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The latest physician jobs brought to you by the NEJM CareerCenter
Preparing for the Virtual Physician-Job Interview

The interview has become a new world, for now, with the pandemic, and both prospective employers and physician candidates are adjusting

By Bonnie Darves

Physicians and other health care professionals know well that functioning — and practicing medicine — in a pandemic is a very different and much altered experience from a year ago. Even though physicians and residents are often providing care in fraught and challenging environments, when it comes to looking for a new practice opportunity, they're not likely to find themselves at the point of care but rather in their living rooms. Interviews have gone virtual in a big way as the risks and logistics of the traditional site interview have prompted employers and even candidates to forgo site visits.

What this means is that both parties are having to adjust. Employers are increasingly vetting candidates without ever shaking hands or watching physicians interact in live group settings. Physicians are trying to figure out how to put their best face forward over video platforms such as Zoom, Skype, GoToMeeting, or Cisco Webex, to name a few, and how to make the most of what can be an awkward exchange.

The good news, for physicians, is that this is a new and evolving experience for all involved. As such, it's important to keep in mind that many people, including employers and senior physicians on the call, might find the video virtual interview challenging. It's not a technology-proficiency test, after all. However, on the technology front, physicians who find themselves in job-search mode during the coronavirus pandemic should do their best to prepare themselves, their environment, and their computers or devices for a successful meeting. The means “attending” the session as professional as possible and ensuring that extraneous factors or technology don’t get in the way of a productive conversation.

Some of the prerequisites for virtual interviews are no different than they are for a formal site-visit interview. First and foremost, look the part and dress professionally. It might feel awkward to don a suit or, for women, other formal business attire, but that's a must. Physicians should be well dressed, well groomed, and reasonably refreshed when going to a video interview. In other words, treat the experience as if it were a formal site visit. In other words, treat the experience as if it were a formal site visit.

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interview that you traveled to and prepared for in advance. Leave the casual demeanor behind, or at least in the other room.

It’s key to know exactly who will be on the video call and what their roles are, so that candidates can read bios and prepare accordingly. It’s also appropriate to ask about the length of the interview and to request an agenda, if one will be prepared.

Following are some of the most important considerations in preparing for a video interview:

Prepare and “professionalize” the immediate environment. For starters, the room should be well and brightly lit and the background clean and free of clutter. That means ensuring that there isn’t an unsightly stove or a television or even a stack of books or laundered T-shirts in view. As a background, a blank wall, an unembellished window, or a background cabinet with a non-distracting tasteful décor item all work well. Alternatively, many video platforms enable use of green-screen effects, which replace the actual background with a digital or virtual background. A word of caution is in order here: Candidates whose home environments are unsuitable and who want to use a background should opt for something clean and simple, not a potentially distracting image of a tropical beach, an old-growth forest, or a fake wine cellar. Finally, make sure that the lighting in the room is unobtrusive and doesn't interfere or produce visible glare.

Do a trial run and then take the time to record a hypothetical session with a friend or family member. In advance of a virtual interview, candidates should receive specific instructions on the technology that will be used, as well as a link for getting into the session. For those who haven't used the technology that will host the meeting, it's important to get a trial subscription and ensure they're familiar with the way it works and any features that might be used. Many physicians in primary care and internal medicine subspecialties have already had their trial by fire conducting patient virtual visits, but for others, video-meeting platforms might be new turf.

Get rid of noise and potential distractions. The interview setting should be quiet and calm. That means ensuring that background noises, including pets and family members, aren’t a factor. Ideally, opt for a completely quiet room — and house or apartment — if possible, and close windows to minimize street noise. Even minor background sounds, such as someone starting a washing machine two rooms away, can be bothersome enough to be overheard or, worse, distract the interviewee. Of course, it goes without saying that cell phones should be silenced and that all computer notifications that might chime during the session are turned off.

Ensure optimal body and face positioning. Even virtual-meeting veterans have likely found out the hard way that having the face positioned too far up or down, and the computer screen below eye level, can affect the experience. The interviewee’s head should be looking straight ahead, not down toward a keyboard, which could be very distracting to the interviewer(s). If a candidate is hunched over, for example, that will be visible to interviewers.

Having the computer or device properly elevated before the interview begins is key, so that the physician doesn’t need to make adjustments during the session. And once the session is underway, it's important to maintain focus by not moving the head too much or looking off to the side. Even if that feels somewhat stiff, it won't come across that way to the interviewer. It's OK to use some body language, when appropriate, but that should be kept to a minimum because there's not a large room to “absorb” it. Finally, physicians who aren't sure how best to position their devices should ask for help from someone with virtual-meeting experience before the interview. In any event, the interviewee and the equipment should be positioned to enable natural-seeming eye contact between all parties.

Get the technology in order. First and foremost, ensure that the Internet connection is solid, and that the computer or device is fully charged and updated, so that it's not likely to interject with an “update-needed” message. It’s also a good idea to close out any applications and websites that might be running in the background, not only because of potential distraction but also to ensure that the call loads efficiently.

Second, although computers and devices have built-in speakers and some have microphones, the quality of that audio experience can vary considerably. Physicians who expect to attend multiple video interviews or a period of a few months should consider purchasing and installing high-quality USB audio technology. One of the frequent complaints that business people make these days about video meetings that involve potentially multiple attendees is that poor-quality audio from an attendee's computer is distracting.
The same goes for the video quality. Most laptops have an integrated web camera, but some might not, and older desktop computers likely don’t have one. If the video quality on the computer is poor, it might be worthwhile to purchase a good-quality web camera. Then, ensure that it’s optimally positioned — ideally above the screen, and look at the camera, not the screen, while speaking.

Finally, if the physician candidate might be asked to share a document or other item onscreen, preparing in advance is crucially important. Spending a fretful minute or two trying to get the requested item in view can be nerve-wracking for the physician and possibly annoying for the interviewer.

Some aspects of interviews haven’t changed

After physicians have prepared their environments and equipment to support a successful interview, they should remember that even with the pandemic, the expectation is that the proceedings will be business focused. Just because there’s not a conference room in the mix, it doesn’t mean that casual behavior is okay. It isn’t. The session likely will be conducted formally and highly professionally. As such, interviewees should avoid chitchat or lengthy discussion about the pandemic unless the interviewer raises the topic and seeks their perspective.

One thing to watch for in the video interview is that people sometimes talk over each other more than they might in a room, when they’re anxious to make a point. That’s never okay in a face-to-face meeting, and it’s potentially more distracting (and apparent) within the confines of a video session. Because there is sometimes a brief lag after someone speaks, depending on the technology in use, it’s advisable to wait an extra second or two before speaking.

As with any interview, candidates should ask questions at the end of the interview — about culture, team makeup, and roles and responsibilities — and during proceedings if it’s appropriate. Those questions should be prepared ahead of time. Candidate should also spend extra time researching the organization and reviewing any information that’s available online about both the practice and the community. Without the benefit of a facility walk-through, the physician candidate might need to elicit important information about the actual working environment, available equipment, and other factors that would affect daily practice. It also helps to keep the names of interview participants handy in any virtual roundtable interview involving more than three participants.

As with any type of interview, timely follow-up is important. Candidates should send an email thank-you note to key interviewers and any recruiter or staff member(s) who arranged the session, ideally within 24 hours. If the candidate is highly interested in the position, it’s appropriate to express that in the thank-you note and to inquire about possible next steps.

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When You Finally Get to Pick — Choosing Your First Job out of Training

By Nisha Mehta, MD

Do you remember checking off the “pre-med” box in college? For many of us, that decision set us on a trajectory for the next decade or more — what classes to take, exams to study for, and rotations to do. Sure, we had some decisions along the way, such as choice of specialty, fellowship, and medical school and training programs, but for the most part, somebody told us where and when to show up, and what to do, and we did so.

As you approach the end of training, there’s a different decision that in many ways is much more complicated. Now you’ve got to figure out what that life you’ve been working so hard for actually looks like. Do you want to be an academic physician, a physician employed by an organization, in private practice, or go out on your own? Do you want to practice full time or part time, and if part time, what does that look like? Do you want to take call or not? What complexity of patients do you want to see? Who do you want your colleagues to be?

For the first time in your adult life, you get to decide what everyday looks like, and for many early career physicians, on any given day, depending on who you speak to, you could be persuaded into a lot of decisions.

This is where it’s really important to take a step back, and ask yourself what it is that you really want. It’s also time to brush away all the answers that you “should” give, which you’ve carefully honed over the years to reflect preconceived notions about what being a doctor looks like. You really don’t have to fit a stereotype anymore. If you want to work two days a week from 9–2, chances are, if you try hard enough and are flexible enough, you can make that happen.

Here’s my advice. First, take some time to list all of your dealbreakers. This goes in both directions in terms of things that you need to be happy and things that will actively make you unhappy. If you know that any job that requires you to take your vacation in one week blocks instead of having the ability to take individual days will detract from your overall happiness, put it on there. Then start listing qualities in the ideal situation. Be brutally honest with yourself about things: how much money you want to earn, where you want to live, and what kind of hours you want. If your ideal job has a true lunch hour where you can eat or exercise, put that down on the list.

If your ideal job requires partners that regularly have journal club and go over cases together, put that down. This isn’t to say you will find a job that has every single thing you want, but it helps to have objective criteria to look at when evaluating options. This way, you don’t get swayed when a job offers you twice what you had listed as the amount of money you need, but is wrong for you in every other way.

Once you have your list ready, try and talk to people who have similar jobs. This can be hard for a lot of trainees, because you may not have a lot of exposure to physicians outside of your academic institution. Reach out to your alumni networks from medical school and residency, online physician communities, medical societies, or elsewhere to see what pros and cons they may point out that you hadn’t thought of. While you have their attention, ask them if they know of any jobs that meet those criteria or places to start looking, and ask them for input about jobs that you may have come across. Often times, someone will have inside information about a particular organization or group that may positively or negatively influence whether you want to take a job.

Of course, your final step is how you actually feel after you’ve interviewed at a job. This is a long topic that likely warrants it’s own post, so I’ll write about that another time.

As straightforward as this may sound, most graduating trainees don’t take the time to go through this process, and it’s probably a big contributor to why job turnover is so high in the first few years into practice. Many people jump on job offers for the wrong reasons — the job is prestigious, recommended to them by a mentor, it’s in the town they’ve always pictured them selves, medical societies, or elsewhere to see what pros and cons they may point out that you hadn’t thought of. While you have their attention, ask them if they know of any jobs that meet those criteria or places to start looking, and ask them for input about jobs that you may have come across. Often times, someone will have inside information about a particular organization or group that may positively or negatively influence whether you want to take a job.

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Native-Valve Infective Endocarditis
Henry F. Chambers, M.D., and Arnold S. Bayer, M.D.

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

The Clinical Problem

Native-Valve Infective Endocarditis is uncommon, with an incidence of approximately 2 to 10 cases per 100,000 person-years. The presumed initiating event is injury to the valvular endothelium or endocardium. This injury exposes subendothelial collagen and other matrix molecules to which platelets and fibrin adhere and form a microthrombotic lesion called a sterile vegetation. Bacteria circulating in the bloodstream then bind to and colonize this lesion. In the absence of an effective host response, bacteria replicate in situ, stimulating further platelet and fibrin deposition to form an infected vegetation that is the hallmark of infective endocarditis (Fig. 1).

Vegetations create a protective microenvironment that is poorly accessible to neutrophils and host defense molecules. Vegetations are loaded with bacteria at very high densities (i.e., 10² to 10⁶ colony-forming units [CFU]/per gram of vegetation) that promote high-grade bacteremia and further growth of the vegetation, which becomes friable and readily fragments into the circulation. These conditions (high bacterial densities, growing vegetation, and friability and fragmentation of the growing vegetation) drive the four mechanisms that are responsible for most of the clinical features of infective endocarditis and its complications: valvular destruction, paravalvular extension of infection, and heart failure; microvascular and large-vessel embolization; metastatic infection of target organs (e.g., the brain, kidneys, spleen, and lungs); and immunologic phenomena such as hypocomplementemic glomerulonephritis and false positive serologic findings of rheumatoid factor, antineutrophil antibodies, or syphilis.

Cardiac conditions that predispose to infective endocarditis include congenital disease (e.g., ventricular septal defect and bicuspid aortic valve) and acquired valvular disease (e.g., degenerative valvular disease, aortic stenosis, and rheumatic heart disease). Rheumatic heart disease, the most common predisposing condition for infective endocarditis in developing countries, is uncommon in developed countries, where the most frequent predisposing cardiac conditions are degenerative valvular diseases, congenital valvular abnormalities, and intracardiac devices. Non-cardiac risk factors include poor dentition, intravenous drug use, hemodialysis, chronic kidney disease, diabetes, compromised immunity, neoplastic disease, and indwelling intravascular devices. Fever and heart murmur, the two signature features of infective endocarditis, are present in approximately 90% and 75% of patients, respectively. Infective endocarditis may present acutely with a rapidly progressive course complicated by congestive heart failure, stroke, systemic or pulmonary embolization (severe sepsis or septic shock), or subacutely with nonspecific symptoms such as low-grade fever, malaise, chills, sweats, dyspnea, back pain, arthralgias, and weight loss over a period of weeks or months.

Microembolic or immunologic phenomena such as splinter hemorrhage, conjunctival hemorrhage, Osler nodes (distal vasculitic lesions of the fingers and toes), Janeway lesions (vasculitic lesions of the palms and soles), and Roth spots (hemorrhage...
The modified Duke criteria provide the framework for the diagnosis of infective endocarditis. A definitive pathological diagnosis can be made if organisms are identified on histologic analysis or culture of the vegetation, intracardiac abscess, or peripheral embolus, or if evidence of a vegetation or intracardiac abscess is confirmed by histologic analysis showing active endocarditis. A definite or possible clinical diagnosis of infective endocarditis is based on a combination of major and minor criteria that are rooted in microbiologic, echocardiographic, and clinical metrics (Table 1). The sensitivity of the modified Duke criteria for infective endocarditis is approximately 90% for definite cases and higher if possible cases are included. These criteria have lower sensitivity in infections related to a prosthetic valve or cardiac device, endocarditis on the right side of the heart, and culture-negative infective endocarditis. The negative predictive value is approximately 90% when criteria are not met for either definite or possible infective endocarditis.

Blood cultures are the most important microbiologic tests for the diagnosis and treatment of infective endocarditis, and they fulfill a major Duke criterion. Antimicrobial therapy largely hinges on the organism isolated. The reported sensitivities are 77 to 100%. Next-generation sequencing, which is expected to be more accurate than PCR-based methods, is anticipated in the coming years. The preferred specimen for molecular assays is an excised valve or vegetations; Plasma DNA amplification assays may as...
Antimicrobial Therapy

Recommendations for antimicrobial therapy for infective endocarditis (Table 3) are based almost entirely on observational studies rather than on randomized clinical trials. These recommendations rest on four basic principles: the ability of the regimen to kill the pathogen, the administration of a prolonged course of therapy (i.e., weeks rather than days), intensive dosing to ensure adequate drug exposure, and source control. In general, vancomycin plus ceftriaxone is a reasonable choice for empirical therapy to cover likely pathogens while cultures are pending in patients with native-valve infective endocarditis, its role in native-valve infective endocarditis is poorly studied and unclear.

### Table 3. Antimicrobial Regimens for Treatment of Native-Valve Infective Endocarditis

<table>
<thead>
<tr>
<th>Microorganism and Regimen</th>
<th>Dose and Duration of Treatment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancomycin or daptomycin</td>
<td>Vancomycin or daptomycin is an option for strains with high-level aminoglycoside resistance; limited data suggest that gentamicin can be discontinued after 2 wk.</td>
<td>Not recommended for strains with high-level aminoglycoside resistance; limited data suggest that vancomycin can be discontinued after 2 wk.</td>
</tr>
<tr>
<td>Methicillin-resistant S. aureus</td>
<td>Methicillin-resistant S. aureus (MRSA)</td>
<td>Not recommended for strains with high-level aminoglycoside resistance; limited data suggest that vancomycin can be discontinued after 2 wk.</td>
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**Antimicrobial Therapy continued:**

is the drug of choice for infective endocarditis that is caused by methicillin-susceptible strains of S. aureus (MSSA). Randomized, controlled trials have shown that combination therapy with an antistaphyloccocal penicillin and either gentamicin or rifampin does not improve outcomes and is associated with adverse events; therefore, this combination is not recommended.22-24 Cefazolin is a reasonable alternative for patients with MSSA who cannot receive penicillin without out-of-pocket expense.22-24 One concern with cefazolin is that some strains have an "inoculum effect," which is defined as an increase in the broth dilution minimum inhibitory concentration (MIC) to 16 μg per milliliter or greater at an inoculum of 5×10^4 CFU per milliliter (100 times the standard inoculum of approximately 5×10^4 CFU per milliliter).22 This inoculum effect, which is due at least in part to hydrolysis of cefazolin by staphyloccocal penicillinase, may be associated with clinical failure.22

Daptomycin or vancomycin monotherapy is recommended for treatment of native-valve infective endocarditis caused by methicillin-resistant S. aureus (MRSA).22-24 The benefit of combination therapy remains unproved. A randomized trial comparing vancomycin (or, in 8 patients, daptomycin) alone or in combination with an antistaphyloccocal beta-lactam antibiotic (primarily flucloxacillin) for MSSA bacteremia in 363 patients (including 42 with infective endocarditis) showed no benefit of the combination for the primary composite outcome of mortality at 90 days, persistent bacteremia at day 5, microbiologic relapse, or microbiologic treatment failure.23 The combination group had higher mortality at 90 days (despite more rapid clearance of blood cultures) and a significantly higher incidence of acute kidney injury. Ancillary data suggest that combining a second agent (e.g., ceftazidime) with vancomycin or daptomycin may benefit patients who have persistent bacteremia or otherwise do not have a response.22-24 However, the most beneficial combination is currently unknown.

Combination therapy is recommended for the treatment of enterocolcal infective endocarditis. Penicillin or ampicillin in combination with low-dose, synergistic gentamicin has been the standard treatment for decades. The usefulness of this regimen is limited by gentamicin toxicity and an increasing incidence of high-level resistance to gentamicin that indicates a lack of

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**Microorganism and Regimen**
- **Penicillin MIC ≤0.12 μg/ml**
  - **Penicillin G**
  - **Ceftriaxone**
  - **Vancomycin**
  - **Penicillin and Gentamicin**
    - Dose and Duration: 24 million units/day intravenously in 2–3 divided doses for 4 wk
  - **Vancomycin Plus Gentamicin**
    - Dose and Duration: 30 mg/kg intravenously in 2–3 divided doses for 4–6 wk
  - **Ceftriaxone Plus Gentamicin**
    - Dose and Duration: 2 g intravenously once daily plus gentamicin (3 mg/kg intravenously once daily) for 2 wk

**Comments**
- **Penicillin G**
  - Avoid gentamicin in patients with preexistent renal disease, in the elderly, and in patients at risk for nephrotoxicity or ototoxicity (i.e., in those receiving other potentially nephrotoxic or ototoxic drugs).
- **Ceftriaxone Plus Gentamicin**
  - Avoid gentamicin in patients with preexistent renal disease, in the elderly, and in patients at risk for nephrotoxicity or ototoxicity (i.e., in those receiving other potentially nephrotoxic or ototoxic drugs).
- **Vancomycin Plus Gentamicin**
  - If the ceftriaxone MIC of the isolate is ≤0.5 μg/ml, ceftriaxone alone is an option.
synergy. Observational data suggest that a 6-week course of ampicillin plus ceftriaxone is an acceptable alternative for treatment of infective endocarditis caused by ampicillin-susceptible strains of E. faecalis. If the ampicillin–gentamicin combination is used, the efficacy of combination therapy for 4 to 6 weeks may be similar to that of the standard combination regimen for 4 to 6 weeks and is less toxic.13,32

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<td>30–60 mg/kg/day intravenously in 2–4 divided doses for 6 wk</td>
<td>The target 24-hr area under the concentration curve is 400–600 μg·hr/ml</td>
</tr>
<tr>
<td>Daptomycin</td>
<td>10 mg/kg/day intravenously once daily for 6 wk</td>
<td></td>
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<tr>
<td>HACEK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>2 g intravenously once daily for 4 wk</td>
<td></td>
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<tr>
<td>Ciprofloxacin</td>
<td>800 mg/day intravenously or 1500 mg orally in 2 divided doses for 4 wk</td>
<td></td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>750 mg intravenously or orally once daily for 4 wk</td>
<td></td>
</tr>
</tbody>
</table>

* HACEK denotes haemophilus species, aggregatibacter (formerly actinobacillus) species, cardibacterium species, Etkellia corrodenti, and kingella species, and MIC minimum inhibitory concentration.
† The duration of therapy once blood cultures have converted to negative is shown.

### Areas of Uncertainty

Modified Duke criteria for the clinical diagnosis of infective endocarditis are not based on the results of molecular diagnostic testing. As these methods improve in accuracy and become routinely available, their role in diagnosis will need to be taken into account.

Whether routine brain magnetic resonance imaging (MRI) and other advanced imaging techniques such as PET-CT improve the diagnosis, treatment, and outcomes in patients with native-valve infective endocarditis is unclear. MRI is more sensitive than CT for detecting central nervous system (CNS) lesions, and the presence of asymptomatic embolic lesions in patients with suspected infective endocarditis is a minor criterion in support of the diagnosis.15,16,35 Routine brain MRI has been recommended to detect silent CNS emboli in patients who are candidates for valvular surgery,16 although whether this improves outcomes is unknown.

Data from randomized, controlled trials to inform the benefits and risks of oral antimicrobial therapy for infective endocarditis are limited. The Partial Oral Treatment of Endocarditis (POET) trial39 showed that in patients with infective endocarditis on the left side of the heart and whose condition had stabilized, treatment with oral antibiotics after an initial course of intravenous antibiotics was noninferior to standard intravenous antibiotic treatment at 6 months after the end of treatment; longer-term follow-up showed no deleterious outcomes with oral step-down therapy.40 However, only 20% of the patients who underwent screening were enrolled, and few had S. aureus infection (none with MRSA).

Additional data are needed to clarify the safety and efficacy of this approach in a variety of clinical settings.41 The timing of surgery in patients with infective endocarditis is a major criterion for the diagnosis of infective endocarditis, and predictors of surgical mortality and poor outcomes need to be better defined. Most guidelines recommend delaying valve surgery for at least 4 weeks in patients with large embolic CNS lesions (>2 cm in diameter), without hemorhage or major neurologic deficits. Several scoring systems have been proposed to predict surgical mortality and postoperative complications in patients with infective endocarditis; however, limitations, including small sample sizes, reliance on retrospective data, changes in surgical practice over time (which may span decades), and lack of large-scale, external validation make it difficult to assess the accuracy of these systems.

### Guidelines

The American Heart Association, the European Society of Cardiology, the Japanese Society of Cardiology, and the American Association for Thoracic Surgery32,33,34 have each published guidelines on the diagnosis and management of infective endocarditis. These guidelines are generally concordant in their recommendations, with relatively minor differences with respect to antimicrobial therapy, forms of imaging, and indications for and timing of surgery. The recommendations presented here are in general agreement with these guidelines.

### Conclusions and Recommendations

The patient described in the vignette has community-acquired enterococcal pyelonephritis with bacteremia. On purely clinical grounds, the presence of bacteremia plus a murmur in a febrile patient is strongly suggestive of underlying infective endocarditis. At presentation, this patient probably satisfies three major criteria for possible endocarditis: fever; two positive blood cultures for E. faulus, but with a primary focus of pyelonephritis (hence, this is not a major criterion); and aortic stenosis, a predisposing cardiac condition.

Additional blood cultures should be obtained, which if positive would meet a major criterion for the diagnosis of infective endocarditis. Although TTE is much more sensitive than TTE for detecting valvular vegetations and paravalvular complications, we would add that an indication for surgery without perforation, valvular extension or persistent bacteremia, and prevention of systemic embolization, especially to the brain (Table 4). In a prospective cohort study involving patients with native-valve infective endocarditis, a multivariable analysis with adjustment for coexisting conditions showed that an indication for surgery without performance of the surgery was an independent predictor of death.15 The appropriate timing of valve surgery is not well defined and is a highly individualized decision that is best made by an experienced multidisciplinary team.15

One small randomized, controlled trial compared early surgery during the initial hospitalization and within 48 hours after randomization (in 37 patients) with conventional treatment (in 39 patients) in patients with endocarditis on the left side of the heart, severe valvular regurgitation (without heart failure), and large vegetations (>10 mm) in diameter.33 Early surgery significantly reduced the risk of the combined end point of in-hospital death or embolic events within 6 weeks after randomization, but this decreased risk was driven entirely by decreases in the risk of systemic embolism. This trial was limited in that patients had few underlying diseases, and patients with staphylococcal infections and mitral-valve infective endocarditis were overrepresented. Two meta-analyses showed that early surgery, as compared with conventional therapy (i.e., medical therapy or late surgery at >20 days), was associated with a 40 to 60% reduction in death from any cause.33,34 However, how best to identify patients who are most likely to benefit from early surgery remains unclear.
Fraction). If TTE is negative or nondiagnostic, then TEE should be considered. If TEE is negative or nondiagnostic, and the patient is severely ill, then it should be repeated several days later.

We would engage a multidisciplinary team in care, including specialists in cardiology, infectious disease, and critical care medicine. Combination antithrombotic therapy for treatment of presumed enterococcal infective endocarditis should be administered promptly. Although susceptibility of the isolate to gentamicin should be confirmed, this patient’s age, diabetes, and chronic kidney disease place him at high risk for acute kidney injury from gentamicin, and we would favor initial treatment with ampicillin and ceftriaxone. Blood cultures should be obtained to confirm clearance of bacteremia with therapy, and the patient should be carefully evaluated for any indications for immediate valve surgery. Anti- microbial therapy should be continued 6 weeks after blood cultures convert to negative. Consideration also should be given to screening for colonic neoplasia, since some data suggest that enterococcal infective endocarditis caused by S. gallolyticus, enterococcal infective endocarditis may be associated with colon neoplasia, although further study is needed.

No potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

References

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<table>
<thead>
<tr>
<th>MONTHS 18-15</th>
<th>MONTHS 15-12</th>
<th>MONTHS 12-9</th>
<th>MONTHS 9-6</th>
<th>MONTHS 6-0</th>
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<tbody>
<tr>
<td>Write and finalize cover letters and CV. Begin to obtain and verify references.</td>
<td>Outline personal, family and professional goals.</td>
<td>Contact Cross Country Search and begin preparing for the interview process.</td>
<td>Consider offers and options; begin to negotiate an employment contract.</td>
<td>Accept an offer of employment.</td>
</tr>
</tbody>
</table>

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December 25
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Baystate Health was named one of America's Best employers by State in 2019 by Forbes. Ranked 14th out of 74 top employers in Massachusetts, Baystate Health is one of New England’s leading healthcare systems and the largest employer in the region.

Baystate Health (Baystate) is western Massachusetts’s premier healthcare provider and home to the University of Massachusetts Medical School - Baystate. The cornerstone of our organization is Baystate Medical Center, a 716-bed tertiary care hospital which boats the state’s single busiest emergency department and the region’s only Level-I trauma center. With 3 registry hospitals, Baystate Children’s Hospital and Baystate Primary Care Medical Practices, we offer a diverse culture that provides outstanding opportunities for physicians to start or advance their career.

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Please reference NEJMCareerCenter.org — Opportunities in China
The Shanghai Ninth People’s Hospital (SNPH), affiliated with the Shanghai Jiao Tong University School of Medicine, was established in 1926. One of the first grade A general hospitals in China, the SNPH is widely recognized for its distinctive specialties and innovative competitiveness in clinical medicine.

Occupying a total land area of 82,667 m² and built-up area of 242,000 m² in three campuses — the South Campus in Huangpu, the North Campus in Baoshan and the East Campus in Pudong — the SNPH has 2,150 beds, 1,000 dental chairs, 52 clinical departments, 10 medical laboratories and more than 5,000 employees, including 132 MD or PhD supervisors and 180 MSc supervisors, who are responsible for 3 postdoctoral training centers, 26 doctoral programs and 31 master programs. In 2019, there were 4.58 million emergency outpatient visits, 170,000 outpatient and 100,000 inpatient surgical operations, and 130,000 hospitalizations with an average length of stay of 5.8 days at the SNPH.

Overview

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Clinical Research

The SNPH has four members of the prestigious Chinese Academy of Engineering: Zhang Disheng, plastic surgeon; Qiu Weiliu, oral and maxillofacial surgeon; Dai Kerong, orthopedic surgeon; and Zhang Zhiyuan, oral/maxillofacial tumor and head/neck surgeon; and global impact.

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Key Achievements

Tissue Regeneration and Bone

A multi-disciplinary orthopedic team of physicians and engineers, led by Prof. Dai Kerong, made breakthroughs in orthopedic implants with shape memory and personalized implants by 3D printing that have been widely used in orthopedic surgeries.

Prof. Cao Yilin team achieved great advances in tissue regeneration technologies in bone, cartilage, tendon, and skin, with some technologies already in clinical practice.

After more than 20 years of research, Prof. Zhang Chenpin team revolutionized the jaw functional reconstruction, a previously unsolved problem, with a “four segment” strategy. By creating the “integrated” implant distraction technology and a digital surgical platform, they further solidified their top global status in the jaw reconstruction.

Visual and Auditory Functions

By elucidating mechanisms of auditory damage by acoustic neuroma, Prof. Wu Hao greatly advanced the audiological science. His team also established the technique and strategy for hearing reconstruction and intraoperative hearing preservation, improving the auditory functions of acoustic neuroma patients after surgery.

A pioneer of the precision orbital surgery, Prof. Fan Xianqun and his team developed biodegradable materials and created an orbital reconstruction system, significantly improving the safety and efficacy of orbital surgery. The team also characterized mechanisms of eye tumors, and improved survival rate and eye salvage rate of ocular tumor patients.

Maxillofacial Surgery and Facial Reconstruction

Prof. Li Qingfeng team put forward the concept of “tissue prefabrication”, and effectively treated complex facial deformities, by implementing a comprehensive strategy of flap prefabrication, stem cell-assisted skin regeneration, and facial organ prelamination.

CONTACT INFORMATION

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