplained iron-deficiency anemia after thorough evaluation for other causes

Immune thrombocytopenia in adults

Table 1. Indications for Testing for Helicobacter pylori Infection, According to Guidelines.*

<table>
<thead>
<tr>
<th>Indications</th>
<th>Testing for H. pylori Infection</th>
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<tr>
<td>Active peptic ulcer disease or a history of peptic ulcer disease, unless H. pylori has been eradicated.</td>
<td>Recommended.</td>
</tr>
<tr>
<td>Low-grade gastric mucosa-associated lymphoid tissue lymphoma (MALToma) or a history of endoscopic resection of early gastric cancer.</td>
<td>Recommended.</td>
</tr>
<tr>
<td>Uninvestigated dyspepsia, with noninvasive testing in patients &lt;60 yr of age who do not have alarm symptoms (e.g., weight loss, severe abdominal pain, dysphagia, hematemesis, melaena, bleeding, and others), but esophagogastroduodenoscopy is recommended in patients ≥60 yr of age if alarm symptoms are present.</td>
<td>Recommended.</td>
</tr>
</tbody>
</table>

* Guidelines are from the American College of Gastroenterology (ACG)41 and the Maastricht V–Florence Consensus.15 Other indications for testing have been suggested, including various demographic features that have been associated with increased risk — such as a family history of gastric cancer, status of being a first-generation immigrant from an area with high prevalence of H. pylori infection, and black race or Hispanic ethnic group16 — and long-term NSAID use.

TREATMENT

Evidence to support benefits of treatment of H. pylori infection for the conditions for which screening is recommended derives from randomized trials and observational studies. A Cochrane review of randomized trials showed that the addition of a third drug to standard triple therapy in patients who tested positive for this infection led to a lower incidence of duodenal ulceration (in 34 trials) or gastric ulceration (in 12 trials) than no treatment.15 The numbers of patients who would need to be treated for H. pylori infection in order to prevent a recurrent duodenal or gastric ulcer were 2 and 3, respectively. In another meta-analysis of clinical trials, the number of patients with H. pylori infection who had positive serology for IgG antibodies that need to be treated for dyspepsia (number needed to treat, 13) was greater than that for peptic ulcer disease.

Studies have compared the prevalence of infection and deaths from gastric cancer before and after the Japanese government began a program to test for and treat H. pylori infection in 2013.23 After the initiation of the program, the number of treated patients in Japan more than doubled, to approximately 1.5 million per year, while the number of deaths from gastric cancer steadily declined from 50,000 to 45,000 per year.32 An observational study in Hong Kong showed a significantly lower incidence of gastric cancer among patients older than 60 years of age who had received treatment to eradicate H. pylori infection than the expected number of cases in the general population.33 In a randomized, double-blind, placebo-controlled trial in South Korea, patients with early gastric cancer who received treatment for H. pylori infection had lower rates of metachronous gastric cancer after a median of 5.9 years than those who received placebo.32

Early-stage MALToma (type I or II) is effective treated with antibiotics to eradicate H. pylori infection. However, the treatment of more advanced stages of MALToma typically also involves surgery, radiation, chemotherapy, or a combination of these interventions.

Randomized trials have shown that screening and treatment for H. pylori infection in persons who are starting or taking long-term NSAID therapy reduces the risk of peptic ulcer disease.34 Although data from randomized trials have not conclusively shown benefits in persons taking nonsteroidal anti-inflammatory drugs (NSAIDs) without peptic ulcer or clinically significant gastrointestinal bleeding,35 randomized trials of both low-dose aspirin, observational data showing a higher risk of bleeding in the upper gastrointestinal tract among aspirin users who have H. pylori infection than among those who do not have the infection underlie recommendations for a similar strategy in this group.

Data from randomized trials have shown increased efficacy in the setting of patients with macrolide exposure and penicillin allergy.32 In an observational study comparing the use of macrolide-based quadruple therapy to clarithromycin-based triple therapy showed no significant difference in the incidence of duodenal ulcer re-eradication (87.7% and 83.2%, respectively),36 whereas the percentages of patients who adhered to treatment and who had adverse events also appear to be similar in the two groups. Treatment with clarithromycin combined with amoxicillin and a PPI is listed first among the ACG recommendations for patients with no history of antibiotic treatment for the infection. This regimen is also recommended by the Maastricht V–Florence Consensus, assuming that the level of clarithromycin resistance where a patient (or his lives) is less than 15%.

Another commonly used regimen includes bismuth, tetracycline, metronidazole, and a PPI (i.e., bismuth-based quadruple therapy).15 This regimen has been advocated since the 1980s but was then largely replaced by the simplified clarithromycin-based triple-therapy regimen. Guidelines recommend the use of bismuth-based quadruple therapy for 10 to 14 days.15,29 A randomized trial comparing bismuth-based quadruple therapy with clarithromycin-based triple therapy showed no significant difference in the proportion of patients with H. pylori infection who had re-eradicated (87.7% and 83.2%, respectively). The percentages of patients who adhered to treatment and who had adverse events also appear to be similar in the two groups. Treatment with clarithromycin is considered to be as effective as tetracycline in the treatment of H. pylori infection.

Because resistance to clarithromycin has increased in many parts of the world, the bismuth-based triple therapy can also be used in such patients. If amoxicillin is replaced with metronidazole, in patients with macrolide exposure and penicillin allergy, the bismuth-based regimen is essentially the only option. If the first two regimens fail, testing for antimicrobial resistance could be take into account whether the patient has had any previous exposure to macrolide antibiotics (e.g., clarithromycin, azithromycin, and erythromycin) and whether the patient has an allergy to penicillin. Because most patients with self-described beta-lactam “allergy” do not have a true allergy,32 skin testing should be performed so that amoxicillin-containing regimens can be identified. If testing is negative, other factors in decision making include other allergies, potential adverse reactions (e.g., gut symptoms and treatment for patients with no history of antibiotic treatment for the infection. This regimen is also recommended by the Maastricht V–Florence Consensus, assuming that the level of clarithromycin resistance where a patient (or his lives) is less than 15%.

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considered (although such testing is not readily available in the United States) or one of the other five recommended treatment regimens could be used (Table 2).

TABLE 2. Evidence-based Treatment Regimens for H. pylori Infection in North America, Listed in Recommended Order.*

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Components</th>
<th>Duration</th>
<th>Comments†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarithromycin-based triple therapy‡</td>
<td>PPI, clarithromycin, and amoxicillin (twice daily for all antibiotics)</td>
<td>10–14</td>
<td>Recommended unless patient has documented allergy to amoxicillin or high level of clarithromycin resistance</td>
</tr>
<tr>
<td>Bismuth-based quadruple therapy (Triplet)‡</td>
<td>PPI, bismuth, tetracycline, and nitromidazole (four times daily for all antibiotics)</td>
<td>10–14</td>
<td>Recommended if patient has high level of clarithromycin resistance or history of macrolide use</td>
</tr>
<tr>
<td>Concomitant therapy</td>
<td>PPI, clarithromycin, amoxicillin, and nitromidazole (twice daily for all antibiotics)</td>
<td>10–14</td>
<td>Not appropriate in patient with high level of clarithromycin resistance or documented allergy to amoxicillin</td>
</tr>
<tr>
<td>Sequential therapy</td>
<td>PPI and amoxicillin, then PPI, clarithromycin, and nitromidazole (twice daily for all antibiotics)</td>
<td>7, then 7</td>
<td>Not appropriate in patient with high level of clarithromycin resistance or documented allergy to amoxicillin</td>
</tr>
<tr>
<td>Hybrid therapy</td>
<td>PPI and amoxicillin, then PPI, amoxicillin, clarithromycin, and nitromidazole (twice daily for all antibiotics)</td>
<td>7, then 7</td>
<td>Not appropriate in patient with high level of clarithromycin resistance or documented allergy to amoxicillin</td>
</tr>
<tr>
<td>Levofloxacin-based triple therapy</td>
<td>PPI, levofloxacin (once daily), and amoxicillin (twice daily)</td>
<td>10–14</td>
<td>Not appropriate in patient with documented allergy to amoxicillin</td>
</tr>
<tr>
<td>Fluoroquinolone-based sequential therapy</td>
<td>PPI and amoxicillin; then PPI, levofloxacin, and nitromidazole (twice daily for all antibiotics)</td>
<td>5–7, then 5–7</td>
<td>Complicated with regard to treatment adherence; not appropriate in patient with documented allergy to amoxicillin</td>
</tr>
</tbody>
</table>

†The evidence-based treatment regimens for H. pylori infection in North America (according to the Toronto Consensus guidelines) are listed in the order of recommendation that appears in the ACG 2017 guidelines. PPIs are to be administered twice daily in all seven first-line treatment recommendations, and the recommended doses are as follows: omeprazole, 20 mg; esomeprazole, 20 mg or 40 mg; lansoprazole, 30 mg; desaiiloprazole, 30 mg or 60 mg; pantoprazole, 40 mg; and rabeprazole, 20 mg. (16,17) The recommended doses of the other agents are as follows: clarithromycin, 500 mg; amoxicillin, 1 g; bismuth, 120 to 300 mg (available in various formulations); tetracycline, 500 mg; nitromidazole, 500 mg; metronidazole (a nitromidazole drug), 500 mg; and levofloxacin, 500 mg. (18,19) Adverse effects of all antibiotic agents include candidiasis, Clostridium difficile infection, and allergic reaction. Adverse effects that are particular to specific components of the regimens include: for clarithromycin, abnormal taste in the mouth; for metronidazole, gastrointestinal symptoms, central nervous system toxic effects (Food and Drug Administration [FDA] black-box warning about risks of delirium, memory impairment, disorientation, agitation, and disturbances in attention), tendinopathy, and tendon rupture, and QT prolongation (and should be avoided in persons with myopathy or gastrointestinal symptoms, including diarrhea and abdominal pain, and for rifabutin (which is often used in combination with antibiotics in treatment and is not typically prescribed by primary care physicians and many gastroenterologists). Reversible myelotoxic effects and potential for increased prevalence of antibiotic-resistant bacteria. Adverse effects of long-term PPI use include an increased risk of C. difficile infection, microscopic colitis, kidney disease, pneumonia, dementia, atrophic gastritis, and malabsorption of iron, magnesium, calcium, and vitamin B12. This therapy has been approved for ulcer therapy by the FDA. (20,21) The Toronto Consensus recommended that all treatment regimens be administered for 10 to 14 days, and the ACG and Maastricht V–Florence Consensus guidelines followed this recommendation. The Houston Consensus Conference on testing for H. pylori infection in the United States proposed additional groups to be tested, including persons with a family history of gastric cancer and first-generation immigrants who had lived in areas with high prevalence of H. pylori infection, and black or Hispanic patients. (22,23,24,25) Guidelines in the United States have suggested that clarithromycin-containing regimens are not used when the level of clarithromycin resistance is more than 25%, but in the United States, there is a lack of broadly applicable data to inform local resistance patterns. A recent meta-analysis of 178 studies, which involved more than 66,000 isolates from all WHO regions, assessed the prevalence and trends in H. pylori resistance to commonly prescribed antibiotics, including rates of primary and secondary resistance to clarithromycin, metronidazole, and levofloxacin. (10) In most regions, except for primary clarithromycin resistance in the Americas (10%) and Southeast Asia (10%) and primary levofloxacin resistance in Europe (11%), the prevalence of combined resistance to both clarithromycin and metronidazole was 19% in the Eastern Mediterranean region but less than 10% in the other regions. Primary resistance to amoxicillin and tetracycline was below 15% in all regions. Antibiotic resistance rates were heterogeneous across countries within the various regions and were generally lower among children and higher among adults; in most regions, there appeared to be increases in resistance over time (from the 2006–2008 period to the 2012–2016 period). For all the antibiotics, there were significant associations between eradication treatment failure and resistance detected before treatment. A recent observational study showed that only 35% of patients who had been treated for H. pylori infection underwent follow-up testing to confirm eradication and that many patients who had treatment failure were retreated with the same regimen. (26) It is critical to test for eradication after treatment is completed and to use a different regimen when eradication failure is documented. (27,28) One randomized trial showed that regimens with rifabutin were effective rescue therapies in patients with treatment failure who had had H. pylori infection that was resistant to both metronidazole and clarithromycin. (29) Areas of Uncertainty Data are needed to inform strategies to improve adherence to the multidrug regimens needed for eradication. Some data, including results of a small, randomized, placebo-controlled trial, suggest that probiotics can reduce the incidence and severity of side effects of antibiotic regimens. (30–32) More data are needed from observational trials of treatment for H. pylori infection in regions in which there is a high prevalence of infection and an increased incidence of gastric cancer. Such findings would help us to better assess the effects of eradication therapy on the risk of gastric cancer.

Strategies are needed to assess H. pylori anti-biotic resistance effectively in practice in various areas of the United States. Efforts to develop a primary care vaccine against H. pylori could facilitate eradication worldwide, but thus far such efforts have been unsuccessful. (33) In Japan, vancomycin, an oral potassium-competitive acid blocker, has been used in place of a PPI in treatment regimens for H. pylori infection. This agent has shown effectiveness that is similar to or greater than that with a PPI when it was used with antibiotics for the eradication of H. pylori. (34,35) Further study is needed to assess whether this approach will be as effective against heterogenous strains in different regions.

GUIDELINES All the recommendations discussed above are consistent with the ACG guidelines for the evaluation and treatment of H. pylori infection. An important recommendation in the 2017 ACG guidelines, which represented a considerable change from the 2007 guidelines, was that all infected persons should be treated and then re-tested to assess for successful eradication. (36) Although the recommendations of other guidelines are generally similar, they vary somewhat in view of regional differences in drug availability, antimicrobial resistance, and rates of gastric cancer. (37,38) For example, in regions that have a higher incidence of infection and earlier onset of gastric cancer, testing is suggested at a younger age, before preneoplastic changes arise. (39) The Toronto Consensus recommended that all treatment regimens be administered for 10 to 14 days, (17) and the ACG and Maastricht V–Florence Consensus guidelines followed this recommendation. The Houston Consensus Conference on testing for H. pylori infection in the United States proposed additional groups to be tested, including persons with a family history of gastric cancer and first-generation immigrants who had lived in areas with high prevalence of H. pylori infection, and black or Hispanic patients. (24,25) Conclusions and Recommendations The patient in the vignette received a diagnosis of H. pylori infection that was made on the basis of IgG serologic testing. More-specific testing, with the use of stool antigen or urea breath testing, would have been preferred to determine whether she had active infection. She initially received a clarithromycin-based treatment, which did not ameliorate her symptoms. Because of cost and ease, I would recommend a stool antigen test to confirm the presence of active infection and the failure of the clarithromycin-based regimen. If the test results are positive, a different treatment regimen would be indicated. Failure of the initial clarithromycin-based regimen would not be surprising because...
40%.

4. "..." would recommend treatment with bismuth-based quadruple therapy for 10 to 14 days, with a subsequent test performed 4 weeks after completion of treatment (including the use of a PPI) to confirm eradication.

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2. Recruit new and retention existing high caliber faculty, staff and trainees in a manner consistent with the division’s core mission of education, research and clinical care, with the ability to mentor an active resident and fellow trainee in ethnic minority and female students and colleagues.
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4. Demonstrate a firm commitment to faculty sound management and prudent allocation of available resources as well as establish and monitor appropriate accountabilities for faculty, staff and trainees.
5. Negotiate the fiscal margin annually with the Chair of the Department of Internal Medicine and proactively seek entrepreneurial opportunities of the division.
6. Be a role model and mentor a highly diverse Division including male and female students, residents, and colleagues from ethnic and racial minorities.
7. Develop a plan for allocation of new resources to develop a hypothesis-driven research program that will engage WSUPG trainees in Michigan Region, and that will lead to substantive extramural funding.
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- Cardiology – interventional
- Cardiovascular surgery
- Colon and rectal surgery
- Endocrinology
- Family/Internal medicine
- Gastroenterology
- General surgery
- Hematology/oncology
- Nocturnist
- Palliative care
- Pediatric cardiovascular surgery
- Pediatric general surgery
- Pediatric neurosurgery
- Pediatrician
- Urology

To learn more about rewarding physician opportunities:
(813) 586-8237

Email your CV to BMGProviderRecruitment@BayCare.org.

Your dream job is something only you can define. That’s why we want to know what matters most to you—personally and professionally. Our recruiters then find the right jobs, perks, and places to make it a reality.

comphealth.com
Emerson Hospital Opportunities

Location, Location, Location

Concord = = = (30) = = = Boston

If you would like more information please contact:
Diane Forte
dforte@emersonhosp.org
phone: 978-287-3002
fax: 978-287-3600

About Concord, MA and Emerson Hospital

Located in Concord, Massachusetts Emerson is a 179-bed community hospital with satellite facilities in Westford, Groton and Sudbury. The hospital provides advanced medical services to over 300,000 individuals in over 25 towns.

Emerson has strategic alliances with Massachusetts General Hospital, Brigham and Women’s and Tufts Medical Center.

Concord area is rich in history, recreation, education and the arts and is located 20 miles west of downtown Boston.

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dforte@emersonhosp.org
phone: 978-287-3002
fax: 978-287-3600

Emerson Hospital

Find out why so many top physicians are practicing at Emerson Hospital. At Emerson you will find desirable practice locations, strong relationships with academic medical centers, superb quality of life, competitive financial packages, and more...

Emerson Hospital has several opportunities for board certified or board eligible physicians to join several practices in the Emerson Hospital service area. Emerson has employed as well as private practice opportunities with both new and existing practices.

Emerson Hospital Opportunities

• Family Medicine – Outpatient Practice and Urgent Care
• Gastroenterology
• Internal Medicine – Outpatient and Hospitalist
• Orthopedic Surgery – Joint Surgeon
• Psychiatry – Inpatient Moonlighter

PHYSICIAN (Multiple Positions)
The FDA’s Center for Biologics Evaluation and Research (CBER), Office of Tissues and Advanced Therapies (OTAT) is recruiting to fill multiple Physician positions. Apply today for this exciting career opportunity for qualified candidates with interest in the drug development, review of clinical trials, and critical interpretation of study design and clinical data analysis.

If you are a physician with primary care or specialty expertise in medicine and/or surgery, we are looking for you.

QUALIFICATIONS:
A U.S. citizen with Doctor of Medicine (M.D.), Doctor of Osteopathic Medicine (D.O.) or equivalent degree.

Official transcripts will be required prior to appointment. Applicants must possess current, active, full, and unrestricted license or registration as a Physician from a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States and 5 years of graduate-level training in the specialty of the position to be filled or equivalent experience and training. U.S. Public Health Service Commissioned Corps Officers may also apply.

SALARY: Salary will be commensurate with education and experience. An excellent federal employee benefits package is available.

LOCATION: Silver Spring, MD

HOW TO APPLY: Submit electronic resume or curriculum vitae (CV) and supporting documentation to CBER.Employment@fda.hhs.gov. Supporting documentation may include: educational transcripts, medical license, board certifications. Applications will be accepted through August 31, 2019, although applicants will be considered as resumes are received. Please reference Job Code: OTAT-18-0012-NEJM.

NOTE: This position may be subject to FDA’s strict prohibited financial interest regulation and may require the incumbent to divest of certain financial interests. Applicants are strongly advised to seek additional information on this requirement from the FDA hiring official before accepting a position. A probationary period for first-time supervisors/managers may be required for supervisory positions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES IS AN EQUAL OPPORTUNITY EMPLOYER WITH A SMOKE FREE ENVIRONMENT

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DEPARTMENT OF HEALTH AND HUMAN SERVICES IS AN EQUAL OPPORTUNITY EMPLOYER WITH A SMOKE FREE ENVIRONMENT

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We provide the support and flexibility needed to balance your career and life outside of medicine.

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93% Clinician Job Satisfaction

2015-2019 Becker’s Hospital Review “150 Great Places to Work in Healthcare”

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Practice made perfect

TEAMHealth
Where work and life balance.

At UCHealth, we coined the phrase, “Work hard. Play hard.” Here, we provide personalized care at the highest level, offering some of the most innovative procedures, advanced treatments and medical technologies in the nation. Then, life seamlessly transitions from work to play in the Rocky Mountain region.

Explore new opportunities: physician.careers@uchealth.org

SSM Health believes that our talented and compassionate physicians are the hearts and hands of our healing ministry, so our leadership actively partners with medical students and residents. We rely on the wealth of talent and expertise of our providers. We engage and empower them to seek innovations, technologies and new programs or services that will lead to high-quality integrated care for our patients. Working together, we are providing exceptional health care services that reveal the healing presence of God.

Discovery the difference of practicing with purpose at SSM Health.

Visit JoinSSMHealth.com to find the right opportunity for you.

Where work and life balance.

Cambridge Health Alliance (CHA) is an award-winning health system based in Cambridge, Somerville, and Boston's metro-north communities. We provide innovative primary, specialty, and emergency care to our diverse patient population through its established network of outpatient clinics and two full-service hospitals. As a Harvard Medical School and Tufts University School of Medicine affiliate, we offer ample teaching opportunities with medical students and residents. We utilize fully integrated EMR and other competitive compensation packages and comprehensive benefits for our employees and their families. Ideal Candidates will have a strong commitment to providing high quality care to our multicultural community of underserved patients.

SSM Health is at the forefront of addressing provider wellness and reducing burnout. SSM Health believes that our talented and compassionate physicians are the hearts and hands of our healing ministry, so our leadership actively partners with medical students and residents. We rely on the wealth of talent and expertise of our providers. We engage and empower them to seek innovations, technologies and new programs or services that will lead to high-quality integrated care for our patients. Working together, we are providing exceptional health care services that reveal the healing presence of God.

Discover the difference of practicing with purpose at SSM Health.

Visit JoinSSMHealth.com to find the right opportunity for you.

Hartford HealthCare, the most comprehensive integrated health care system in CT, is seeking a Cardiologist to join our Heart & Vascular Institute on the desirable shoreline of CT / RI. Practice in Westerly, RI and Mystic, Connecticut. This rapidly expanding Institute includes six acute care hospitals, including Hartford Hospital. Hartford HealthCare is at the forefront of addressing provider wellness and reducing burnout.

• An outstanding opportunity to practice the full spectrum of clinical Cardiology with an established group in two state-of-the-art offices, including full-service cardiac testing

• Opportunity for diagnostic catheterization, advanced imaging, heart failure

• The successful candidate is an energetic clinician excited to grow a practice while enjoying support of a large internal referral network, a welcoming medical community, and 3 seasoned colleagues.

Located along the beautiful shoreline of Southeastern RI / CT, you and your family will live like you are on vacation! Just 2 hours from Boston and New York City, we are in the heart of some of New England’s most stunning communities offering your family nationally acclaimed schools, a choice to live at the shore, in vibrant urban areas, or quaint historic towns. Imagine a home in Watch Hill, RI or Stonington, CT.

The Hartford HealthCare Behavioral Health Network (The BHN), the most extensive behavioral health network in New England, is rapidly growing. Under the new leadership of Dr. John Santopietro, MD, DHFAA, we have exciting opportunities for BC/BE Psychiatrists interested in general adult psychiatry as well as those with specialty interests in child and adolescent, addiction, and geriatric psychiatry who want to join our expanding network of care.

Join a respected behavioral health team within Connecticut’s most comprehensive fully integrated health system. Work with an inspired, talented, multi-disciplinary team practicing innovative care in progressive programs and well-resourced facilities, including:

• The Institute of Living - Founded in 1822, one of America’s “Ivy League” Behavioral Health Centers and a national leader in innovative and comprehensive treatment, research and education

• Natchaug Hospital and Rushford - Leaders in inpatient and outpatient mental health and addiction services

• Backus Hospital, The Hospital of Central Connecticut, Windham Hospital and Charlotte Hungerford Hospital - thriving acute care community hospitals

Psychiatrists in our practice benefit from:

• Teaching and research opportunities

• Highly competitive compensation with loan repayment

• Outstanding quality of life in the heart of idyllic New England with easy access to Hartford, Providence, Boston and New York City

If it matters to you and your career, it matters to us. Find out more today.

Interested candidates should email Mary Ann Tanguay, Physician Recruiter at maryann.tanguay@hhchealth.org or call her at 860-716-9850.

For more information please visit www.hartfordhealthcare.org.

Career | Family | Patients | Lifestyle | Everything Matters

Your Clinical Career Navigator

Where does your career path go?

With 800+ provider career opportunities at some of the nation’s top not-for-profit health systems, we can navigate you to the perfect practice for a lasting career solution.

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MASTERCARD, AND STAND UP TO CANCER

STAND UP TO CANCER IS A DIVISION OF THE ENTERTAINMENT INDUSTRY FOUNDATION, MASTERCARD IS A REGISTERED TRADEMARK, AND THE CIRCLES DESIGN IS A TRADEMARK, OF MASTERCARD INTERNATIONAL INCORPORATED.

For more information please visit www.standuptocancer.org.

MASTERCARD AND STAND UP TO CANCER FUND GROUNDBREAKING RESEARCH AND PROGRAMS TO IMPROVE OUTCOMES FOR CANCER PATIENTS AND SURVIVORS.

The U.S. Food and Drug Administration (FDA) is seeking an Associate Director for Cancer Pharmacology and Therapeutics in the Office of Clinical Pharmacology (OCP). The incumbent will also partner with the FDA Oncology Center of Excellence (OCE). OCP is a dynamic, purpose-driven organization dedicated to promoting and protecting global health through application of clinical pharmacology and experimental medicine principles. The OCE is a multicenter organization focused on creating a unified approach to clinical evaluation for all drugs, biologics, and devices used in medical oncology. The Associate Director supervises experts in regulatory science, policy implementation, and drug regulation. They will have regulatory decision-making and management responsibilities, participate in engagement activities as part of the OCP and OCE senior leadership teams, oversee a regulatory science and policy portfolio, develop high-level policies and strategic priorities relevant to oncology pharmacology, and lead or represent OCP in stakeholder engagement activities with professional, scientific, and advocacy groups.

The ideal candidate will have a combination of the following:

• Experience in leading an interdisciplinary scientific team

• Expert knowledge of drug development and/or regulatory evaluation, with preferred experience in oncology and/or precision medicine

• Track record of being a scientific thought leader

• Exceptional oral and written communication skills

• Ability to network and build consensus within a multi-disciplinary organization

General Information: Candidates must be United States Citizens. Financial Disclosure statement may be required. Certain positions with FDA are subject to restrictions on financial holdings that are part of significantly regulated organizations (SROs). See attached link for SROs:

https://www.fda.gov/about-fda/ethics/prohibited-financial-interests-fda-employees

Background Investigation Requirement: All employees must pass a security investigation. Failing to pass the background check may be grounds for removal or legal action. If hired, you may be subject to additional investigations later.

Application Procedures: Applicants should submit a letter of interest and current resume by September 30, 2019 to:

Issam Zineh, PharmD, MPH, FCP, FCCP, Office Director, Office of Clinical Pharmacology c/o Ashley Burke Ashley.Burke@fda.hhs.gov
Tel: 240-402-3135

ALL APPLICATIONS WILL RECEIVE EQUAL CONSIDERATION WITHOUT REGARD TO RACE, ORIGIN, COLOR, RELIGION, SEX, DISABILITY, OR ANY OTHER NON-MERIT FACTOR. FDA IS AN EQUAL OPPORTUNITY EMPLOYER AND HAS A SMOKE FREE ENVIRONMENT.
Infectious Disease / Internal Medicine

We are currently seeking an Internal medicine physician, board certified in Infectious Disease to join our Internal medicine department. The ideal candidate should show commitment to academic medicine, working with transition year trainees and ID fellows, a diverse patient population and advancing the cause of public health. He/she will provide infectious disease consults and clinical coverage as well as covering the Infectious Diseases service, and participate with various hospital committees. This position offers the opportunity for an academic appointment through Tufts.

The Lemert Shattuck Hospital is a fully accredited teaching facility that provides acute, subacute, and ambulatory care to patients referred by public agencies and private sector providers. The Hospital’s services help economically and socially disadvantaged patients get high quality, cost-effective care from a staff that respects their dignity. The hospital is also a highly sought-after facility for various medical, surgical, urban and correctional clinics as well as fellowship programs.

Please e-mail cover letter and CV to: Ireta.Ashby@state.ma.us

private sector providers. The Hospital’s patients referred by public agencies and acute, subacute, and ambulatory care to accredited teaching facility that provides infectious disease consultation and clinical coverage as well as covering the Infectious Diseases service, and participate with various hospital committees. This position offers the opportunity for an academic appointment through Tufts.

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Situated in the Annapolis Maryland – Anne Arundel Medical Group – part of the Anne Arundel Medical Center (AAMC) is forward-thinking leadership that is transforming healthcare into Preventive Healthcare. AAMC is becoming a distinctive teaching institution – with Surgery, Internal Medicine and OB/GYN residency programs. Come and be part of a health system that delivers healthcare across four counties and continues to grow.

AAMC is a non-profit, which means you may be eligible to apply for the Federal and/or State Loan Forgiveness Program.

Physician

Anne Arundel Medical Group - Mental Health Services (Annapolis) is looking for a Full-time Adult Inpatient Psychiatrist. Our brand new 16 bed inpatient mental health center – 2. Kent McNeil Family Medical Center is slated to open in the summer of 2020. We need the right psychiatrist today to help us ramp up and ready for the opening of this mental health medical center. When complete, the campus will provide Inpatient 24 hour – 365 days a year mental health care; Psychiatric partial hospitalization program; residential and outpatient substance use services; referral and care coordination to community-based treatment and support services.

Neurologist and Primary Care

Our growth is now your opportunity! Full-time General Neurologist for our brand new state-of-art Easton Pavilion on the eastern shore of Maryland.

Full-time Family Medicine providers near Easton, Maryland and Annapolis. Live and work in one of the best places in Maryland – Annapolis and/or Easton, Maryland. The schools are above average and there is abundance of history cultural arts, colonial chart and the Chesapeake Bay.

Make a Change and Make a Difference!

These positions will offer you:

• COMPETITIVE SALARY • COMPREHENSIVE MEDICAL, DENTAL, VISION INSURANCE • COVERED MALPRACTICE • FLEXIBLE SPENDING ACCOUNTS • 403B WITH MATCHING • Loan Repayment Consultant • CHE ALLOWANCES (DAY/FINANCIAL) • MUCH MORE

Qualifications:

• Board Certified Physicians • Epic - EMR experience a plus but not necessary

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Utah has no shortage of outdoor adventure. It’s also home to one of the best healthcare networks in the nation. Intermountain Healthcare is hiring throughout Utah, for numerous physician specialties.

Physician Job Openings for Brand-New Inpatient Units in Adult, Child, and Geriatric Psychiatry

The Department of Psychiatry at North Shore Medical Center (NSMC), in affiliation with Massachusetts General Hospital (Mass General), has outstanding opportunities for full-time or part-time BC/BE psychiatrists to work in a new, state-of-the-art, 120-bed psychiatric inpatient facility on the NSMC campus in Salem, MA. The facility, opening in the fall of 2019, will feature two adult units, one child and adolescent unit, and one geriatric unit. Each unit will be fully renovated with secure access to attractive outdoor space. The program will be fully integrated with the Medical Center, enabling the provision of excellent medical and subspecialty care to psychiatric inpatients. A full range of behavioral health services will be provided, including substance use disorder treatment and dementia care.

Compensation is highly competitive. The evening and weekend call schedule are very reasonable and provide significant additional compensation. Each unit will be well staffed with social workers and will also have an NP or PA to support physician workflow, optimize workflow, and improve patient care.

There are multiple opportunities for teaching on-site, including supervision of NPs and PAs from Mass General, as well as teaching/supervision of other staff. There are also robust educational and research opportunities at Mass General and Harvard Medical School for the appropriate interested candidate. NSMC offers a vibrant educational environment, with multiple-top-notch CME conferences, clinical case reviews, and an atmosphere of noncompetitive lifelong learning and professional development. There is strong mentoring and support for early career psychiatrists, and expert tase consultation is readily available for complex patients.

Qualified candidates will receive a clinical appointment at both NSMC and Mass General, offering interested candidates an ideal opportunity for education and research engagement and broader collaboration. The Department of Psychiatry at Mass General is consistently ranked among the best in the nation by U.S. News and World Report and works with NSM as a community partner.

Salem is located on the North Shore of Massachusetts, with multiple natural and cultural attractions including beautiful beaches and nearby mountains as well as easy access to museums, art, restaurants, and shops. It is only 15 miles north of Boston (a global life sciences hub, where both Mass General and Harvard Medical School are located) and so has all the advantages of proximity to a wonderful metropolitan area.

Ideal applicants have an M.D. or D.O., have completed residency training in psychiatry (and for the child and adolescent and geriatrics units, the relevant fellowship training) through an ACGME approved program. Candidates must be able to obtain full medical licensure in the Commonwealth of Massachusetts.

North Shore Medical Center is an affirmative action/equal opportunity employer. Minorities and women are strongly encouraged to apply. Pre-employment drug screening is required.

www.joinnspg.org/Psychiatry/Opportunity

Interested individuals should send their CV and letter of interest to Louis Caliguiri, Director of Physician Services at lcaliguiri@partners.org. Applicants with relevant experience will be considered.
Trinity Health Of New England puts our physicians first, because they put their patients first. We entrust our powerful mission and unlimited healing potential in the hands of the best and brightest physicians. And, through their commitment to care, we are constantly innovating and advancing the way we serve patients. Put your career path in focus with what matters—at Trinity Health Of New England.

Find your focus at www.jointrinityne.org/careers/nejm.