Residents and Fellows Edition

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The latest physician jobs brought to you by the NEJM CareerCenter

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A career in medicine is challenging, and current practice leaves little time for keeping up with changes. With this in mind, we have developed these new features to bring you the best, most relevant information in a practical and clinically useful format each week.

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

Sincerely,

Eric J. Rubin, MD, PhD
Physician Mentorship: Why It’s Important, and How to Find and Sustain Relationships

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

— John A. Fromson, MD

By Bonnie Darves

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

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

Anne Pereira, MD, MPH, assistant dean for curriculum at the University of Minnesota Medical School, thinks that some physicians in training fail to recognize the value of establishing and cultivating relationships with mentors. “Absolutely, in-person mentorship remains fundamentally important in medicine, because a lot of mentorship is about developing a relationship that’s close enough that your mentor wants to support you,” Dr. Pereira said. “Unfortunately, I think that the value of having mentors is probably underestimated by many trainees.”
One reason, she points out, is that many young people today who end up in residency have never worked because they have been on a fast track. They’re essentially high-achieving, highly driven professional students who have been “on a fairly regimented pathway,” she explains, “and they haven’t reached a point where there are multiple pathways they could take.”

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

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

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

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

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

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

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

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

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

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

— Thomas Norris, MD, board member, Educational Commission for Foreign Medical Graduates and former chair of the American Board of Medical Specialties; former vice dean for academic affairs, University of Washington

“I think the majority of mentor relationships today are informal. By that I mean that you don’t go ask someone, ‘Will you be my mentor?’ I don’t think I’ve ever said that out loud. Instead, look for someone you admire who is ahead of you in the field, or in a position that you might envision for yourself, and establish a relationship by asking a specific question. Then later, ask if that person will grab some coffee with you sometime.”

— Fatima Fahs, MD, dermatology resident, Wayne State University; budding mentor
What qualities or traits should physicians look for in a mentor?

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

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

“It’s important to look for mentors who can connect with you on a one-to-one basis and who will inspire you and also give you a pat on the shoulder. It shouldn’t be about idolization; you want someone who will celebrate you as an individual, not intimidate you, and someone who will also help you figure out how to overcome roadblocks.

I’ve always found the best mentors to be people who fill up my tank a bit to give me more energy to meet the next milestone.”

— Joseph Vercellone, MD, internal medicine resident in Royal Oak, Michigan, who previously worked in the film and information technology industries

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

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

“Look for a person who has the time and desire to truly invest in your future. It matters less what their area of expertise is. You want someone who can act like a sponsor for you and connect you with the right people. And you should ensure that person doesn’t have selfish motives, like recruiting you.”

— Dr. Pereira

How many mentor relationships should young physicians try to establish?

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

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

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

— Dr. Pereira

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

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

— Nathaniel Scott, MD, director, combined emergency medicine/ internal medicine residency, Hennepin County Medical Center, Minneapolis
The physician who identifies a potential mentor should be direct, and say, ‘I’d like you to be one of my career advisors.’ If that person agrees, the two should set expectations about the kind of communication that will occur and how often, and when the mentor will check in to see how things are going. It’s important to set out the expectations of the exchange, because if one party has higher expectations than the other, that could strain the relationship.”

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

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

— Dr. Cosco

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

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

— Dr. Fahs

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

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

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

— Dr. Pereira

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

— Nitin Agarwal, MD, neurosurgeon trainee-PGY 4, University of Pittsburgh; American Association of Neurological Surgeons resident advisor

What should physicians do if they’re in a mentor relationship that isn’t working out?

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

— Dr. Best

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

— Dr. Scott

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

— Dr. Norris

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Outside the Fold: Exploring Nonclinical Work Opportunities for Physicians

By Bonnie Darves

Most physicians go into medicine fully expecting to spend their careers in patient care, and the vast majority do just that for three decades or so. Some physicians, however, might decide that they want to expand or alter their horizons — or even leave clinical practice altogether — by pursuing other types of work. Twenty years ago, it might have been difficult to make a major transition from patient care to nonclinical work. That’s not the case anymore. Within the health care realm generally, there are many kinds of nonclinical work available, and much of that work can be done on either a part-time or full-time basis.

Residency-trained physicians, particularly those who have spent at least three to five years in patient care, find many nonclinical avenues where their skills and experience might yield gratifying work. Common areas where such jobs are plentiful include pharmaceutical drug development and consulting, medical technology and informatics, health insurance and utilization management, and within regulatory agencies. Public health, education, and hospital leadership also offer numerous nonclinical opportunities, as do nonprofit organizations. In addition, “side gigs” abound in chart review, expert witness work, and, of late, in biotechnology and the ever-growing health care business and technology startup sectors. Still others find gratifying, if not necessarily highly compensated, work in medical writing.

The reasons that physicians choose to explore nonclinical work are myriad, but the key ones are a desire to seek new challenges or the awakening that full-time patient care isn’t the best fit. In some cases, physicians pursue nonclinical work almost by happenstance, when they’re exposed to something in the course of their clinical practice or are trying to figure out their own next move.

That’s what happened for Heather Fork, MD, a dermatologist turned career coach. Although she liked dermatology, after a decade in the field she decided that she needed to find a different way to help people. That led her to become a master certified coach and, eventually, to focus on physicians. Today, Dr. Fork operates The Doctor’s Crossing, a Texas firm that counsels physicians seeking to invigorate their careers or transition to nonclinical pursuits.

Dr. Fork encourages physicians to explore new career options if they’re feeling stuck or less than gratified with patient care, but she cautions them to ensure they’re not just running away from something. “Before making any changes, I always recommend doing everything you can at your current position to make things better. Part of this process involves gaining clarity on what is and isn’t working,” she said. For some physicians, she explained, that process leads them to the realization that if they can work fewer hours and have more flexibility, their current job is actually okay. For others, who might be in a toxic environment, the solution might be finding a better practice setting. “A thorough self-assessment might also reveal that medicine was never the right fit to begin with, and that a new path is in order. Taking on new challenges and interests, either in medicine or outside medicine as a sideline or hobby, can help feed the mind and spirit,” she said.

Following interests to find nonclinical opportunities

Yasmine S. Ali, MD, a cardiologist at Vanderbilt University in Tennessee, was struggling with her decade-old career when she decided to shake it up by parlaying two of her lifetime interests — writing and preventive medicine — into two new ventures. Today, as president of LastSky Writing, LLC, Dr. Ali works with individuals and companies seeking medical consulting and writing services across a broad range of health and wellness areas. She also helps physicians launch their own writing careers, and now operates a preventive medicine practice. “In my cardiology practice, I felt like I was doing a lot of damage control, so I decided to pursue my interest in preventive medicine by starting my own practice and writing about health and wellness,” said Dr. Ali.

Today, Dr. Ali serves as chief editor of the atherosclerosis and congenital heart disease sections at Medscape. She also writes for pharmaceutical and nutrition companies, and she writes and speaks frequently on wellness and disease risk prevention. “It took me a long time to realize that I could help patients in other ways,” she said. “I’ve discovered the power of writing to expand my impact, and it’s been very gratifying.”

Nisha Mehta, MD, a radiologist in Charlotte, North Carolina, like Dr. Ali, turned the concept of exploring nonclinical opportunities into her own...
business. She founded and operates a Facebook forum called Physician Side Gigs, a three-year-old venture that now has 38,500 physician members.

“It’s a very active forum. It draws physicians who want to learn about business or finance or are looking to shift direction to pursue nonclinical opportunities or something they’re passionate about. Some simply want to supplement their income or pay off their loans faster,” said Dr. Mehta, by exploring opportunities in real estate or investing, for example. “What our group says, I think, is that it’s OK not to want to be a traditional doctor. We try to connect physicians to opportunities, regardless of whether they’re related to the physician market.” Overall, the forum has evolved as a vibrant networking forum, she adds, that connects physicians from across the specialties.

In Dr. Mehta’s case, Physician Side Gigs provides a revenue stream from public speaking and other activities associated with the forum. She practices full time at the VA. “For me personally, I think that my Sides Gigs venture is actually promoting my career longevity. It has enabled me to pursue something fulfilling in a different way,” she said.

Straddling clinical and nonclinical realms

Hodon Mohamed, MD, a Michigan obstetrician-gynecologist, also moves between clinical and nonclinical work. She still practices two shifts a week as an OB/GYN hospitalist but has pursued a handful of sidelines in recent years, as a medical director, in utilization management, and as a career coach for physicians. “I enjoy my specialty, but I was definitely feeling the burn from the system,” she says. “I wanted to try something new.”

Dr. Mohamed has enjoyed all her side gigs but finds the coaching — she focuses on physicians in transition — especially rewarding. “I have found that as physicians, we don’t really talk to each other about the issues we experience in our lives. That’s why I really enjoy helping physicians find their passions beyond medicine, whether they stay in clinical practice or not,” she said.

Some physicians decide to make the transition to nonclinical in a relatively rapid fashion. Ophthalmologist Frances Cosgrove, MD, did that when she moved from clinical practice to the pharmaceutical sector about a year ago. Today, she is a clinical case manager and medical reviewer in the Global Patient Safety division for Eli Lilly and Company in Indiana. As she tells it, she had reached a juncture in her medical career, after nearly a decade in practice, where she wasn’t sure she wanted to spend another 20 years doing essentially the same thing. She started out by doing contract work in the pharmaceutical field and found she liked it, then took the job at Eli Lilly.

The focus of her work now is looking at side effects and adverse events that might be associated with drugs that are either in development or already on the market, performing pharmacovigilance. It’s been a good move, even if it required substantial adjustment. “It’s been a while since I learned a whole new culture — one that’s very different than the one I knew. And I’ve enjoyed it,” she said. “I’ve been very impressed, too, by all the continuous learning opportunities in the industry.” She also appreciates the fact that it’s a Monday–Friday job. “No more nights and weekends,” she said.

Physicians who move into nonclinical work often do so for a combination or professional and personal reasons. Family medicine physician Lisa Ho, MD, was looking for more flexibility in her work life — she has four children — than a breakneck-paced practice would permit, without losing a connection to patients. She found it in a mixed portfolio of part-time jobs, as a Social Security disability consultant, nursing home reviewer, and Medicaid utilization management specialist. “I still get the chance to work as a doctor, but I’m not tied to an 8–5 — or sometimes 8–10! — job, and I get to work from home. The jobs are flexible, and I can choose my hours and the amount of work I do,” Dr. Ho said. “What I like best is that what I do is necessary, because I think we all realize that resource utilization is important.”

Gauging income potential in nonclinical work

Dr. Ho has also found that nonclinical work does not, as a rule, pay less than clinical work. “I think a lot of physicians think that they’ll take a pay cut, but that’s not necessarily the case,” she said. Other sources interviewed for this article concurred. What physicians will — or potentially can — earn in nonclinical work depends on several factors. These range from their time in practice, to their specialty, to their skills sets and their ability to wax entrepreneurial when the opportunity arises.

Some nonclinical jobs’ compensation is on par with a physician’s salary, Dr. Fork reported, while other jobs may be lower earning and still others, significantly higher. For example, entry-level jobs in health insurance, utilization management, the pharmaceutical industry, and physician-advising
pay between $160,000 and $300,000, but there can be considerable upside income potential as physicians advance, Dr. Fork and other sources said.

Further, physicians who obtain business, health administration, or clinical informatics degrees are likely to find themselves in high demand and with the potential to command very good salaries. Those in highly compensated specialties such as surgery, however, might need to prepare for a drop in income, Dr. Fork said.

Testing the nonclinical waters, over time

Following personal and professional interests where they lead, in an incremental fashion, is a prudent way to find a new career path, some physicians contend. That’s how a long-term journey from patient care-focused practice to clinical informatics evolved for pediatrician Feliciano “Pele” Yu, MD, chief medical information officer at Arkansas Children’s Hospital in Little Rock. He began his transition nearly two decades ago, when he became interested in computers, learned to code, and developed a “miniature” electronic medical record (EMR) for his practice. Over the ensuing years, while still practicing pediatrics, he did a fellowship in health services research via a National Institutes of Health award and picked up degrees in public health and health informatics.

Today, Dr. Yu works in a full-time administrative role in which he focuses on the intersection of health informatics, outcomes research, and quality of care. Although he misses direct patient care, in his view he is still involved by extension. “I truly feel that I am still taking care of patients, but in a different way now,” he said, “and it’s an exciting time for clinical informatics.” From an informal sideline that once attracted a handful of “geeky” physicians, clinical informatics is now an American Board of Medical Examiners-designated specialty, and there are 33 ACGME-accredited programs.

For physicians who are interested in informatics but don’t want, or aren’t ready to leave their practice positions, there are avenues, paid and volunteer, to explore the field part time, Dr. Yu said. Health care organizations of all sizes are seeking physicians who can act as subject-matter experts (SMEs) to help them optimize their existing EMRs and information systems to improve quality and extract useful data. He also recommends attending informatics conferences (or devoted presentations or tracks at specialty conferences). In addition, medical software and information systems vendors are often looking for physicians to act as SMEs or consult on their products.

“There are plenty of opportunities for physicians to pursue their interests or check out the field,” Dr. Yu said. He added that physicians working in informatics full time are also happy to connect with young physicians.

Like Dr. Yu, Jeffrey Grice, MD, also took the long road to his nonclinical career. As medical director for member experience and branding for Kaiser Permanente in Washington, the Seattle-based obstetrician-gynecologist has held numerous leadership roles over the years. He helped build a women’s cancer department, served as department chair and later chief of medicine, and then, in 2015, took a senior role in corporate human resources and compliance in Kaiser’s California headquarters before taking his current position. He reluctantly stepped away from part-time clinical practice because it just wasn’t feasible to continue, but Dr. Grice finds that his current work still provides the satisfaction that he is helping patients.

“In a typical week, I’ll bounce from working with the marketing and branding team, to analyzing data on our performance, to spending time with a patient who experienced a complication of surgery and didn’t feel supported enough,” Dr. Grice said. He urges young physicians to try something new every seven to 10 years, to challenge themselves intellectually and keep their professional lives fresh. He also counsels physicians to rejuvenate themselves by looking first for opportunities around them, whether that is working on a committee that interests them, engaging in quality improvement, doing peer review, or taking leadership courses. “It’s helpful to start by looking for an unmet need that interests you and taking it from there,” he said.

Be prepared for pushback

One issue that physicians contemplating nonclinical work face is concern about what their colleagues — especially their mentors — will think. That’s a valid consideration, but it shouldn’t deter physicians from seeking another path. The thing to keep in mind, Drs. Ali and Mohamed said, is that being true to yourself is a lot more important than reacting to what others say or think. That response, in most cases, will be fleeting, as most physicians are more focused on their own careers than those of a former residency or clinical colleague.
“At first, there was a reaction of surprise to what I was doing, and then the conversation began to go in a different direction. People started asking questions,” Dr. Ali said. “The thing to remember is that when people appear to question what you’re doing, it’s really more about their perceptions and opinions than it is about you.”

“There will be some backlash — but you’ll get over it,” Dr. Hodon said. “I think that will change, though. The younger generation of physicians is saying ‘this is my life, and I should do what I find gratifying.’”

Physicians who enter leadership nonclinical roles, whether early or mid-career, might also face opposition from colleagues, whether that sentiment is uttered or not, Dr. Grice admitted. “Unfortunately, there’s still a bit of the us-versus-them mentality, that physicians who go into leadership in nonclinical roles have ‘gone to the dark side.’ You have to remember that the work you are doing still benefits patients, but in a different way,” he said.

Planning the transition

The physicians interviewed for this article offered a range of helpful tips for their colleagues who are considering moving into nonclinical work on a part-time or full-time basis. Here are a few:

**Thoroughly explore your options — and your motivations.** Dr. Fork recommends that physicians spend considerable time looking at what’s out there in the way of nonclinical work, by visiting social media sites (see Resources) and doing research. “It’s also very important to talk to someone who doesn’t have an agenda to help you sort out your thoughts and feelings,” Dr. Fork said. “A trusted colleague or mentor can be helpful. What’s not helpful is talking with physicians who are very negative about their situation but are unwilling to do anything about it.”

**Start networking and keep doing it.** Physicians tend to underestimate both the importance and value of networking when they’re considering any kind of shift, Dr. Cosgrove said, but it’s critically important. “I think many physicians are concerned about saying out loud that they want to make a change, but every time I reached out and heard someone’s story or sought their counsel, it made me feel a bit better about what I was considering,” she said.

**Don’t quit your day job — yet — and don’t expect greener pastures.** Physicians considering leaving clinical medicine altogether should plan on a minimum two-year transition timeframe, according to Dr. Hodon. They should also be prepared to invest in themselves by gaining skills during that period and finding people in the envisioned pursuit to guide them. Dr. Fork adds that physicians should really ensure that they’re not running away. “Doing an honest self-assessment about what you truly want (from a) job and what would be a good match for your personality, skills, and interests is a key part of avoiding career-change mistakes. You don’t want to end up in a remote nonclinical job that doesn’t interest you and where you’re tied to a computer,” she said.

**Resources**

Nonclinical careers podcast: https://vitalpe.net/pnc-podcast
Physician Side Gigs: www.facebook.com/groups/PhysicianSideGigs
The Doctor’s Crossing: https://doctorscrossing.com
Nonclinical Job Hunters: www.facebook.com/groups/NonclinicalJobHunters
Clinical Practice

Immune Thrombocytopenia

Nichola Cooper, M.D., M.B., B.S., and Waleed Ghanima, M.B., Ch.B., Ph.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.

A 72-year-old woman who is receiving apixaban for atrial fibrillation but otherwise does not have a clinically significant medical history presents to the hospital with lower gastrointestinal bleeding. On admission, her hemoglobin level is 8.5 g per deciliter, platelet count 2000 per cubic millimeter, and white-cell count 5300 per cubic millimeter. She receives a transfusion of packed red cells and platelets that results in an increase in the hemoglobin level and a decrease in bleeding, but only a transient increase in the platelet count. The examination is unremarkable. A peripheral-blood smear shows no abnormalities other than thrombocytopenia; these findings are consistent with a diagnosis of immune thrombocytopenia. How should this case be managed?

The Clinical Problem

Immune thrombocytopenia (ITP) is an autoimmune disease characterized by isolated thrombocytopenia. Patients may be asymptomatic at presentation or they may present with mild mucocutaneous to life-threatening bleeding. Although only 5% of patients with ITP present with severe bleeding, bleeding leading to hospital admission within 5 years after diagnosis develops in approximately 15%. Irrespective of bleeding problems, patients with ITP often report fatigue and impaired health-related quality of life. The risk of venous thromboembolism is twice as high among patients with ITP as among persons in the general population; the management of venous thromboembolism may be especially problematic given the concomitant risk of bleeding.

ITP may be a primary condition or it may be caused by other diseases. The differential diagnosis of thrombocytopenia and the potential secondary causes of ITP are outlined in Table 1. Overall, the incidence of ITP ranges from 2 to 4 cases per 100,000 person-years, with two peaks: one between 20 and 30 years of age with a slight female predominance and a larger one after 60 years of age with equal sex distribution. Although some patients have one episode of ITP followed by an immediate remission, chronic ITP develops in up to 70% of adults with this condition. Both spontaneous and treatment-induced remission can occur many years after diagnosis.

The pathophysiology of ITP is complex and remains incompletely understood (Fig. 1). The traditional concept is that antibody-coated platelets are prematurely destroyed in the spleen, liver, or both through interaction with Fcγ receptors. Autoantibodies can also induce complement-mediated or desialylation-induced
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Table 1. Differential Diagnosis and Secondary Causes of Immune Thrombocytopenia (ITP).∗

<table>
<thead>
<tr>
<th>Variable</th>
<th>Clinical and Laboratory Findings</th>
<th>Other Tests and Findings to Confirm Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pseudothrombocytopenia</td>
<td>No symptoms, in vitro phenomena</td>
<td>Platelet aggregation on peripheral-blood smear, repeat platelet count in citrated blood.</td>
</tr>
<tr>
<td>Renal or liver disease</td>
<td>Symptoms, signs, and clinical history</td>
<td>Renal function and liver-function tests and imaging of abdomen, including liver and spleen.</td>
</tr>
<tr>
<td>Myelodysplastic syndrome, acute leukemia</td>
<td>Other cytopneas and abnormal peripheral-blood smear</td>
<td>Peripheral-blood smear, bone marrow aspirate and biopsy, with flow cytometry and cytogenetic testing.</td>
</tr>
<tr>
<td>Aplastic anemia</td>
<td>Pancytopenia</td>
<td>Bone marrow aspirate and biopsy with cytogenetic testing.</td>
</tr>
<tr>
<td>Genetic diseases that cause thrombocytopenia (e.g., Bernard–Soulier syndrome and MYH9-related disorders)</td>
<td>Young age at presentation, family history of thrombocytopenia, abnormal size and morphologic features of platelets or abnormalities seen in peripheral-blood smear, other clinical abnormalities (e.g., renal disease and deafness in patients with MYH9-related disorders).</td>
<td>Peripheral-blood smear, mean platelet volume, genomics testing.</td>
</tr>
<tr>
<td>Thrombotic thrombocytopenia purpura</td>
<td>Neurologic or cardiac symptoms</td>
<td>Schistocytes on peripheral-blood smear, elevated LDH level, low haptoglobin and ADAMTS13 levels, direct antiglobulin test-negative hemolytic anemia.</td>
</tr>
<tr>
<td>Heparin-induced thrombocytopenia</td>
<td>Venous thrombosis, previous exposure to heparin</td>
<td>Platelet factor 4–heparin antibody tests, platelet-activation assays.</td>
</tr>
</tbody>
</table>

Other Tests and Findings to Confirm Diagnosis

- Tests to detect drug-dependent antibodies, if available
- Serologic and PCR tests for HIV, HVB, HCV, cytomegalovirus, EBV, and Helicobacter pylor
- Arthritis or arthritis, hair loss, sun sensitivity, mouth ulcers, rash, thromboembolism
- Thrombocytopenia and direct antiglobulin test-positive hemolytic anemia

- Schistocytes on peripheral-blood smear
- Elevated LDH level
- Low haptoglobin
- ADAMTS13 levels
- Direct antiglobulin test-negative hemolytic anemia

Use of certain drugs

- Sudden onset after initiation of new medica
- Complete blood count; peripheral-blood flow cytometry, bone marrow flow cytometry, or both; bone marrow aspirate and biopsy
- Protein electrophoresis imaging of abdomen, chest, and neck to assess lymphadenopathy and spleen size (as appropriate)
- Immunoglobulin quantification; lymphocyte subset count, genetic testing

Diagnosis

ITP is defined as a platelet count below 100,000 per cubic millimeter in patients in whom other causes of thrombocytopenia have been ruled out. A clinical history, including assessment of the use of drugs, physical examination, and complete blood count, is important to rule out other causes of thrombocytopenia and to evaluate for secondary causes of ITP (Table 1). Examination of the peripheral-blood smear in a patient with ITP shows reduced numbers of platelets with no other abnormalities (e.g., schistocytes and dysplastic changes), although some patients have large platelets, this is not a pathognomonic feature. (Fig. 2). There is no diagnostic test for ITP; antiplatelet antibodies are detected in only 50 to 60% of patients with ITP and measurement of such antibodies is not recommended in the diagnostic workup. Bone marrow examination is not diagnostic in patients with ITP and is performed only in those with other hematologic abnormalities and in those who do not have an adequate response to treatment. The current goals of treatment are to stop active bleeding and reduce the risk of future bleeding. If the patient has active serious bleeding, urgent treatment is indicated. Specific measures, where appropriate, include the withdrawal of anticoagulant and antiplatelet agents and treatment with platelet transfusions, glucocorticoids, intravenous immune globulin (IVIG), or all of these measures; data from randomized trials are lacking, and the use of these treatments is supported generally by small observational studies. Platelet transfusions can help to limit bleeding, but they have only transient effects (for a few hours), and therefore the patient may need to undergo transfusions repeatedly. They should not be used alone but rather in combination with IVIG and glucocorticoids.

- IVIG raises the platelet count within 1 to 4 days in 80% of patients, but effects last only 1 to 2 weeks. IVIG is indicated in patients with active serious bleeding and in those with very low platelet counts (<10,000 per cubic millimeter), who are at increased risk for serious bleeding. Concomitant use of glucocorticoids with IVIG can be associated with a more sustained response than that with IVIG alone.
- In life-threatening situations, additional treatments may be required. Antifibrinolytic treatment (tranexamic acid) can help to stop bleb-
The pathophysiology of immune thrombocytopenia (ITP) is incompletely understood, the key event being considered to be the production of antiplatelet autoantibodies. These autoantibodies target platelets for destruction by macrophages in the spleen, liver, or both, through activation of Fcγ receptors; this process is controlled by spleen tyrosine kinase (Syk). Autoantibodies may also destroy platelets through other mechanisms and inhibit platelet production by megakaryocytes. Antigens from phagocytosed platelets are thought to be presented by the major histocompatibility complex class II (MHCII) to T-cell receptors (TCRs), stimulating autoreactive T cells. T-cell-mediated platelet destruction and inhibition of megakaryocytes.

Although 60 to 80% of patients with ITP have mild mucocutaneous bleeding, the decision to treat should be guided by the risk of future bleeding and patient preferences. However, predicting the risk of future bleeding among patients with ITP is challenging. Several scoring systems have been developed, but their usefulness in clinical practice is limited by their complexity and lack of validation in large studies.12,13

A platelet count of less than 20,000 to 30,000 per cubic millimeter is frequently used as a criterion for treatment.20 This criterion is consistent with findings of an increase in the 1-year risk of bleeding requiring hospitalization of 2.5 times among patients with platelet counts between 25,000 and 50,000 and 7 times among those with platelet counts below 25,000 per cubic millimeter.2 However, treatment decisions should also take into account other risk factors that influence bleeding; these include older age (e.g., >65 years), history of bleeding, concomitant use of anticoagulants and platelet inhibitors, the presence of coexisting conditions such as renal impairment, and the risk of trauma from daily activities.2,1

It is generally recommended that patients who are receiving anticoagulants or antiplatelet agents should receive treatment to maintain platelet counts above 50,000 per cubic millimeter.

**Glucocorticoids**

Glucocorticoid treatment is the standard initial therapy for patients with ITP. Two commonly used regimens are pulsed high-dose dexamethasone and a more prolonged course of oral prednisone or prednisolone (Table 2). In a meta-analysis of randomized trials comparing these two regimens, platelet counts were higher at 14 days in patients receiving dexamethasone, but overall responses at 6 months did not differ significantly.21 Adverse events such as weight gain and cushingoid appearance were more prevalent with prednisone or prednisolone.21 Other studies have suggested more neuropsychiatric effects with dexamethasone.21 Although 60 to 80% of patients with ITP have an initial response to glucocorticoids, only 30 to 50% of adults have a sustained response after glucocorticoids are discontinued.22,23 In some studies, continued use has been associated with a higher incidence of long-term remission,24 but prolonged exposure to glucocorticoids is not recommended because of adverse effects.

**Other Medical Therapies**

Medical therapies for patients with ITP who do not have an initial response to glucocorticoids or who have recurrent decreases in platelet counts after glucocorticoids are discontinued include thrombopoietin-receptor agonists and immunomodulators.25 In the absence of randomized trials directly comparing these therapies or of biomarkers to guide the choice of medication, treatment...
## Table 2. Dosages, Efficacy, and Adverse Effects of Various Treatments for ITP.

<table>
<thead>
<tr>
<th>Agent</th>
<th>Dosage</th>
<th>Onset of Action</th>
<th>Durability of Effect</th>
<th>Side Effects and Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucocorticoids</td>
<td>Prednisone or prednisolone*</td>
<td>1–2 wk</td>
<td>Response with treatment in 60 to 90% of patients</td>
<td>Hirsutism, acne, weight gain, insomnia, mood changes, cushingoid appearance, glucose intolerance, osteoporosis, increased risk of infection (particularly with prolonged use of prednisone or prednisolone), gastrointestinal symptoms, neuropsychiatric symptoms (particularly with dexamethasone)</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>Intravenous weekly for 4 wk or 1 g administered twice with 2 wk between doses; lower doses (100–200 mg) weekly for 4 wk have also been shown to be effective</td>
<td>4–8 wk</td>
<td>Response in 30–60% of patients</td>
<td>Headache, aseptic meningitis, renal failure</td>
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</table>

## Clinical Practice

Eltrombopag and romiplostim are thrombopoietin-receptor agonists that are approved by the Food and Drug Administration (FDA) for patients with ITP that is refractory to other treatment and with disease lasting more than 6 months (eltrombopag) or 12 months (romiplostim). In randomized, placebo-controlled trials of each of these agents involving patients with chronic ITP in whom at least one previous therapy has failed, 70 to 95% of patients had an increased platelet count with initial treatment and 40 to 60% had durable responses with ongoing treatment.23–27 Although these agents have not been compared head to head, the incidence of response appears to be similar. A meta-analysis of 13 randomized trials of either agent showed that, as compared with placebo or standard of care, they were associated with significantly higher rates of platelet response and durable response, and they reduced episodes of bleeding and the use of rescue and concurrent medications.23–27

Eltrombopag is administered as a daily tablet (with dietary restrictions), whereas romiplostim is administered in weekly subcutaneous injections (Table 2). The choice between the two agents is guided by the preferred form of administration and anticipated adherence. Limited observational data suggest that if one agent is ineffective, switching to the other results in a platelet response in up to 50% of patients.23,29

An initial response to thrombopoietin-receptor agonists usually occurs within 1 to 2 weeks. Once a response is achieved, ongoing treatment is ordinarily required to maintain effect. However, retrospective and prospective cohort studies have shown that 10 to 30% of patients can discontinue treatment after receiving thrombopoietin-receptor agonists for many months or years, and the disease remains in remission, although late relapses may occur.11,12

In early studies, concerns were raised regarding possible adverse effects of these agents on bone marrow. However, these effects have not
been confirmed with more than 10 years of follow-up; moderately increased bone marrow reticulin fibrosis has been observed in fewer than 10% of patients treated with either of these agents and has been reversible on discontinuation.43 The main safety concern is an increased risk of venous thromboembolism.44 In extension studies of both agents, thromboembolism developed in 6% of patients during a median follow-up of 2 years.45,46 Thromboembolic events occurred predominantly in patients with other coexisting conditions and risk factors. Although both the underlying ITP may partially account for these findings, the incidence of venous thromboembolism in these clinical trials was higher than expected, which raises the possibility that thrombopoietin–receptor agonists may tip the balance to thrombosis in susceptible patients. Other adverse effects of eltrombopag include elevated liver aminotransferase levels (which are reversible when the dose is reduced), and, as shown in animal studies, cataracts (although this finding has not been substantiated in long-term studies involving humans).44

Aromatase inhibitors, other oral thrombopoietin–receptor agonists such as romiplostim, which can be administered without dietary restrictions, was approved by the FDA in June 2019 for the treatment of adults with chronic ITP. This approval was based on results of phase 3 clinical trials showing a longer median number of weeks with platelet counts of 50,000 per cubic millimeter or higher during the first 26 weeks in patients who administered romiplostim than in those who received placebo (12.4 weeks vs. 0 weeks).36

Immunomodulators

Rituximab is the most widely used immunomodulator with significant response rates in patients with ITP, although it is not approved by the FDA for this indication. A systematic review of single-group studies showed a response in 60% of patients, with a complete response in 40% of patients.37 A meta-analysis including rituximab in 6% of patients with ITP, endoscopic controlled trials showed a significantly higher incidence of complete response at 6 months with rituximab than with glucocorticoids or placebo.38 A response to rituximab is typically observed within 1 to 8 weeks (Table 2). In some single-group studies, young women (<50 years of age) with a short duration of disease (<2 years) were reported to have a higher incidence of response and more durable responses than other patients.39

The main advantage of rituximab is sustained platelet response that lasts more than 2 years in 50% of patients who have a response.40,41 Although ITP eventually relapses in most patients, a response can be achieved in 40% of those with thrombocytopenia who were treated with rituximab and have a response to retreatment with rituximab. An increase in minor infections has been reported with rituximab. However, major complications such as progressive multifocal leukoencephalopathy are exceedingly rare.42,43

Fostamatinib, an oral spleen tyrosine kinase (Syk) inhibitor, was approved by the FDA in 2018 for patients with ITP in whom one previous therapy has failed. In pooled randomized trials, a stable response (defined as a platelet count ≥50,000 per cubic millimeter on at least four of six visits twice a week during weeks 14 to 24) was achieved in 18% of patients receiving fostamatinib and in 2% of those receiving placebo. A response (a platelet count ≥50,000 per cubic millimeter within the first 12 weeks of treatment) was achieved in 43% of patients receiving fostamatinib and in 14% of those receiving placebo. The mean time to response was 15 days. Diarrhea, hypertension, transaminitis, and nausea were common adverse effects that occurred in up to 30% of patients.44

Other immunomodulatory agents such as mycophenolate mofetil, azathioprine, dapsone, and danazol are also used in patients with ITP with glucocorticoids or placebo.38 A response to dapsone was achieved in 36% of patients receiving dapsone and in 2% of those receiving placebo. A response to azathioprine was achieved in 30% of patients receiving azathioprine and in 2% of those receiving placebo. A response to mycophenolate mofetil was achieved in 25% of patients receiving mycophenolate mofetil and in 2% of those receiving placebo.45

Splenectomy

A systematic review showed that splenectomy, which remains the most effective therapy for ITP, induces long-lasting remissions in 60 to 70% of patients.46 Nevertheless, owing to the emergence of effective medical therapies, the potential complications of splenectomy, and the inability to predict which patients will have a response,47 the frequency of splenectomy in patients who do not have a response to or cannot receive standard medical therapies because of side effects and in whom at least a year has passed since diagnosis (so as to allow for remission to occur) has decreased substantially during the past two decades.48

Short-term risks of splenectomy include operative and postoperative complications, including venous thromboembolism and sepsis. Laparoscopic splenectomy is associated with lower postoperative mortality and morbidity and a shorter hospital stay than open splenectomy.49 Laparoscopic splenectomy is associated with lower postoperative complications in this group. It is generally recommended that splenectomy be performed for patients with ITP who have undergone splenectomy as compared with those who have not undergone splenectomy.50

Patients who have undergone splenectomy have an increased risk of infection with encapsulated bacteria and require repeated vaccinations. A large registry-based study showed a higher risk of both early and late sepsis among patients with ITP who had undergone splenectomy than among those who did not.40 A higher incidence of other vascular complications, such as coronary artery disease, stroke, and chronic thromboembolic pulmonary hypertension, has also been reported among patients with ITP who have undergone splenectomy, but the data are not consistent among studies.51 Conversely, one study showed no significant difference in mortality in the first year after splenectomy and viremia among those who did not.52

Splenectomy is generally not performed in frail elderly patients because of increased surgical complications in this group. It is generally not performed in patients with secondary ITP owing to a lower incidence of response and more adverse events in these cohorts than in others.47

Areas of Uncertainty

The pathogenesis of ITP is not fully understood, and biomarkers are needed to predict responses to specific treatments. Randomized trials are lacking in the treatment of patients who do not have a response to or cannot receive standard medical therapies because of side effects and in whom at least 1 year has passed since diagnosis (so as to allow for remission to occur). The frequency of splenectomy has decreased substantially during the past two decades.48

The patient described in the vignette has a low platelet count without other hematologic abnormality (with the exception of the concern for acute bleeding), consistent with ITP. Urgent treatment to stop the bleeding should include discontinuation of antiaggregants, the use of an intravenous platelet transfusion, IVIG, and glucocorticoids. Once her condition has stabilized, her diagnosis should be reviewed, with a careful history to rule out other causes of thrombocytopenia and conditions resulting in platelet transfusions. IVIG and glucocorticoids should be administered without dietary restrictions, was approved by the FDA in June 2019 for the treatment of adults with chronic ITP. This approval was based on results of phase 3 clinical trials showing a longer median number of weeks with platelet counts of 50,000 per cubic millimeter or higher during the first 26 weeks in patients who administered rituximab than in those who received placebo (12.4 weeks vs. 0 weeks).
poietin-receptor agonist, given randomized trials showing a high incidence of sustained elevation in the platelet count with each of these agents. However, thrombopoietin-receptor agonists are currently outside the approved indications for ITP, which are limited to ITP lasting for at least 6 months. Ruxitumab is an alternative therapeutic strategy, although the incidence of response appears low and response occurs more slowly than with a thrombopoietin-receptor agonist. Given the patient’s age and coexisting conditions, splenectomy would be contraindicated. Dr. Cooper reports receiving fees paid to his institution for serving as a principal investigator for clinical trials, advisory board fees, and lecture fees from Amgen, Novartis, and Vertex, fees paid to his institution for serving as a principal investigator for clinical trials from Lilly Pharmaceuticals, fees paid to his institution for serving as a principal investigator for clinical trials from Pfizer, and fees paid to his institution for serving as a principal investigator on an advisory board from Praxity. Dr. Lucenti, receive book royalties and lecture fees from Amgen and grant support paid to his institution, advisory board fees, and lecture fees. Other potential conflict of interest related to this article was disclosed.

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

GUIDELINES

References


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Experience an average of 300 days of sunshine, unlimited outdoor activities and a thriving arts and cultural community in the beautiful multi-cultural Southwest. El Paso can serve as your base point for travel in any direction – within a few short hours you can ski in Ruidoso; take in the cultural ambience of Albuquerque – perhaps play a few slots or catch a headline concert; arrive in Phoenix for professional sports, or a short detour to Tucson for beautiful hikes and farmer’s markets. Just north of El Paso is Las Cruces, home to huge pecan orchards and agriculture. El Paso itself offers a dynamic community of local culture, military culture, Southwest charm and Tex-Mex served hot! We have year-round sports and outdoor recreation due to the abundant sunshine. Road cycling is a celebrated pastime – as is motorcycling through the mountain scenery. You can always find a new trail to hike – from the Franklin Mountains to Hueco Tanks. El Paso has tons to offer: an international airport, renown medical school, Spaceport America – host to Virgin Galactic; the largest US Army Installation, minor league baseball team; a low-index cost of living; tons of outdoor activities. We welcome you to El Paso – a place to work, play and stay!

Licensure in any state is acceptable. As a Federal employer, the Department of Veteran Affairs offers competitive salaries and generous benefit package. Recruitment/Relocation Incentive may be offered to highly qualified candidates.

Interested applicants may contact:
Gerald Berumen, (915) 564-7963 or Gerald.Berumen@va.gov
For application information go online at www.USAJOBS.gov

Sarcoma Medical Oncologist
Division of Solid Tumor Oncology, Department of Medicine

Memorial Sloan Kettering Cancer Center (MSK) is one of the world’s premier cancer centers, committed to exceptional patient care, leading-edge research, and superb educational programs. The blending of research with patient care is at the heart of everything we do. The institution is a comprehensive cancer center whose purposes are the treatment and control of cancer, the advancement of biomedical knowledge through laboratory and clinical research, and the training of scientists, physicians and other health care workers.

The Division of Solid Tumor Oncology is made up of over 160 medical oncologists in 10 subspecialty Services, including the Genitourinary Oncology Service, Breast Medicine, Early Drug Development & Immunotherapeutics, Gastrointestinal Oncology, Gynecologic Medical Oncology, Head and Neck Oncology, Clinical Cancer Genetics, Melanoma, Sarcoma andThoracic Oncology practicing in multiple sites in New York City and regionally in New York and New Jersey.

We currently have a position available in the Sarcoma Oncology Service in the Division of Solid Tumor Oncology, Department of Medicine. We are seeking a full-time faculty member in a Clinical Investigator position. Candidates should have superb clinical and interpersonal skills, an established and focused research agenda, and a track record of outstanding leadership in clinical research.

Interested and qualified applicants should send their CV, bibliography and brief statement of clinical research. We are seeking a full-time faculty member in a Clinical Investigator position. Candidates should have superb clinical and interpersonal skills, an established and focused research agenda, and a track record of outstanding leadership in clinical research.

Interested and qualified applicants should send their CV, bibliography and brief statement of interests to topak@mskcc.org. Please specify the Position title in the email subject line and include your cover letter as the body of the email.
The Division of Medical Neuro-oncology at Duke University Hospital seeks an internist to manage inpatient brain tumor service. Must be BE/BC in internal medicine. This is a daytime position, Mon – Fri, 8:00 am to 5:00 pm, approximately 10 weekends of call per year. Average daily census 5 or less. No ICU admissions. The position provides opportunity for combination of patient care and teaching. Compensation commensurate with qualifications and experience.

The greater Triangle area of Raleigh, Durham, and Chapel Hill, also known as the Research Triangle Park, is family-friendly yet offers singles many options for an active outdoor and social life. Three major universities surround this globally prominent high-tech research and development center making it a culturally diverse, economically resilient, and a nationally recognized great place to live.

Send letter of interest and CV to: Christina Cone Administrative Director of the Preston Robert Tisch Brain Tumor Center e-mail: christina.cone@duke.edu

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Physician Advisor/Attending Physician (3-309-1014)
The University of Maryland School of Medicine The Department of Transfusion Medicine in the Clinical Center, National Institutes of Health is recruiting a full-time, non-tenure track faculty position. The holder of the responsibilities for this position will be in an administrative capacity, working as a Physician Advisor for the University of Maryland School of Medicine. Duties of this position will be to collaborate with medical staff leadership, clinical services, and care management leaders to develop and implement methods to optimize use of hospital services for all patients, as well as educate and inform medical staff regarding issues of compliance, medical necessity, and resource utilization. This individual will be expected to develop solutions for difficult discharges in collaboration with care management staff and community partners, participate in strategic planning and interventions to optimize payment of care delivered in the hospital and will serve as a liaison between utilization management and clinical service areas, as well as business units and treating physicians. Working with hospital leadership, this position will ensure medical practice, will achieve quality, safety and resource utilization goals, will act as a clinical consultant providing medical expertise regarding physician practice patterns and will function in accordance with OHP Hospital Conditions of Participation for Utilization Review and other applicable regulatory, compliance, and accreditation requirements. Clinical responsibilities will include regular attendance coverage on one of our general medical and/or inpatient hospitalist teams for up to 2 months per year.

Ideal candidates must be board certified in internal medicine and eligible for unrestricted licensure in the State of Maryland. This position requires a medical degree from a recognized accredited domestic university (or foreign equivalent), a strong commitment to patient care and teaching, and the ability to work well in a team setting.

Expected faculty rank will be Assistant Professor or higher; however, rank, tenure status and salary will be dependent upon selected candidate’s qualifications and experience. We offer an excellent salary and benefits package.

Qualified candidates must submit application using the following link: https://umb.jobs/arcervation/jobDetail.309-1014 When applying, please submit a CV and names of three references.

For additional questions after application, please email: facptyposting@medschool.umaryland.edu

UMMS is an equal opportunity/affirmative action employer. All qualified applicants will receive consideration for employment without regard to race, sex, color, religion, national origin, disability, protected Veteran status, age, or any other characteristic protected by law or policy.

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ASSOCIATE HOSPITAL EPIDEMIOLOGIST, YALE NEW HAVEN HOSPITAL
ASSISTANT PROFESSOR INFECTIOUS DISEASES, YALE UNIVERSITY SCHOOL OF MEDICINE

A leadership and ladder-track faculty position is available at the level of Assistant Professor in the Section of Infectious Diseases in the Department of Internal Medicine at the Yale University School of Medicine. The successful candidate will serve as Associate Hospital Epidemiologist at Yale New Haven Hospital. Applicants should have an M.D. or M.D./Ph.D., training in infectious diseases, and exceptional potential for a career in hospital epidemiology and academic medicine. Candidates are expected to also participate in the clinical/educational and/or research activities of the department of infectious diseases. Applicants should apply using the following link and upload their curriculum vitae and a brief synopsis of future plans.

Interfolio link: http://apply.interfolio.com/62388
Review of applications will begin immediately and will continue until the position is filled.

Yale University is an affirmative action, equal opportunity employer. Applications from women, persons with disabilities, protected veterans and minorities are encouraged.

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This practice opportunity exists in select California locations with California Correctional Health Care Services and the California Department of Corrections and Rehabilitation. Working together, these two State of California departments provide much needed inpatient psychiatric care to patients at the following State-owned and -operated correctional facilities:

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- California Medical Facility – Vacaville, CA
- Salinas Valley State Prison – Soledad, CA

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Atrius Health is a well-established, Boston based, physician led, nonprofit healthcare organization 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 EHR (Epic), excellent salaries and an exceptional benefits package.

We have openings in the following specialties:

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- Moonlighting Opportunities
- Adult Weekday & Weekend Urgent Care – Braintree
- Allergy
- Non Invasive Cardiology
- OB/CYN
- Outpatient Primary Care – Internal Medicine and Family Medicine

Visit our website at www.atriushealth.org, or send confidential CV to: Brenda Reed, 275 Grove Street, Suite 3-300, Newton, MA 02466-2275

E-mail: Brenda_Reed@atriushealth.org

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Boston Children’s Hospital
Chair, Department of Pediatric Anesthesia, Critical Care and Pain Medicine

“Attending Boston Children’s, we are servant leaders. It’s not about me. It’s not about any single one of us. We all contribute our expertise, our geniuses, our care, our devotion and our passion. We are here as a team to do one thing and that is to care for our patients and families, and to support each other in doing that as colleagues, as team members, and as our own Boston Children’s family.” — Kevin B. Churchwell, MD, President and COO

Renowned for its outstanding clinical services, research programs and medical education, Boston Children’s Hospital (BCH) is a 415-bed comprehensive center for pediatric health care. As one of the largest pediatric medical centers in the United States, Boston Children’s offers a complete range of health care services for children from birth through 21 years of age, and in some cases, into adulthood. The hospital has approximately 25,000 inpatient admissions each year and its 250+ specialized clinical programs schedule 620,000 visits annually. In 2018, the hospital performed more than 28,000 surgical procedures and 215,000 radiological examinations. As one of the premier pediatric teaching hospitals in the world, BCH is affiliated with Harvard Medical School (HMS), and is revered for its ongoing commitment to foster cutting-edge research.

BCH in conjunction with HMS, seeks to recruit the next Chair, Department of Pediatric Anesthesiology, Critical Care and Pain Medicine, BCH and Professor of Anesthesiology, HMS. This prestigious appointment will lead a top Department comprised of 101 faculty with 11 Endowed Chairs, including 18 Professors, 31 Associate Professors (27 MD, four PhD), 51 Assistant Professors (45 MD, six PhD), and 51 Instructors (40 MD, 11 PhD). The Department employs 31 CRNAs and DNPs working in conjunction with Department providers who manage approximately 40,000 cases annually across 60 locations, with nearly 9,000 ICU days.

The key attributes of the incoming Chair will be a distinguished record of clinical excellence, scholarly accomplishment, leading by example, and emotional intelligence. S/he will have a keen understanding of clinical operations as well as the ability to manage a significant financial and operating budget. The Chair will be skilled in fostering the growth of others, recruiting aspiring investigators, and grooming clinical faculty within the Department who have the capability to make bold new discoveries. A Medical Degree with unrestricted medical license is required. Must be board certified in Pediatric Anesthesia (or equivalent experience) and eligible for licensure within the Commonwealth of Massachusetts.

All inquiries are confidential. Interested candidates, please forward a personal statement with your CV to:

James R. Kasser, MD
Surgeon-in-Chief, Boston Children’s Hospital and
Catharine Oramond Professor of Orthopaedic Surgery, Harvard Medical School
Orthopaedic Surgery & Sports Medicine, BCH3220
300 Longwood Avenue, Boston, MA 02115
Phone: (617) 355-6617 / Facsimile: (617) 730-0683
Email: James.Kasser@childrens.harvard.edu

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

Boston Children’s Hospital
Chair, Department of Pediatric Anesthesia, Critical Care and Pain Medicine

“Attending Boston Children’s, we are servant leaders. It’s not about me. It’s not about any single one of us. We all contribute our expertise, our geniuses, our care, our devotion and our passion. We are here as a team to do one thing and that is to care for our patients and families, and to support each other in doing that as colleagues, as team members, and as our own Boston Children’s family.” — Kevin B. Churchwell, MD, President and COO

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We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, gender identity, sexual orientation, pregnancy and pregnancy-related conditions or any other characteristic protected by law.
Cambridge Health Alliance (CHA) is an award-winning health system based in Cambridge, Somerville, and Boston's metro-north communities. We provide innovative primary, specialty, and emergency care to our diverse patient population throughout an established network of outpatient clinics and two full-service hospitals. As a Harvard Medical School and Tufts University School of Medicine affiliate, we offer ample teaching opportunities with medical students and residents. We utilize fully integrated EHR and offer competitive compensation packages and comprehensive benefits for our employees and their families. Ideal candidates will have a strong commitment to providing high-quality care to our multicultural community of underserved patients.

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  - Family Medicine
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  - Pediatrics
  - Float
- Hospitalist/Night/Float
- ICU Hospitalist/Night/Float
- Moonlighter & Loosen Hospitals
- Optometrist
- Otolaryngology & Allergy
  - Division Chief
  - General ENT
- Urologist
- Vascular Surgeon
- General Surgeon
- Dermatologist
- General Radiologist
- Dentistry
- Respiratory Program/Clinical Director
- Physician Assistant
  - Primary Care

To apply please visit www.CHAProviders.org. Candidates may submit CV confidentially via email to ProviderRecruitment@challiance.org.

About Concord, MA and Emerson Hospital

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

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

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

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

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

Emerson Hospital Opportunities

- Family Medicine – Outpatient Practice and Urgent Care
- Gastroenterology
- Internal Medicine – Outpatient Practice
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Chair, Department of Pediatrics

Northwestern University Feinberg School of Medicine invites applications and nominations for the position of Chair of the Department of Pediatrics.

The new chair will report to the dean of the medical school and leadership at Ann & Robert H. Lurie Children’s Hospital of Chicago. In their role, the new Chair is responsible for oversight of the academic, research, clinical, and administrative affairs of the Department at Ann & Robert H. Lurie Children’s Hospital of Chicago, Pediatric Faculty Foundation, and school of medicine.

The Department of Pediatrics is home to over 800 medical school faculty working in 22 subspecialties. Ann & Robert H. Lurie Children’s Hospital of Chicago ranks among the top children’s hospitals in U.S. News & World Report, with 10 clinical specialties in the U.S. News & World Report survey of children’s hospitals ranked within the top 30 nationally, 4 within the top 10.

Ranked 19th in U.S. News & World Report, principal investigators appointed through the Feinberg School of Medicine are supported by $534 million of annual research funding. The medical school is embedded among Ann & Robert H. Lurie Children’s Hospital of Chicago and two additional Honor Roll hospitals, Northwestern Memorial Hospital, ranked 10th, and the Shirley Ryan AbilityLab, ranked 1st.

Northwestern University is an Equal Opportunity, Affirmative Action Employer of all protected classes, including veterans and individuals with disabilities. Women and minorities are encouraged to apply. Hiring is contingent upon eligibility to work in the United States.

Successful candidates will possess an MD or MD/PhD with board certification and be eligible for a faculty appointment as a full-time Professor with proven scholarly accomplishments and national recognition in a clinical or science discipline.

Please email nominations and CVs of appropriate candidates to Dr. Ila Allen, pediatricssearch@northwestern.edu, recruitment coordinator.

Applications will be taken until the position is filled.

Northwestern University is an Equal Opportunity, Affirmative Action Employer of all protected classes, including veterans and individuals with disabilities. Women and minorities are encouraged to apply. Hiring is contingent upon eligibility to work in the United States.

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Applications will be taken until the position is filled.

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Sophia Kotsomalis at Sophia.Kotsomalis@yhb.org

Our practice is located throughout Long Island, Manhattan, Queens, Brooklyn, Westchester, and Connecticut. We are currently seeking a Family Medicine physician to serve as a core faculty member in the residency program at

About Monmouth Medical Center:
Located in Long Branch, NJ, Monmouth Medical Center, an RWJBarnabas Health facility, is one of New Jersey’s largest academic medical centers and is a teaching affiliate of Rutgers Robert Wood Johnson Medical School.

U.S. News & World Report has recognized Monmouth as a regional leader in cancer, genetics, gynecology, neurology and neurosurgery. As part of RWJBarnabas Health, Monmouth Medical Center is a leader in designing unparalleled new ways for delivering healthcare care. The medical center provides quality-driven, safe, efficient, cost-effective and innovative health care services that meet the needs and exceed the expectations of our community.

To learn about this and other positions, please feel free to contact Melissa Granet, Physician Recruiter via e-mail at: melissa.granet@rwjbh.org or phone: 973-322-4447. We look forward to hearing from you!

RWJBarnabas Health is currently seeking a Family Medicine physician to serve as a core faculty member in the residency program at Somerset Medical Center in Somerville, NJ. The position includes clinical supervision of residents and medical students within both inpatient and outpatient clinical settings. Core faculty members participate and mentor residents in research, scholarly activities, and are an integral part of the educational initiative at Monmouth Medical Center. The Internal Medicine Residency at Monmouth Medical Center is fully accredited by the ACGME.

As the largest integrated health care delivery system in New Jersey, RWJBarnabas Health offers competitive compensation and a robust benefits package including health, life, disability, and malpractice insurance, 401k retirement, plus PTO and added time off for CME.

Successful candidates must be:
- ABIM board certified
- Licensed in NJ or eligible for NJ licensure
- Experienced in teaching with strong enthusiasm for academic environments

More About the Position:
- Outpatient location in close proximity to the hospital
- Robust support staff
- Faculty appointment at Rutgers Robert Wood Johnson Medical School

Located at the very desirable Jersey Shore, this position provides the chance to practice in a highly sought after area near beautiful beaches, top-notch schools, and charming suburban neighborhoods.

About Monmouth Medical Center:
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To learn about this and other positions, please feel free to contact Melissa Granet, Physician Recruiter via e-mail at: melissa.granet@rwjbh.org or phone: 973-322-4447. We look forward to hearing from you!
At Geisinger, all moments both big and small teach us how to provide exceptional healthcare. Through communication and collaboration, our physicians and expanded care teams continuously learn new and innovative ways to help members of our communities live longer, healthier lives.

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