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

Sincerely,

Eric J. Rubin, MD, PhD

November 11, 2021

What FTE is right for you?

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

Nobody asks for their daily schedule during medical school or residency interviews. For years during medical training, you go to work when somebody tells you to, you take as much vacation as has been allotted to you, and do the work that you’ve been assigned — and then some.

That attitude often carries over into the job search. It’s shocking how many physicians will apply to and even accept positions without a realistic picture of what a normal day in a particular job looks like. We often wear our ability to get the job done as a badge of honor, and rarely question it, not realizing that as time goes on, this is often to the detriment of our career longevity.

The fact is, “full time” for physicians is often greater than the normal 40-hour work week experienced by many other professions, and many times, “part time” for a physician doesn’t feel so part time. To state the obvious, the number of hours worked is inversely proportional to the number of hours of free time you have. While most of us derive significant personal satisfaction from our jobs, we also need time with our families and time for other activities that fill the proverbial cup.

These days, I spend a lot of time encouraging physicians to “create the life in medicine that they want,” the essence of which comes down to being more intentional about how you approach your career. Job turnover is quite common in the early years of practice, and can even lead physicians to want to exit medicine entirely. Therefore, when searching for your job, it’s imperative that in addition to all the other factors that go into the job search, the number of hours you want to work is also considered.

There are many factors that may play into this decision, including finances, debt, children, the work schedule of your significant other, interests outside of medicine, the practicalities of a specialty, and what types of positions exist. While there’s no guarantee that all of these can align perfectly, mapping out what an ideal work week looks like will allow you to tailor your job search better. At the end of the day, if you can work 30 years as a 0.8 FTE because you love it and feel that your personal and professional goals are aligned, many would choose this over working at a 1 FTE but experiencing such significant burnout that you elect to stop working as

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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, a Seattle-based freelance health care writer

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 professionally 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 would be 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
Starting a video 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 decor item will 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 walkthrough, 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.

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.
A previously healthy 28-year-old woman presents to the emergency department with a 2-day history of abdominal pain that began in the umbilical area and migrated to the right lower abdomen. She is a single mother who works remotely and is raising a 5-year-old child. Her temperature is 37.8°C; other vital signs are normal. She rates her pain at 7 on a scale of 1 to 10, with 10 representing the worst possible pain. Examination reveals tenderness in the right lower quadrant, with moderate localized rebound. The result of a pregnancy test is negative, as is the result of a polymerase-chain-reaction assay for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Her white-cell count is 12,500 per cubic millimeter. Computed tomography (CT) performed after the intravenous administration of contrast material shows a dilated, inflamed appendix without appendicolith, abscess, perforation, or tumor. How would you manage this case?

From the Department of Emergency Medicine, UCLA Ronald Reagan Medical Center, and the David Geffen School of Medicine at UCLA — both in Los Angeles (D.A.T.) and the Department of General Surgery, ASUR Marche, AVS, Hospital of San Benedetto del Tronto, San Benedetto del Tronto, Italy (S.D.S.). Address reprint requests to Dr. Talan at the Department of Emergency Medicine, David Geffen School of Medicine at UCLA, 924 Westwood Blvd., Ste. 300, Los Angeles, CA 90095, or at dtalan@ucla.edu.

The Clinical Problem

Acute Appendicitis is the most common reason for emergency abdominal surgery. The peak incidence occurs among persons 10 to 19 years of age, and the lifetime risk is 7 to 8%. Untreated appendicitis, when complicated with rupture, can lead to abscess, peritonitis, and death. Uncomplicated appendicitis (i.e., localized appendicitis), which has traditionally been treated with urgent appendectomy, accounts for approximately 80% of cases. In the past three decades, numerous trials of nonoperative treatment in patients with acute uncomplicated appendicitis have been conducted, and the use of antibiotic agents as a first strategy has become acknowledged as a safe option. In this article, we review the expected outcomes associated with initial operative and nonoperative treatment of acute uncomplicated appendicitis and offer guidance on counseling patients to help them choose between the two approaches.

Strategies and Evidence

Appendectomy

Appendectomy requires general anesthesia and, typically, hospitalization, although outpatient surgery is possible. Patients with rupture and large abscesses or phlegmon (complicated appendicitis) are usually treated with antibiotics and, if possible, undergo percutaneous drainage to avoid more extensive operations, such as celiotomy.

Appendectomy is a relatively low-risk surgery. In the United States and Europe, most surgeries are performed laparoscopically, an approach that is associated with fewer wound infections and faster recovery than open appendectomy but may be more costly. Approximately 8% of adults with suspected appendicitis that is confirmed on CT have a normal appendix at operation. The 30-day case fatality rate associated with appendectomy among patients with uncomplicated appendicitis is approximately 0.5 per 1000, and among elderly persons, the fatality rate is about twice as high as it is among adolescents. Although most patients are candidates for appendectomy, nonoperative treatment is more often considered in patients who have a positive surgery for an increased risk of complications.

Operative versus Nonoperative Treatment

Nonoperative treatment is a strategy in which patients first receive antibiotics with the aim of avoiding surgery. Appendectomy is reserved for patients who do not have a response to antibiotics or have recurrence of appendicitis. Outcomes in more than 4000 patients with uncomplicated appendicitis who received nonoperative treatment have been reported in at least 10 randomized, controlled trials and 5 prospective comparative studies as well as in more than 20 other investigations, most of which were conducted in Asia, Europe, and the United States.

Investigations of operative and nonoperative treatment have involved children and adults with localized appendicitis. In most studies, the diagnosis was confirmed on imaging (excluding patients with findings suggesting tumor or abscess), though some investigations relied on clinical evaluation with selective imaging (Table 1). Most studies excluded patients in whom appendicolith was identified on imaging. Appendicolith is found in approximately 25% of patients in whom appendicitis is confirmed on imaging and is associated with an increased likelihood of appendiceal rupture; it is unclear whether the appendicolith is involved in causing rupture or impairing its healing.

Patients with severe sepsis, immunodeficiency, or inflammatory bowel disease and those who were pregnant were also excluded. A minority of trials excluded patients who reported having symptoms for more than 48 hours, who had a white-cell count of 18,000 per cubic millimeter or more, or who had an appendiceal diameter of more than 11 mm.

To summarize the effectiveness of operative versus nonoperative treatment, we reviewed three randomized, controlled trials conducted in a large, multicenter investigation in which imaging was used to confirm diagnosis (typically ultrasound sonography in children and CT in adults) and that accounted for approximately two thirds of the patients included in each trial. These included two randomized, controlled trials involving adults: the Finnish trial Appendicitis Acuta (APFAC), which included 530 participants and reported outcomes over a period of 5 years, and the U.S. trial Comparison of the Outcomes of Antibiotic Drugs and Appendectomy (CODA), which included 1552 participants and reported outcomes at 90 days. What we believe to be the largest pediatric trial, which involved 1008 children between the ages of 7 and 17 years, was that conducted by the Midwest Pediatric Surgery Consortium (MWPSC) at 10 children’s hospitals.

This article ends with the authors’ clinical recommendations.
Patients are hemodynamically stable, without evidence of severe sepsis or septic shock. Patients who are not pregnant or immunocompromised and have no history of inflammatory bowel disease.

Cautions

Patients with imaging-identified appendicolith (which is present in approximately 25% of patients and is associated with appendicWall rupture) are at increased risk for complications such as abscess and undergo appendectomy more frequently than patients without appendicolith.

Antibiotic response may be delayed in patients who are 45 years of age or older and in those who have appendicolith, extraluminal fluid or air, fever, or elevated inflammatory markers and in those who have had symptoms for more than 48 hours, all of which are associated with appendiceal abscess.

Quality of Life

Clinical trials have shown similar quality of life after nonoperative treatment and appendectomy. In the CODA trial, findings from the 30-day assessment of the European Quality of Life-5 Dimensions (EQ-5D) test, in which mobility, self-care, usual activities, pain, anxiety, and depression are assessed, showed that quality of life in the antibiotics-first group was inferior to that in the appendectomy group.1 Among children in the MWPSC study who were treated nonoperatively, scores assessing physical, emotional, social, and academic functioning were superior at 30 days and similar at 1 year to the scores of children who underwent appendectomy.3 Findings on quality of life in the APPAC trial were also similar in the groups at 7 years on the EQ-5D-5L.3,4

Health Care Utilization

Whereas hospitalization was required for patients who were in the nonoperative group in the APPAC trial and the MWPSC study, in the CODA trial, patients whose condition was stable were allowed to be discharged from the emergency department and hospital for their index visit as those assigned to the appendectomy group (mean, 1.3 days) but had a greater number of later hospitalizations but fewer other emergency care visits that were not associated with hospitalization (24% vs. 5% and 9% vs. 5%, respectively).4 Findings on quality life in the APPAC trial were similar to the risks among those who underwent appendectomy in the APPAC or CODA trials or the MWPSC study. In a pediatric trial conducted by Minneci et al.,4 ultrasonography was the primary form of imaging used in diagnosis, and patients with appendicolith were excluded. Lundholm et al.,14 reported outcomes from a randomized trial involving adults with uncomplicated appendicitis confirmed on computed tomography (CT). Patients with appendicolith were excluded. Lundholm et al.,14 reported outcomes from a randomized trial involving adults with uncomplicated appendicitis confirmed on computed tomography (CT). Patients with appendicolith were excluded.}

Figure 1. Five-Year Incidence of Appendectomy among Adult Patients with Acute Appendicitis Initially Treated Nonoperatively.

The incidence of appendectomy following initial care is shown for two reports of clinical investigations.3,4 Salminen et al.14 reported outcomes from a randomized trial involving adults with uncomplicated appendicitis and appendicolith were included. Not shown is the incidence of appendectomy reported at early follow-up from the largest known comparative investigations involving adults and children.4,13 The Comparison of the Outcomes of Antibiotic Drugs and Appendectomy (CODA) trial included 776 adults who received antibiotic treatment, 212 of whom had appendicolith identified on CT. At 90 days, if those treated with antibiotics, 25% of those without appendicolith and 41% of those with appendicolith had undergone appendectomy.3 In a pediatric trial conducted by Minneci et al.,4 ultrasonography was the primary form of imaging used in diagnosis, and patients with appendicolith were excluded. Among the children included in the trial, 370 were treated with antibiotics. At 1 year, 33% of the children had undergone appendectomy.

Table 1. Considerations in Identifying Appropriate Candidates for Nonoperative Treatment of Appendicitis

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Details</th>
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<tbody>
<tr>
<td>Appropriate candidates</td>
<td>Patients have a clinical diagnosis of localized appendicitis without examination findings of diffuse perforation or imaging evidence of large abscess, phlegmon, perforation, or tumor.</td>
</tr>
<tr>
<td>Caution</td>
<td>Patients with imaging-identified appendicolith (which is present in approximately 25% of patients and is associated with appendicWall rupture) are at increased risk for complications such as abscess and undergo appendectomy more frequently than patients without appendicolith. Antibiotic response may be delayed in patients who are 45 years of age or older and in those who have appendicolith, extraluminal fluid or air, fever, or elevated inflammatory markers and in those who have had symptoms for more than 48 hours, all of which are associated with appendiceal abscess.</td>
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Tension less than appendectomy (e.g., ileocecalcectomy) were rare and occurred with similar frequency in those undergoing appendectomy. In two trials reporting follow-up for 5 years, 30 to 40% of the patients who underwent appendectomy with antibiotics ultimately underwent appendectomy, usually within 1 to 2 years (Fig. 1).14,15

Complications

In the APPAC and CODA trials and the MWPSC study, the risks of complications and adverse events among those receiving antibiotics who did not have appendicWall abscess were lower than or similar to those among those who underwent appendectomy.1,4,13 At 5 years, the incidence of complications in the APPAC trial was similar among those who had initial appendectomy and those who had initial antibiotic therapy and among those who had appendicWall abscess or who had undergone appendectomy.4 There is no evidence that delaying surgery while taking antibiotics increases the risk of perforation. In the CODA trial, for example, investigators observed that the incidence of perforation among patients who did not have appendicWall abscess was lower among those receiving antibiotics than among those undergoing surgery, and among those who had appendicWall abscess, the rates of perforation were similar among those who received antibiotics and those who underwent surgery.1 Among participants in the CODA trial who had appendicWall abscess, the proportion with at least one complication that met the definition of the National Surgical Quality Improvement Program (NSQIP) who had been discharged from the emergency department or urgent care visits that were not associated with hospitalization (24% vs. 5% and 9% vs. 5%, respectively) over a period of 90 days.1 In the MWPSC study, over a period of 1 year, there were more later hospitalizations but fewer other emergency department visits (includes urgent care visits; personal communication; P. Minneci) among patients who received antibiotics as compared with those who underwent surgery (23.0% vs. 3.0% and 3.5% vs. 7.0%, respectively).4

Cancer Detection

In rare instances, cancer may cause appendicitis or symptoms mimicking appendicitis, or it may be found incidentally on appendectomy. In a study of 21,069 appendectomy specimens, researchers detected cancer in 0.9%, with a lower incidence of detection among persons younger than 50 years of age and among those with uncomplicated appendicitis.17 Thus, nonoperative treatment carries a small risk of delayed diagnosis and disease progression; data are lacking to inform the effect of diagnostic delay on patient outcomes. At the 5-year follow-up in the APPAC trial, cancer was diagnosed in 4 of 272 patients who had been assigned to surgery (all at initial appendectomy), as compared with none of the 260 patients who had been assigned to receive antibiotics.4

Shared Decision Making

A common concern among adult patients and the parents of nonadult patients is that an inflamed appendix will burst without emergency surgery and cause death.18,19 This notion has largely been abandoned, and patients should be assured that they have time to consider treatment options. Shared decision making is recom-
Control of Pain and Nausea

Disposition

In the United States, most patients go home from the hospital the day after undergoing laparoscopic appendectomy,12 individual recovery times vary, but patients usually return to normal activities within 1 to 2 weeks. Those who have laparoscopic surgery return to normal activities approximately 5 days sooner than those who have open surgery.13 Patients are typically advised that they can return to work or school when they feel well enough but should avoid strenuous activity for 3 to 5 days after laparoscopic surgery and for 10 to 14 days after open surgery.14

After the initiation of antibiotics only, pain, fever, leukocytosis, and anorexia typically resolve within approximately 2 days in patients with uncomplicated appendicitis.15,16 As many as 20% of patients with uncomplicated appendicitis confirmed on CT are found during surgery to have appendiceal rupture and abscess.3 Patients with appendicolith identified on CT, those with extraluminal fluid or air, those who are older than 45 years of age, and those who have fever, symptoms for more than 48 hours, and elevated levels of inflammatory markers (findings associated with appendiceal abscess) may be anticipated to have a delayed response to antibiotics.17,18

Emergency department discharge can be considered in adults who recover from operative treatment once their condition is deemed to be stable on clinical assessment, their pain is controlled, and they are able to take oral fluids. They should also be able to adhere to treatment guidelines and be amenable to follow-up. A standard diet can be resumed as long as food is tolerated. Other patients are initially hospitalized for further observation and supportive care. Data are lacking on outpatient treatment in children.

Follow-up

After discharge, all patients should be advised to contact their doctor if they have persistent or increasing pain, fever, or vomiting. Those who have had surgery should contact their doctor if they have redness at the site of the wound, swelling, or drainage. Those who receive nonoperative treatment should be contacted within 1 to 2 days after discharge to evaluate their progress; if there are concerns, reexamination should be conducted. It is important to advise patients of medical attention if they have symptoms suggesting recurrence or symptoms suggesting another pathologic condition, such as weight loss.

For patients who undergo appendectomy, antibiotics should be discontinued postoperatively.26,27

Use of Antibiotics

A parenteral antibiotic regimen that is active against aerobic and anaerobic bacteria and consistent with community-acquired intraabdominal infection guidelines should be initiated as soon as the diagnosis of appendicitis has been reasonably established, regardless of whether treatment will be operative or nonoperative.28 The administration of nonsteroidal antiinflammatory drugs before appendectomy has been shown to be safe (i.e., without an increased risk of bleeding) and spares the use of opiates. Multimodal analgesia are most effective, especially when prescribed to be taken on a scheduled basis as compared with an as-needed basis.29 Antiemetics can also provide symptomatic relief.

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Within 3 months after symptom resolution, but data are lacking regarding the effectiveness of this strategy in patients with uncomplicated appendicitis.

GUIDELINES

Guidelines from professional societies changed from appendectomy being primarily recommended in 2015 to nonoperative treatment now being endorsed as a safe first-line alternative (Table 2).13,30

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Trials in which outcomes among patients who are treated with antibiotics are compared with those among patients who are treated with appendectomy are common. However, outcomes among those who received antibiotics were not blinded, and criteria for the absence of a response to antibiotics and the need for surgery have been subjective and neither monitored by radiologic markers nor clinically evaluated. In some cases, appendectomies have been performed at the request of the patient when there were no clinical indications for surgery, and for the purposes of randomized trials, patients who had a successful nonoperative treatment of complicated appendicitis, some experts recommend follow-up colonoscopy or screening with full-dose, contrast-enhanced CT.
the traditional narrative regarding the treatment of appendicitis is revised and as experience with this new form of care increases. Data are limited regarding the benefits and risks of nonoperative treatment in certain populations (e.g., pregnant women and elderly patients). Uncertainty remains regarding the care of patients with appendicocid, and it is not known whether initial appendicocids among these patients differ from that among those without appendicocid. Special considerations may apply in remote settings and in cases in which surgical care is not available. Long-term data are needed from the CODA trial and others to better inform the cumulative risk of appendicocid after initial nonoperative resistance. Treatment of enterobacteriaceae to fluoroquinolones and beta-lactams (the latter mediated by beta-lactamase production) is emerging. Further study is needed to guide the selection of patients for whom nonoperative treatment is appropriate and to inform best practices for the use of oral antibiotic regimes and outpatient treatment—an approach that may be possible in most cases.

A randomized trial in which supportive care alone in selected low-risk patients hospitalized with uncomplicated appendicocids showed no significant between-group differences in treatment failure rates, suggesting that some cases of appendicocid may resolve spontaneously; more study is needed to determine when such a strategy may be safe. The clinical effect size of appendicocid as a manifestation of appendicocid in patients managed nonoperatively is uncertain; the rarity of cancers makes this issue challenging to study. In addition, it is not clear whether the appendix serves a useful function. Some studies have reported an association between appendicocid and an increased risk of intestinal cancer, but findings are inconclusive.

CONCLUSIONS AND RECOMMENDATIONS

The patient in the vignette has clinical findings consistent with appendicocid. She is a candidate for either nonoperative treatment or appendicectomy. If the patient chooses nonoperative treatment, a long-acting parenteral antibiotic, such as etromicin, should be administered. As long as her pain and nausea are effectively controlled and her condition is clinically stable, she is a candidate for outpatient care while receiving oral antibiotics such as cefdinir and metronidazole in order to cover both Gram-negative and anaerobic bacteria. A regimen of 7 to 10 days would be appropriate.

Initiation of pain control with a scheduled regime of nonsteroidal anti-inflammatory drugs and acetaminophen, as well as opiates (as needed), is recommended. An anesthetic agent should also be prescribed and taken as needed for the next few days. Improvement should be expected during a 48-hour period. Follow-up—including a call in the ‘fom televindian music’—is advisable. Worsening symptoms would prompt referral back to the emergency department. Diffuse peritonitis, sepsis, or the absence of improvement during a 48-hour period after hospitalization would be indications for appendicectomy.

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

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REFERENCES

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We are Cross Country Search, formerly Cejka Physician Search. Our name has changed but our commitment to your future remains the same. Whether you’re finishing up your residency or fellowship, looking to advance your experience, or seeking a path that provides you more physician work/life balance, the best way to begin your physician job search is with our team of consultants.

For over 30 years, Cross Country Search has worked with all organization types: Health Systems, Hospitals, Single and Multi-Specialty Medical Groups, Managed Care, and more. Our consultants partner with these organizations to align them with the best and brightest physicians across the country. Our commitment to you is just as important. For us, it’s not just about sharing resumes. It’s about preparing you for a first-class recruitment experience. We’ll prepare you for every stage of the recruitment process, serving as an advisor and partner in your quest to find that dream career.

Our recruitment experts can assist you in all your job search needs, including:

- Assistance with site visits
- CV creation/revisions
- Interview tips & preparation
- Contract negotiation

Why Cross Country Search?

- Initial contract to offer signing in less than half the time with our consultation
- Over 30 years of experience advising organizations and physicians on healthcare recruitment
- Our partnerships with healthcare organizations are long-standing with a sterling reputation
- Our recruiters are among the most tenured in the healthcare industry

Our best-practice job search timeline ensures you are always one step ahead in reaching your career goals. Start your career off early! Follow these Cross Country Search employment strategies beginning 18 months before the completion of your training:

<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>
</tr>
</thead>
<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>

Check out our physician opportunities available now on crosscountrysearch.com.
Classified Advertising Rates

We charge $9.95 per word per insertion. A 2- to 4-time frequency discount rate of $7.40 per word per insertion is available. A 5-time frequency discount rate of $7.10 per word per insertion is also available. In order to earn the 2- to 4-time or 5-time discounted word rate, the request for an ad to run in multiple issues must be made upon initial placement. The minimum charge for display ads is $120.00 per issue per advertisement if no classification is offered, we will determine the most appropriate classification. Cancellations must be made 20 days prior to publication date. Send all advertisements to the address listed below.

How to Advertise

All orders, cancellations, and changes must be received in writing. Email your advertisement to us at ads@nejmcareercenter.org, or fax it to 1-781-893-3800. We will contact you to confirm your order. Our closing date is typically the Friday 20 days prior to publication date; however, please consult the rate card online at mjcareercenter.org or contact the Classified Advertising Department at 1-800-635-6991. Be sure to tell us the classification heading you would like your ad to appear under (see listings above). If no classification is offered, we will determine the most appropriate classification.

How to Calculate the Cost of Your Ad

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

Bradley S. Smith III, MD .......... = 5 words
Send CV ______________________ = 2 words
December 10, 2007 ............... = 3 words
617-555-1234 ......................... = 1 word
Obstetrician/Gynecologist ........ = 1 word
A ........................................ = 1 word
Bradley S. Smith III, MD
617-555-1234
A
Elizabeth Smith

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

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

Sequence of Classifications

This advertisement is 56 words. At $9.95 per word, it equals $537.20. This ad would be placed under the Chiefs/Directors/Department Heads classification.

Policy on Recruitment Ads

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

PHYSICIANS CAREER CENTER AT THE US ONCology Network

The US Oncology Network brings the expertise of nearly 1,000 oncologists to fight for approximately 750,000 cancer patients each year. Delivering cutting-edge technology and advanced, evidence-based care to communities across the nation, we believe that together is a better way to fight. usoncology.com

We are seeking opportunities for oncologists (training opportunities available), Oncology, Hematology, and Nephrology, as well as quality assessment, clinical research, interdisciplinary collaboration, and other scholarly activities. Additionally, the Division has a robust mentorship program to support career growth.

The US Oncology Network...

To learn more about physicians jobs, email...

practitioner@usoncology.com

How do I approach working locum tenens?

How can I find the best assignment for me?

Who provides the best support?

Who can guide me through the process?

866.951.2926
NEJMCareerCenter.org

The Division of Hospital Medicine at Washington University School of Medicine in St. Louis, one of the largest academic hospital programs in the nation with over 130 hospitals, is recruiting faculty members (internal medicine, medicine-surgery, pediatrics, and transitional medicine) to join our innovative, growing hospital program.

Mark V. Williams, MD, FACEP, FHM, a nationally renowned leader in Hospital Medicine will join the prestigious leadership team from this new program.

Email: ads@nejmcareercenter.org

The US Oncology Network is supported by McKesson Specialty Health.

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Email: ads@nejmcareercenter.org
If you’re dedicated to elevating mental health care...

\[ \text{YOU BELONG HERE.} \]

Looking for Potential NHSC Loan Repayment?

If you’re a psychiatry resident seeking a worksite eligible for possible National Health Service Corps (NHSC) Loan Repayment, consider a career with California Correctional Health Care Services and the California Department of Corrections and Rehabilitation in one of the following locations:

- Avenal State Prison – Avenal
- California Correctional Institution – Tehachapi
- Ironwood State Prison – Blythe
- Kern Valley State Prison – Delano
- Pelican Bay State Prison – Crescent City
- Substance Abuse Treatment Facility – Corcoran

Contact Hasanah Melochick at hasanah.melochick@cdcr.ca.gov or apply online at www.ha.org.hk.

Associate Consultant Positions for Experienced Doctors without Full Registration


(Ref: HO2104001)

Salary depending on experience in addition to QM annual salary. Please provide documentation of COVID-19 vaccination or medical/religious exemption.

Submit your CV to Hasanah Melochick at hassanah.melochick@cdcr.ca.gov or apply online at www.ha.org.hk.

Enquiries
Please contact Ms Alice Lam, Hospital Authority Head Office at + 852 2300 6359 or send email to laa408@ha.org.hk.

Berkshire Health Systems

Physician Opportunities

Berkshire Health Systems currently has hospital-based and private practice opportunities in the following areas:

- Anesthesiology
- Cardiology
- Endocrinology
- Gastroenterology
- Hematology/Oncology
- OB/GYN
- Primary Care
- Pulmonary/Critical Care
- Rheumatology
- Otolaryngology
- Urology

Berkshire Medical Center (BMC), BHS’s acute-care community teaching hospital, is a major teaching affiliate of the University of Massachusetts Medical School. With the latest technology and a system-wide electronic health record, BMC is the region’s leading provider of comprehensive healthcare services.

We understand the importance of balancing work with quality of life. Berkshire, a 4-season resort community, offers world-renowned music, art, theater, and museums, as well as year-round recreational activities from skiing to kayaking. Excellent public and private schools make this an ideal family area while being affiliated with a health system with award winning programs, nationally recognized physicians, and world class technology.

Interested candidates are invited to contact: Michelle Snow, Provider Recruitment Berkshire Health Systems (413) 395-7066

Email: msnow@bhs1.org

Where Quality of Life and Quality of Care Come Together
The Division of Rheumatology, Inflammation, and Immunity (RII) at Brigham and Women’s Hospital seeks an outstanding, board certified/eligible rheumatologist.

The Division of RII at BWH is nationally ranked and has an outstanding record of clinical care, education, and research. We are dedicated to delivering exceptional, cutting-edge patient care. Our 38 staff physicians provide care at the Brigham and Women’s Hospital as well as at 5 satellite facilities, seeing >37,000 patient visits each year. The hospital provides infusion services, nursing staff and administrative support and uses the same integrated EHR for inpatient and outpatient care.

This clinical position includes ambulatory clinic time as well as 2-3 weeks of inpatient call per year. The successful candidate will also engage in teaching medical students and fellows in the inpatient and outpatient settings a minimum of 30 hours a year to satisfy the FNS requirement for an academic appointment. There is potential to develop a clinical research program and an educational role as mutual goals allow. Annual base salary is guaranteed for 2 years.

Applicants should send a CV and letter of interest to:

Ellen M. Gravallese, M.D.
Chief, Division of Rheumatology, Inflammation, and Immunity
Brigham and Women’s Hospital
60 Fenwood Road, Suite 6002U
Boston, MA 02115
or via email: egravallese@bwh.harvard.edu

The Brigham and Women’s Hospital is an equal opportunity/affirmative action employer. Applicants are encouraged to apply.

The Brigham and Women’s Hospital is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, sexual orientation, protected veteran status or any other characteristic protected by law.

The Brigham and Women’s Hospital is committed to advancing the health of all communities, including those historically underserved. The Brigham and Women’s Hospital is dedicated to building a culture of inclusive processes and workforce that are diverse, equitable, and inclusive at all levels. We value diversity in experience and background, and we encourage all qualified candidates to apply.

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Please direct your questions regarding any issue to the hiring manager at egravallese@bwh.harvard.edu.

Discipline: Immunology
Board certification or eligibility
Salary: Competitive
Benefits: Comprehensive
Position type: Full-time
Application deadline: Open until position is filled

Salary is guaranteed for 2 years. This is a full-time academic position. The Brigham and Women’s Hospital and Harvard Medical School offer a comprehensive benefits package.

Applicants should send a CV and letter of interest to:

Ellen M. Gravallese, M.D.
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**Clinically driven. Guided by purpose.**

SSM Health is the destination for exceptional clinicians and leaders who want to practice meaningful medicine that truly makes a difference. Our relentless clinical drive and unwavering commitment to purpose guide everything we do. Together, we are improving the health of our communities and the lives of everyone we serve — including our employees.

As you embark on furthering your professional career, discover the difference of practicing with purpose at SSM Health.

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**What kind of Doctor works in Corrections?**

DOCTORS JUST LIKE YOU.

By now, doctors know California Correctional Health Care Services (CCCHS) offers more than just great pay and State of California benefits. Whatever your professional interest, CCCHS can help you continue to hone your skills in public health, disease management and education, addiction medicine, and so much more.

Join doctors just like you in one of the following locations:

- Pelican Bay State Prison — Crescent City
- Salinas Valley State Prison — Soledad
- Salinas Valley State Prison (Psychiatric Inpatient Program) — Soledad

**Competitive compensation package, including:**

- 40-hour workweek (affords you true work/life balance)
- State of CA pension that vests in 5 years (www.CaPERS.ca.gov for retirement formulas)
- Relocation assistance for those new to State of California service

For more information, contact Deborah Kim (877) 793-4473, CentralizedHiringUnit@cdcr.ca.gov or www.cchcs.ca.gov.

In addition to a CA medical license, you must possess an X-waiver (or ability to attain within 14 days of hire) as well as documentation of COVID-19 vaccination or medical/religious exemption.

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Visott JoinSSMHealth.com to find the right opportunity for you.
Atrius Health

Atrius Health is a well-established, Boston based, physician led, healthcare organisation and for over 50 years, we have been nationally recognized for transforming healthcare through clinical innovations and quality improvement.

At Atrius Health we are working together to develop and share best practices to coordinate and improve the care delivered in our communities throughout eastern Massachusetts. We are a teaching affiliate of Harvard Medical School/Tufts University School of Medicine and offer both teaching and research opportunities.

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

We have openings in the following specialties:

Clinical Staff

- Breast Surgery
- Cardiology
- Dermatology
- Gastroenterology
- Hematology/Oncology
- Maternal Fetal Medicine
- Nephrology
- Neurology
- Non-Invasive Cardiology
- OB/GYN
- Outpatient Primary Care
  - Internal Medicine
  - Family Medicine
- Pediatrics
- Pulmonary & Sleep Medicine
- Psychiatry
- — Adult
- — Child
- Physical Therapy—Pain Management
- Reproductive Endocrinology
- Rheumatology
- Urgent Care
  - (Weekday)
  - 24/7 (Weekend)

Visit our website at https://atriushealthproviders.org, or send confidential CV to:

Brenda Reed, 275 Grove Street, Suite 3-300, Newton, MA 02466-2275
E-mail: Brenda_Reed@atriushealth.org

Optum.co/Reliant

ONLY

ONE

PLACE TO DELIVER

YOUR BEST CARE.

Your skills are in demand at many health systems. But only Optum offers you the right care culture in which to flourish. To collaborate and share your expertise. To give patients the attention they deserve. To leverage the latest treatment advances, information technologies and analytics to push the boundaries of medicine. Join us and there’s only one thing to do — your life’s best work.

Current opportunities include Site Chief and Staff Physicians in Primary Care.

Optum.co/Reliant
Explore the latest innovations in healthcare with North Shore Physicians Group—the largest multi-specialty physicians group north of Boston. As a physician-led organization, we respect your insights, voice and vision. We’re always seeking new ways to improve the patient-provider relationship and to make the practice of medicine smarter and more efficient. Here, ideas come from everyone, in the best interests of every patient.

At Atrius Health, we offer:
•  respect for your contributions and input and a culture that supports our practitioner's
•  the stability provided by our membership in the Mass General Brigham healthcare system
•  an integrated care model that promotes innovation, collaboration and team-based care
•  opportunities to teach residents
•  clear pathways to pursue leadership positions and advance your career
•  respect for your contributions and input and a culture that supports our practitioner's ability to find a healthy balance of work and life

WE’RE A BEACON OF NEW THINKING IN INTEGRATED MEDICINE. JOIN US.

To apply or learn more about our physician opportunities, email your CV or visit
mgorham@partners.org

www.joinnspg.org/NEJMResFellow/Careers

WE ARE SEEKING PHYSICIANS TO PROVIDE NEW THINKING AND EXPAND OUR PRACTICE CAPABILITIES IN THE FOLLOWING SPECIALTIES:
• Internal Medicine
• Pediatric Medicine
• OB/GYN
• Urology
• Sleep Medicine
• Primary Care
• Emergency Medicine
• Ophthalmology

Opportunity highlights:
• Communities based on patient priority with diverse patient population
• Integrated care with primary care providers, specialists & ancillary departments
• Pulmonary responsibilities include direct outpatient care (both in-person and virtual visits) with a focus on obstructive lung disease such as COPD, asthma, bronchiectasis; care coordination & e-consultations services, making RCT studies and population health management in collaboration with pulmonary population health providers.
• Sleep Medicine clinic responsibilities include a combination of both in-person and virtual visits, interpretation of sleep studies with protected sleep study read time.
• Light pulmonary call coverage 1 in 4 shared with 1 pulmonologist and nurse practitioner. (How will call be managed? Will they be in two separate call rotations?)

Qualifications:
• BC/BE Pulmonary Medicine, Sleep Medicine with Fellowship training
• Ongoing education with a preference for completed sleep medicine fellowship
• Excellent clinical and communication skills
• Demonstrated ability to work in a team environment


We are offering:
• Exceptional benefits package including health, dental and life insurance, 401(k) match, disability, CME
• Light pulmonary call coverage 1 in 4 shared with 1 pulmonologist and nurse practitioner. (How will call be managed? Will they be in two separate call rotations?)
• Integrated care with primary care providers, specialists & ancillary departments
• Pulmonary responsibilities include direct outpatient care (both in-person and virtual visits) with a focus on obstructive lung disease such as COPD, asthma, bronchiectasis; care coordination & e-consultations services, making RCT studies and population health management in collaboration with pulmonary population health providers.
• Sleep Medicine clinic responsibilities include a combination of both in-person and virtual visits, interpretation of sleep studies with protected sleep study read time.

For doctors, the story has changed.
Head to locumstory.com to find unbiased information about locum tenens and see if it should be your next chapter.
WE ARE GROWING… OUR FUTURE IS BRIGHT AND SO IS YOURS!

LOAN SUPPORT
Plus LOCATION STIPEND!

Join Luminis Health Medical Group (LHMG), an expanding, multi-specialty group practice with primary care at its core! We are looking to add to our already busy practices in Easton, Maryland and Centreville, Maryland.

Our primary care physicians and nurse practitioners enjoy a team-based, innovative work environment designed to preserve the joy of clinical practice.

Key Points:
• Participation in the Maryland Primary Care Program, which rewards physicians and nurse practitioners for delivering advanced primary care
• Average number of patients seen per day: 18 to 22
• No hospital rounding
• Flexible work schedule

Role includes:
• Provides patient education and counsel appropriate to the medical needs of the patient.
• Communicates with other physicians about patient treatments/therapy.
• Takes call for group on scheduled days and refers patient to appropriate specialists as condition or circumstances warrant.

Benefits Include, but not limited:
• Medical, Dental and Vision
• 403(b) Plan
• Long Term and Short Term Disability
• Loan Forgiveness Program Consult/Support
• CME Allowances (financial and paid time-off)
• Malpractice Paid
• Competitive Salary - First year income guarantee – with quality incentive.
… and so much more

Did you know?
• Located in Talbot County – known as the 8th best small town in America
• Less than 8 miles from St. Michaels (fine dining, trendy shopping and so much more)
• Close drive to Ocean City, MD, Annapolis, MD and DE
• Family oriented communities
• Waterfront living – splendid Chesapeake Bay and tributaries
• Outdoor and cultural activities include sailing, boating, fishing, biking, historical tours, art museums, wine trails, antiquing, festivals, and farmers markets

The Next Step Is Yours!
Pursue your purpose and let’s work together to support our commitment of providing high-quality patient care for our communities.

Contact or send your CV to:
Marcia Brown, Physician Recruiter
mbrown23@aahs.org
mbrown23@aahs.org   Phone: 443-481-5166   Fax: 667-204-7258

NEJMCareerCenter.org

Location, Location, Location

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

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

Emerson Hospital Opportunities
• Anesthesiologist
• Cardiology
• Certified Registered Nurse Anesthetists
• Foot and Ankle Orthopedic Surgeon
• Hospitalist – Director of Clinical Operation and Attending Hospitalist
• Neurology
• Primary Care
• Urgent Care

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

NEJMCareerCenter.org
When Opportunity Knocks, It’s Probably Us.

Whether you’re looking to further your career or just starting, let Cross Country Search open the door to the healthcare’s best opportunities.

We’re ready to match your expertise to the ideal job today.

Contact us to get started! Visit crosscountrysearch.com or call 800.678.7858.