Inside

Career: Physician Mentorship: Why It’s Important, and How to Find and Sustain Relationships. Pg. 1

Career: Targeting Physician Burnout. Pg. 9

Career: Physician Shortage Spikes Demand in Several Specialties. Pg. 16

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MD Career Path Edition
Final Year Residents and Fellows, Program Directors

Featured Employer Profile

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

Sincerely,

Christopher R. Lynch
Vice President for Publishing
Physician Mentorship: Why It’s Important, and How to Find and Sustain Relationships

Mentorship is a key factor in promoting and maintaining fulfillment in medical practice. Senior colleagues who share your clinical, research, administrative, or community service interests should be approached early in your formal training. An open and honest dialogue can be instrumental in setting your professional goals, defining its trajectory, and learning how to overcome barriers by adopting successful strategies.

—John A. Fromson, MD

By Bonnie Darves

Most physicians who make their way into satisfying practice careers in a specialty they enjoy — and especially those who also end up in leadership roles — are usually quick to point out to their younger colleagues that they received some help, perhaps even a whole lot of assistance, along the way. Almost invariably, these physician success stories usually have a common thread: an important mentor, or possibly more than one key mentor, whose guidance proved invaluable.

In an era when it’s easy to network and seek guidance online in pretty much any area of one’s life, the notion of the traditional physician mentee-mentor relationship carried out over a series of regularly scheduled formal in-person meetings and the occasional phone conversation might seem almost quaint. It isn’t, and such relationships might be more important now than in the past because the in-touch-and-constantly-connected online environment doesn’t necessarily foster or sustain the deep, candid exchanges that characterize good mentor-mentee interactions.

Anne Pereira, MD, MPH, assistant dean for curriculum at the University of Minnesota Medical School, thinks that some physicians in training fail to recognize the value of establishing and cultivating relationships with mentors. “Absolutely, in-person mentorship remains fundamentally important in medicine, because a lot of mentorship is about developing a relationship that’s close enough that your mentor wants to support you,” Dr. Pereira said. “Unfortunately, I think that the value of having mentors is probably underestimated by many trainees.”

One reason, she points out, is that many young people today who end up in residency have never worked because they have been on a fast track. They’re essentially high-achieving, highly driven professional students who
have been “on a fairly regimented pathway,” she explains, “and they haven’t reached a point where there are multiple pathways they could take.”

When physicians do get to that juncture, having an established mentor relationship might make the difference between a good, thoughtfully considered decision and a poor one later regretted, longtime physician mentors say. Ideally, that relationship — regardless of the logistics of how the parties meet and how frequently they connect — is a deep one predicated on two-way trust and defined objectives.

“In mentorship, I think anything that leads to a mutually beneficial relationship and the accomplishment of shared goals is fair game, but it’s definitely helpful to meet in person,” said Jennifer Best, MD, associate dean for graduate medical education at the University of Washington in Seattle. “Social media and the online universe can present a false sense of depth, and I think that we sometimes present different ‘selves’ in that environment.”

If there is one absolute prerequisite for a successful mentor-mentee relationship, it is a commitment to candor, according to Nathaniel Scott, MD, director of the combined emergency medicine/internal medicine residency program at Hennepin County Medical Center in Minneapolis. “There has to be some degree of personal connection, even in the most formal mentor-mentee relationship, and that both parties must be invested in it and honest if it is going to provide a benefit,” he said. “I think what the local relationship offers over a remote or online one is that your mentor will be more aware of the circumstances you’re in and the issues you are confronting on a more intimate level.”

To look at how young physicians can identify mentors and ultimately thrive in those relationships, NEJM CareerCenter recently spoke with physicians who have served as mentors or benefitted from the guidance that mentors have given them — or both — to obtain their perspectives on key issues.

When should physicians start looking for a mentor, and what’s the best way to go about that?

“Ideally, people should start looking for a formal mentorship program when they’re looking for a residency program. Especially in a large program, having some help finding a mentor is important because it’s difficult to get your feet under you, and get to know the institution and individuals well enough to reach out on your own. I think that mentorship should be an important part of the culture in training programs.”

— Anne Pereira, MD, MPH, University of Minnesota Medical School

“The most important thing is to just start connecting with people in your institution, anyone — you can’t exist in a vacuum. You can do this without necessarily going out and looking for a mentor, by asking someone you admire for advice on a research project, for example, or guidance on how to publish a paper. Start with a specific request, and often, these exchanges will grow organically into a relationship. It’s also helpful to reach out to national physician organizations that provide mentor services on a group or individual level.”

— Chemen M. Neal, MD, assistant professor of clinical obstetrics and gynecology, Indiana University School of Medicine; mentor chair, American Medical Women’s Association

“All physicians should seek mentors as early as possible, and having a mentor when starting training is especially beneficial for international medical graduates (IMGs), because of the cultural challenges they might face. That initial mentor, ideally, should be a successful physician from the IMG physician’s country – whether the mentor is on the program faculty or not. It’s important for hospitals and health systems to help IMGs make those connections, but professional societies can also be helpful.”

— Thomas Norris, MD, board member, Educational Commission for Foreign Medical Graduates and former chair of the American Board of Medical Specialties; former vice dean for academic affairs, University of Washington
"I think the majority of mentor relationships today are informal. By that I mean that you don’t go ask someone, ‘Will you be my mentor?’ I don’t think I’ve ever said that out loud. Instead, look for someone you admire who is ahead of you in the field, or in a position that you might envision for yourself, and establish a relationship by asking a specific question. Then later, ask if that person will grab some coffee with you sometime.”

— Fatima Fahs, MD, dermatology resident, Wayne State University; budding mentor

What qualities or traits should physicians look for in a mentor?

“A good mentor is someone who says, ‘How can I help you succeed?’ and truly wants you to succeed. A lot of people still think that physician mentorship is hierarchical, but it isn’t — and shouldn’t be. When physician mentorship is done well, for the right reasons, the mentor-mentee relationship is a partnership.”

— Susan Reynolds, MD, PhD, president and CEO, The Institute for Medical Leadership

“Start by looking for physicians you admire for their expertise or their skills, who are willing to give you good advice. Also look for people who you see as good people, as models for how you would like to lead your life.”

— Janis Orlowski, MD, chief health care officer, Association of American Medical Colleges

“How many mentor relationships should young physicians try to establish?

“Most of us benefit from having at least a few mentors — a clinical mentor, a research mentor, and an overall career mentor. They don’t all have to be in your field. I think it’s helpful to have a personal mentor, too, someone you bond with who’ll check in and ask you how you’re doing and whether you’re getting enough sleep.”

— Dominique Cosco, MD, associate internal medicine program director, Emory University, Atlanta

“Physicians absolutely need more than one mentor, maybe not in the beginning but definitely toward the end of residency as they start looking for their first job. There’s no perfect single mentor, so I think it’s helpful to create a quilt of mentors — a mentor who can help you procedurally, once who can help you with career planning, and another mentor for life planning.”

— Dr. Pereira
How should young physicians approach about the issue of expectations in a mentor-mentee relationship, and do they even need to address that formally?

“It’s important to make the expectations somewhat explicit from the start. For example, after a first meeting, you might ask the potential mentor if it’s OK to meet for coffee every few months. And if the person says, ‘sure,’ the mentee should reach out to set up the next meeting. After the relationship is established, there should be expectations set about what the mentor and the mentee will do, and by when, and what both are seeking from the meetings.”

— Nathaniel Scott, MD, director, combined emergency medicine/internal medicine residency, Hennepin County Medical Center, Minneapolis

“The physician who identifies a potential mentor should be direct, and say, ‘I’d like you to be one of my career advisors.’ If that person agrees, the two should set expectations about the kind of communication that will occur and how often, and when the mentor will check in to see how things are going. It’s important to set out the expectations of the exchange, because if one party has higher expectations than the other, that could strain the relationship.”

— Jennifer Best, MD, associate dean for graduate medical education, University of Washington

“I think that expectations can be fluid at the start, but as the relationship develops, the parties should set goals and establish what the mentee wants to work on and what he or she will bring to the meeting. It’s important that there be a timeline for goals or projects.”

— Dr. Cosco

What should physicians be sure to do, or avoid doing, when they’re seeking a mentor or working with one?

“Frame your request by telling the person the concrete thing(s) you are interested in, and be specific. One of my pet peeves is when I receive an email that reads ‘Hello, Dr. Fahs. I am interested in dermatology. What advice do you have?’ The right way would be: ‘Hello, Dr. Fahs. I am interested in dermatology. Do you have any advice on how I can obtain a research project in medical school when I don’t have a lot of clinical experience?’”

— Dr. Fahs

“It’s very important to be honest with yourself and with your mentor about the kind of help you’re seeking or what you’re struggling with. Be willing, once the relationship is established, to ask for feedback on what you could do better, and then try not to be defensive, because that could damage the relationship. That honesty should be on both sides. Mentors should be open in sharing the things they didn’t do right in their careers.”

— Joshua Corsa, MD, trauma surgeon who trained at Orlando Regional Medical Center and is doing a critical care fellowship at Harborview Medical Center in Seattle

“Do your homework before you approach your mentor with a question, and don’t use your mid-career mentors or senior faculty member to obtain information that you can get online. Go to your mentor with those more nuanced questions where their expertise and experience will enable you to understand things in a way that you couldn’t by just reading about it.”

— Dr. Pereira

“Prepare well for every meeting with your mentor, and remember that every good mentor is looking for a mentee who is passionate, devoted to the field, and diligent. Because unless the relationship is also gratifying to the mentor, that mentor won’t want to stay in it. Keep in mind that your mentor is very busy, and he or she needs to have a reason to devote that time to you.”

— Nitin Agarwal, MD, neurosurgeon trainee-PGY 4, University of Pittsburgh; American Association of Neurological Surgeons resident advisor
What should physicians do if they’re in a mentor relationship that isn’t working out?

“During training, you only have so much bandwidth. If the relationship isn’t a good fit, let the mentor know that you’re thinking about going in a different direction. Thank the person for the guidance so far, and say, ‘I hope you’re willing to stay in my life in an advisory capacity.’ It’s important to go out on a positive note.”

— Dr. Best

“Most of the time when mentor arrangements aren’t working, things tend to fall off naturally. If it’s a mismatch of expectations — one person wants to meet more frequently than the other — that should be addressed in a way that allows the two parties to just move on.”

— Dr. Scott

“If the chemistry [doesn’t] feel right when you start talking or meeting, find someone else. Working with a mentor is a little bit like dating; if you don’t connect early on, it’s probably a relationship that’s not going anywhere.”

— Dr. Norris

Targeting Physician Burnout

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): www.im.org/page/charm

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

Mayo Clinic Physician Well-Being Program: www.mayo.edu/research/centers-programs/physician-well-being-program/overview

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience: nam.edu/initiatives/clinician-resilience-and-well-being/

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

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Physician Shortage Spikes Demand in Several Specialties

By Bonnie Darves

Physicians wrapping up their training might be a bit anxious about whether they’ll land a position, but these days, in nearly all specialties, that just isn’t a valid concern. The U.S. physician shortage — perennial, if lessening in primary care and becoming more acute by the year in several specialties — pretty much assures that most graduates will have ample practice opportunities.

In the physician workforce, the shortage comes down to the intersection of not just supply and demand, but increasingly, changing demographics as well — notably the aging population. From the standpoint of the projected need for medical services, that particular demand driver is being called, not so jokingly anymore, the “silver tsunami.”

Somewhat ironically, the supply situation will be exacerbated by the aging of the physician workforce: in 2015, 43.2% of active U.S. physicians were age 55 or older. In addition, the number of Medicare-funded training spots has been effectively frozen for two decades, squeezing the pipeline.

This is what the overall shortage looks like, based on the Association of American Medical Colleges’ recently updated projections: By 2025, the country will have a shortfall of between 61,700 and 94,700 physicians. The shortage range AAMC predicts is 14,900 to 35,600 in primary care, and between 37,400 and 60,300 in non–primary care specialties.

That latter category worries a lot of people in academic medicine, health care delivery organizations, and the health policy sector. Janis Orlowski, MD, MACP, the AAMC’s chief health care officer, said that while primary care and psychiatry are two sectors designated federal Health Professional Shortage Areas by the U.S. Health Resources and Services Administration (HRSA), there are growing shortages in many specialties, especially surgical ones, that are less well tracked.

Psychiatry remains a persisting shortage specialty, research suggests, and there is no solution in sight, particularly in child and adolescent psychiatry. A recent study conducted for the Department of Health and Human Services found that the specialty’s workforce — now numbering approximately 45,580 — would need 2,800 more psychiatrists just to meet current care demands. In addition, large areas of the country have no psychiatrists.

The shortage is almost palpable to psychiatry residents, even early in their training. Rashad Hardaway, MD, who finished his fellowship at Seattle Children’s Hospital in June 2017, remembers being “casually recruited” before he completed his first year of residency.

“It started as soon as I began my training,” said Dr. Hardaway, who is an attending at Zucker Hillside Hospital in Glen Oaks, New York, and practices in the Northwell Behavioral Health College Partnership Program. “My family members knew people working in community health centers, and they would say, ‘Have Rashad let me know when he gets ready to finish training, because we have a job for him.’ It puts a little pressure on you, just knowing that there is such a need everywhere — that you won’t be able to serve those populations.”

Kali Cyrus, MD, an assistant professor of psychiatry at Yale University who practices at the Connecticut Mental Health Center in New Haven, started receiving a steady influx of recruitment email inquiries even before her chief year, and then it intensified noticeably. “It really escalated then. I tended not to unsubscribe because it’s nice to know what is out there, even though I planned to stay in the East. It was a little overwhelming,” said Dr. Cyrus, who recently completed a public psychiatry fellowship and now also heads Yale’s Social Justice and Health Equity Curriculum Design.

Surgical specialties’ supply threatened

The AAMC’s 2016 update on physician supply and demand identified several non–primary care specialties where shortages are becoming acute. “We are hearing a lot about an increasing shortage in the surgical specialties, particularly vascular surgery and neurosurgery, but also general surgery, urology, and ophthalmology. And these shortages are severe in some rural areas,” Dr. Orlowski said.

The AAMC report indicates that under even conservative scenarios, the surgical specialties shortfall will reach at least 25,200 by 2025 but might hit 33,200. Although that prediction is cause enough for concern, the maldistribution of physicians — higher concentrations in urban areas and a relative dearth in rural ones — makes shortages particularly acute in some specialties. A recently published HRSA report developed by the firm IHS, which conducts research on the physician workforce, projected a 41%
shortfall in urology by 2025. The report also predicted a deficit of 2,970 general surgeons, 6,180 ophthalmologists, and 5,650 orthopedic surgeons by 2025. By far, the most severe surgeon shortfalls will occur in the South, a deficit of 10,210 FTEs, according to IHS research.

There are inherent challenges in predicting the effect of shortfalls in surgical specialties, Patrick V. Bailey, MD, medical director of advocacy for the American College of Surgeons, points out. “Unlike primary care, there has been no objective definition established by HRSA as to what constitutes a surgical shortage area for general surgeons,” he said. What that means is that when projections are made, primary care's baseline is in the deficit range, Dr. Bailey explained, while “the baseline for surgery is assumed to be zero because no definition has been objectively established. This puts surgery at an unfair disadvantage despite its importance as a necessary component of a community-based health system.”

Neurosurgery, vascular surgery sound alarm

The worst-case scenario in AAMC's surgeon-shortage predictions is top of mind in vascular surgery. Michel Makaroun, MD, president-elect of the Society for Vascular Surgery and chief of vascular surgery at the University of Pittsburgh, states the case in simple terms. “We're bringing in 130 new vascular surgeons each year, but we really need closer to 200 to meet future services demand,” Dr. Makaroun said, “because we have one of the highest mean ages among the surgical specialties. Probably one-third of practicing vascular surgeons are over 55 today.”

A research report published in Health Affairs in November 2013 (Dall, T. et al.) supports Dr. Makaroun’s point, predicting demand growth of 31% by 2025 — the highest for any specialty. It’s a distressing number for a small specialty, which has only an estimated 3,800 board-certified physicians.

The vascular surgery shortage translates in to more than ample practice opportunities for graduates. “Our trainees are getting a lot of job offers — and it's estimated that for every graduating vascular surgeon, there are two or three jobs waiting out there,” Dr. Makaroun said. “And search firms tell us that one of the biggest needs for locum tenens is in vascular surgery. Some of our members use their vacation time to help fill that need.”

Niten Singh, MD, FACS, who directs the vascular surgery training program at the University of Washington, echoed Dr. Makaroun’s observation about the job market for graduates. “I think at first our trainees are nervous they won't find a job. But we reassure them that they have a lot of options — that it’s a great time to be in vascular surgery,” Dr. Singh said. He and other faculty encourage residents to make some decisions early on, about “what they're looking for and where their family will be happiest,” he said, to help ensure they choose the right job. Dr. Singh cites one recent case of a trainee who had lined up seven interviews for highly desirable opportunities within weeks of starting his search.

“I also remind our residents that there are many great places to practice in this country where there's a need,” Dr. Singh said. “But if they want to live in New York City, they'll obviously have to compete with the volume of surgeons there.”

Neurosurgery is another small specialty — there are only approximately 3,800 board-certified U.S. neurosurgeons — that is struggling mightily to address not only the current shortfall but the expected worsening shortage as the population ages. Today, there is only one practicing neurosurgeon for every 60,000 Americans, but that number takes trainees into account, according to Robert Harbaugh, MD, director of the Institute of the Neurosciences and chair of neurosurgery at Penn State University in State College.

“There really is a shortage, and it will only get worse for a lot of reasons,” said Dr. Harbaugh, a former president of the American Association of Neurological Surgeons. Many of the common things that neurosurgeons deal with — spine, stroke, and tumor, for example — all occur at much higher rates, he observed, as the population ages. And like vascular surgery, neurosurgery is also an “aging” specialty; 45% of all practicing neurosurgeons, including trainees, are over age 55.

In addition, the number of training spots has been essentially flat for more than a decade, increasing only 1%, and a mere 200 physicians enter neurosurgery training each year. “That is essentially just replacement level,” Dr. Harbaugh points out.

“The other thing feeding into the shortage is we're simply doing a lot more now in neurosurgery. Using deep brain stimulation for Parkinson's or tremor is common today, and it wasn't even around 15 years ago,” Dr. Harbaugh said.

The upshot, he added, is that all practicing neurosurgeons are “enormously busy. At the same time, it's hard for patients to find a neurosurgeon outside
the urban area. People talk about the shortage of primary care physicians, but the shortage of neurosurgeons is every bit as acute,” he said, considering the specialty’s crucial role in trauma and stroke services.

The worrisome news for the specialty as a whole is a boon of sorts to new neurosurgery graduates. Residents all get plenty of job offers, training program directors report. “Right now, there are many more positions than there are people to fill them, and neurosurgeons are being contacted about positions long before they start their chief year,” Dr. Harbaugh said.

Emily Sieg, MD, MS, a Pennsylvania neurosurgeon who is completing a fellowship in critical care at Penn State, knows that her dual training — a relatively new services approach in the neuro-ICU setting — puts her in especially high demand. “At every place where I have interviewed or looked at, people are very interested in and excited about bringing in a neurosurgeon on the critical care faculty,” she said. “This [combination] is opening a lot of doors for me — it’s something that a lot of hospitals don’t have but are interested in offering.”

On a related note, the shortage is neurology is posing challenges for dedicated neuroscience programs and health systems, and by extension, for recruiters. According to a 2016 HRSA report, the supply of neurologists will grow by 11% between now and 2025, while demand is projected to grow by 16%.

“Neurology is a big one where I’ve having trouble filling positions, and where many of us recruiters have been struggling for quite a while,” said Wanda Parker, president of the National Association of Physician Recruiters (NAPR) and a principal with the Healthfield Alliance in Danbury, Connecticut. “I think that in primary care, practices are able to deal with some of the shortage by bringing in physician assistants and nurse practitioners, but you really can’t do that in specialties like neurology.”

Other specialties feel the pinch

In some of the other non–primary care specialties, the shortage is hard to quantify but readily discernible to those in the field and to recruiters who struggle to help organizations fill positions. Patrice Streicher, associate director of the search division for Vista Staffing Solutions, cites her top-five shortage-fueled recruiting challenges: psychiatry, emergency medicine, hospitalist medicine, endocrinology, and rheumatology. “As an industry globally, both in-house and agency recruiters are all struggling with these specialties,” said Ms. Streicher, a NAPR board member.

Ms. Streicher pointed to another specialty, this one a relative newcomer, where rising demand is eclipsing supply: urgent care. “We hear so much about the primary care shortage, but we’re also seeing a worsening shortage in urgent care, perhaps because of consumer trends,” she said. “People want to be able to see a physician when it’s convenient, even if that’s a Saturday afternoon, for medical issues that don’t require going to the emergency room.”

Cardiology, like neurosurgery and vascular surgery, is a specialty that is already coping with the growing influx of baby boomer patients and increasing rates of cardiovascular disease while simultaneously dealing with an aging workforce (more than 40% of general cardiologists were over 55 in 2013). The shortage persists despite brisk enrollment in training programs — there were 2,598 general cardiology fellows in 2014, a 20% increase from 2005; and applications to interventional cardiology training programs increased by over 30% from 2011 to 2015, according to an October 2016 report in the American Journal of Cardiology (Narang, A. et al.).

Other significant contributors to the shortage in cardiology — the aforementioned Health Affairs report predicted a 20% increase in services demand by 2025 — are the aging workforce and maldistribution, according to George Rodgers, MD, an assistant professor at the University of Texas at Austin, who led a landmark 2009 American College of Cardiology workforce report.

“Yes, there’s a sense that we have a shortage of cardiologists because there’s been little difference in the number of new cardiologists being minted since 2009. But our biggest issue is the maldistribution,” Dr. Rodgers said. “We’ve got a high concentration in urban areas and a low concentration in rural areas — that’s throughout the United States.” Many practices that have struggled to recruit cardiologists have implemented care teams incorporating advance practice clinicians such as nurse practitioners, Dr. Rodgers noted, but that isn’t a solution to the imminent demand surge, given that more than 40% of the population is expected to have cardiovascular disease by 2030.

For now, Dr. Rodgers observed, the skewed supply-and-demand picture “means that 100% of physicians finishing a cardiology fellowship get a job, but many areas of our country will remain underserved,” he said.
I have no trouble attracting cardiologists to Austin, but if I were in McAllen, Texas, it would be much harder.

Seeking remedies for the shortage

A debate about the severity of the physician shortage is ongoing, but there is consensus that addressing the shortfall will require a multifaceted approach. It’s also accepted that simply creating team-based care models incorporating nonphysician providers won’t suffice. Likewise, the fast-track training pathways, such as the integrated residencies in some surgical and non–primary care specialties, will help alleviate the shortage — but not anytime soon.

“We’re making inroads into addressing the shortage, but the numbers are going to be impressive, so we have to continue to work on this,” Dr. Singh said.

The approach that holds the greatest potential for reducing the shortage, many physician organizations, training program leaders, and policymakers maintain, is to increase the number of government-funded graduate medical education (GME) training spots to better reflect the increasing and aging U.S. population. Recently crafted legislation, the Resident Physician Shortage Reduction Act of 2017, calls for an additional 15,000 Medicare-supported residency positions over the next five years.

“There will be a significant workforce shortage under all likely projections, and the most effective solution will be to train more physicians,” Dr. Orlowski said.

The American Medical Association, a longtime proponent of increasing the number of medical residency slots, is intensifying its efforts. The AMA’s SaveGME campaign, an initiative urging Congress to protect federal funding for GME, encourages residents to get involved by writing to their elected officials and educating patients on the role that trainees play in care access.

The AMA also recently urged the Centers for Medicare and Medicaid Services (CMS) to modify requirements that new residency programs meet stringent criteria within five years to continue qualifying for an appropriate GME funding level, to allow programs in underserved or economically depressed areas more time to get established.

Omar Maniya, MD, MBA, an AMA board member and emergency medicine resident in New York City, said that the five-year period is unrealistic in some cases. “The current five-year deadline for developing new residency programs in underserved areas before a cap is placed on the amount of Medicare funding they can receive is not effective,” he said. “We will urge CMS to give institutions the time they need to identify qualified, willing teaching partners to create residency programs … to meet the needs of patients in underserved areas.”

Did you find this article helpful? What other topics would you like to see covered? Please send us an email to let us know what you thought at resourcecenter@nejm.org.
Introduced in the early 1990’s, Relative Value Units (RVUs) have become more significant in determining total compensation. The largest single element impacting physician experience, quality of care, coordination of care, the number of procedures performed. It is a product toward similar value-based measures. Compensation outcomes, physician compensation is gravitating as the healthcare industry shifts toward value-based compensation packages.

Today’s physician compensation models are like the healthcare industry: highly dynamic and increasingly complicated. Many doctors find it challenging to assess how the compensation package of their first job will align with their personal and professional priorities.

Let’s review some of the approaches involved in compensation packages.

**VALUE-BASED MEASURES**

As the healthcare industry shifts toward value-based outcomes, physician compensation is gravitating toward similar value-based measures. Compensation is no longer driven exclusively by patient volume and the number of procedures performed. It is a product of many factors including cost of care, patient experience, quality of care, coordination of care, and productivity. Typically, productivity remains the largest single element impacting physician compensation. But, it is important to recognize value-based factors, which now comprise up to 20% of total compensation.

**RVUs**

Introduced in the early 1990’s, Relative Value Units (RVUs) have become more significant in determining everything from physician compensation to medical practice buyouts and consolidations. In general terms, the physician’s component of the RVU accounts for: time, technical skill and effort; mental effort and judgment; and stress to provide a service.

Practices are using work RVUs and a practice-specific conversion factor to determine compensation. Another typical approach is predicated on using a base salary plus a bonus calculation based on the number of RVUs generated.

**STACKING**

As if compensation packages weren’t complicated enough, organizations are utilizing an approach referred to as stacking. This is an arrangement where physicians are performing multiple roles and being compensated individually for each. For example, a hospitalist has a full-time schedule where they are in the facility every other week. During the off-weeks, the hospitalist works shifts in the critical care unit, and also puts in 10 hours a week as the medical director of the hospitalist program. By the time all of those responsibilities are accounted for, the hospitalist’s total compensation package is greater, but more complex.

**HOW LOCATION AFFECTS PHYSICIAN COMPENSATION**

Geographic region and market size significantly influence compensation and how far your income will stretch. So, it is important to adjust for the cost of living in dollars and assess the location with your lifestyle expectations in mind.

Work schedules, after-hours activities, vacation coverage, and weekend shifts influence work/life balance. It’s important to know what a future employer expects, and how they assist physicians in managing stress, avoiding burnout and cultivating career satisfaction.

**MORE COMPENSATION COMPONENTS**

Compensation begins with, but doesn’t end with a base salary. Most employers combine an agreed upon salary with variable components that affect total compensation. You need to determine – and be comfortable with – how much of your pay will be based on your individual performance, organizational performance and other factors like patient satisfaction. It is fair to ask how those variables have affected compensation in recent years – and why.

Potential employers routinely offer first year incentives, such as signing bonuses, student loan repayments, and reimbursement for relocation, licensing and board certification. Looking further ahead, there may be opportunities to earn more by taking on supervision of advanced practitioners, precepting medical students, or serving as a medical director. Depending on your tolerance for risk, negotiating ownership shares is another way to potentially benefit financially from the future growth and performance of a practice.

With all of the complicating factors contributing to compensation, physicians have to do their homework to determine which opportunity offers a fair package, a satisfying work environment, strong cultural fit with the organization and a happy life outside of work.

Today’s physician compensation models are like the healthcare industry: highly dynamic and increasingly complicated. Many doctors find it challenging to assess how the compensation package of their first job will align with their personal and professional priorities. As a resource for physicians, Jackson Physician Search has introduced a newly updated physician compensation resource center includes an interactive calculator that enables you to:

- Easily access customized physician compensation data
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If you have any further questions about how physician compensation works, please connect with our recruiters for information and guidance.
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This advertisement is 58 words. At $9.04 per word, it equals $532.52. Because a reply box was requested, there is an additional charge of $75.00 for each insertion. The price is then $599.52 for each insertion of this ad. The ad would be placed under the Chiefs/Directors/Department Heads classification.

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Donna Lafean
Central Maine Medical Center
300 Main Street
Lewiston, ME 04240
Email: Lafeando@cmhc.org;
Fax: 207/344-0658; Call: 800/445-7431
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The Division of Infectious Diseases in the Department of Internal Medicine at Eastern Virginia Medical School (EVMS) is recruiting a full-time faculty as an Assistant or Associate Professor. The position includes clinical care, teaching, and research opportunities with a competitive salary and benefit package.

The EVMS Division of Infectious Diseases is well established and highly respected in the region. The division has seven (7) full-time faculty members, three (3) part-time faculty members, four (4) Advanced Practice Clinicians (APCs), and a fellowship training program. The faculty are engaged in a diverse outpatient infectious diseases practice including HIV care supported by Ryan White part A, B, and C programs.

There is an offsite Wound Care and Hyperbaric Medicine clinic. Infectious consultations are provided at the affiliated 525-bed acute care hospital to all medical and surgical specialties including busy heart Pre-Transplant/Transplant and Renal Transplant services. The division members have a major role in the development and teaching of integrated microbiology curriculum for M1 and M2 medical students. In addition, we provide class room and bedside teaching for M3, M4, and PA students. Research programs include NIH funded translational and epidemiology/surveillance projects. The division members are consistently engaged in many other academic activities including IRB approved prospective research projects, major scholarly contributions to Infectious Diseases Literature I6SA organizational/educational activities and national international collaborations. The new faculty member will be provided mentorship and support in order to excel in all three areas of academic medicine.

EVMS is located in the historic port city of Norfolk which is centrally located in the 1.8 million person Hampton Roads area on the Chesapeake Bay, a short drive from the Virginia Beach oceanfront. This area is rated nationally for best places to raise a family. Forward CV and letter of interest to:

http://www.evms.edu/about_evms/administrative_offices/human_resources/jobs

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Our physicians enjoy close clinical relationships, superior staffing resources, minimal call, a fully integrated EMR (Epic), excellent salaries and an exceptional benefits package.

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EVMS Eastern Virginia Medical School

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Norfolk, VA 23507
E-mail: lafeando@cmhc.org
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Check out our 300+ opportunities nationwide at cejkasearch.com. We can help you secure a stipend while you finish your training!

FELLOWSHIP OPPORTUNITY – Cardiology (Advanced Heart Failure)

The program is a one-year program which continues to accept applications from highly qualified physicians who have completed their board eligibility in Internal Medicine. We are currently interviewing for the 2019 and 2020 academic years. The ideal candidate must have successfully completed a three-year residency in an ACGME accredited Internal Medicine program, a three-year fellowship in an ACGME accredited Cardiovascular Disease program, and should be certified or eligible for certification in Internal Medicine by the American Board of Internal Medicine. Currently, three (3) fellows are accepted each year for this one-year fellowship, chosen by the UT Health Advanced Heart Failure Program leadership.

This program is currently ACGME accredited in Advanced Heart Failure and Transplantation specialty. The goal of our training program is to produce outstanding Advanced Heart Failure cardiologists who excel in all areas of core competencies in Advanced Heart Failure and these other six (6) areas: (a) patient care, (b) medical knowledge, (c) practice-based learning and improvement, (d) interpersonal and communication skills, (e) professionalism, and (f) systems-based practice. The training program views professionalism to be one of the most important attributes of Advanced Heart Failure cardiologists and encourages the fellows to strive for and attain the highest level of professionalism that lasts a lifetime.

If interested, please contact:
Jessica Fiske, Senior Administrative Manager at jessica.fiske@uth.tmc.edu

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We are seeking candidates with a record as a respected scholar and productive investigator. The successful candidate will have access to considerable resources for promoting exceptional scholarship spanning model systems to outcomes research and nurturing the next generation of Allergy & Immunology specialists within a highly collaborative environment.

The candidate should be an M.D., M.D./Ph.D. or Ph.D. with relevant experience in clinical, translational and/or basic science research programs. Physician candidates should have primary training in a relevant adult or pediatric specialty.

Contact:
William G. Powderly, M.D.
Allergy & Immunology Search Committee
Campus Box 8051; 660 South Euclid Avenue
St. Louis, MO 63110
wpowderly@wustl.edu

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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, pregnancy or pregnancy-related conditions or any other characteristic protected by law. Women and minority candidates are particularly encouraged to apply.

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Genitourinary Medical Oncologist
The Lank Center for Genitourinary Oncology

The Dana-Farber Cancer Institute (DFCI) is recruiting an outstanding medical oncologist to join the Lank Center for Genitourinary Oncology, which is a thriving clinical and translational research unit dedicated to the treatment of genitourinary cancers. The focus of this position is on a clinical investigator with experience in clinical trials and clinical care of patients with genitourinary cancers. The successful candidate will also engage in teaching students, house staff, and fellows in the clinic and inpatient settings. The successful candidate is also expected to develop, participate, and take an active role in the Lank Center’s clinical activities.

Appointment at the Instructor, Assistant or Associate Professor level at Harvard Medical School will be commensurate to academic accomplishment.

The position will be based in both the Department of Medical Oncology at DFCI and the Department of Medicine at the Brigham and Women’s Hospital and includes collaboration with other institutions affiliated with the Dana-Farber/Harvard Cancer Center and the Harvard Medical School. Candidates must be board eligible or certified in medical oncology.

Please send a cover letter, a curriculum vitae, and names and email of three references by July 15, 2018 to:
Toni Choueiri, MD, Director, Lank Center for Genitourinary Oncology, Chair, Genitourinary Medical Oncology Search Committee, Dana-Farber Cancer Institute, c/o Cristina Veranian, 450 Brookline Avenue, D1230, Boston, MA 02215, Email: Cristina_Veranian@DFCI.HARVARD.EDU, Fax: 617-632-2165

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Contact Information:
Kriste Baker, Sr. Physician Recruiter
866-977-5488, 864-560-6331
kbaker@vlex.com | www.spartanburgenortheast.com

Angela Allen-Cornelius, Provider Recruiter
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If you are interested in this opportunity, please contact Christine Bourbeau, Regional Director, Physician & Advanced Practitioner Recruitment, at 800.888.3134 or via email at CHAproviders@challiance.org. CHA Department of Provider Recruitment may be reached at 800.888.3134.

For more information, please call Christine Bourbeau, Regional Director, Physician & Advanced Practitioner Recruitment, at 800.888.3134 or email your CV and letter of interest to CHAproviders@challiance.org.
The Division of General Internal Medicine (GIM) within the Department of Internal Medicine at Eastern Virginia Medical School (EVMS) is recruiting full-time faculty at the level of Assistant or Associate Professor. The position includes clinical care, teaching, and research responsibilities with a competitive salary and benefit package.

The EVMS Division of General Internal Medicine is a well-established and highly respected group of full-time faculty with extensive teaching and clinical responsibilities. Faculty members care for a diverse panel of patients in our resident faculty practice as well as in underserved clinics. Faculty members also supervise inpatient teaching teams at our affiliate academic centers, Norfolk General Hospital, Sentara Norfolk General Hospital, and the VA Central Virginia Health Care System. In addition to clinical care and teaching, faculty have many important administrative roles within the school, and at our affiliated clinical sites. Mentorship and support is available to allow incoming faculty to grow and excel in all three areas of academic medicine.

EVMS is located in the historic and vibrant port city of Norfolk which is centrally located in the 1.8 million person Hampton Roads area on the Chesapeake Bay, a short drive from the Virginia Beach oceanfront. This area is rated nationally for best places to raise a family.

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- Pulmonology/Critical Care
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- Gynecology/Oncology
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- Pediatric Hospital Medicine
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- Psychiatry-Adult and Child
- Wound Care
- Urology
- Colorectal Surgery
- Hematology/Oncology

The Pioneer Valley is a thriving area located in western Massachusetts and provides extensive access to urban, suburban and rural amenities. Anchored by the city of Springfield, our region boasts a myriad of opportunities for recreation, music, education and art enthusiasts. When you live and work in the Pioneer Valley, you will enjoy picturesque four-season living, excellent schools and year-round social and cultural events. In fact, Massachusetts was once again ranked #1 in Education nationally by U.S. News and World Report.

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- Emergency Medicine
- EMS Regional Medical Director
- Pulmonology/Critical Care
- Endocrinology
- Gastroenterology
- Geriatrics
- Adult Hospital Medicine
- Reproductive Endocrinology
- Maternal Fetal Medicine
- Gynecology/Oncology
- Child Neurology
- Pediatric Hospital Medicine
- Neonatology
- Psychiatry-Adult and Child
- Wound Care
- Urology
- Colorectal Surgery
- Hematology/Oncology

The Pioneer Valley is a thriving area located in western Massachusetts and provides extensive access to urban, suburban and rural amenities. Anchored by the city of Springfield, our region boasts a myriad of opportunities for recreation, music, education and art enthusiasts. When you live and work in the Pioneer Valley, you will enjoy picturesque four-season living, excellent schools and year-round social and cultural events. In fact, Massachusetts was once again ranked #1 in Education nationally by U.S. News and World Report.

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