Physician jobs from the *New England Journal of Medicine* • March 2018

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Primary Care Edition

Featured Employer Profile

**GUTHRIE**
Dear Physician:

As a primary care physician about to enter the workforce or in your first few years of practice, you may be assessing what kind of practice will ultimately be best for you. The New England Journal of Medicine (NEJM.org) is the leading source of information for job openings for physicians in the United States. To further aid in your career advancement we've also included a couple of recent selections from our Career Resources section. The NEJM CareerCenter website (NEJMCareerCenter.org) continues to receive positive feedback from physicians. Because the site was designed based on advice from your colleagues, many physicians are comfortable using it for their job searches and welcome the confidentiality safeguards that keep personal information and job searches private.

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A career in medicine is challenging, and current practice leaves little time for keeping up with new information. While the New England Journal of Medicine’s commitment to delivering top-quality research and clinical content remains unchanged, we are continually developing new features and enhancements to bring you the best, most relevant information each week in a practical and clinically useful format. Notably, in January, the NEJM.org website was updated to make it easier for you to find and use the information you trust to stay informed and at the forefront of your field.

We've included a reprint of the February 15, 2018, article, “Clinical Practice: Initial Treatment of Hypertension.” Our popular Clinical Practice articles offer evidence-based reviews of topics relevant to practicing physicians. We also have audio versions of Clinical Practice articles. These are available free at our website or at the iTunes store and save you time, because you can listen to the full article while at your desk, driving, or exercising.

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

Sincerely,

Jeffrey M. Drazen, MD
pressed dress shirt and jacket, and women, the corollary to that. That’s the standard of etiquette for an onsite interview,” said Mr. Kram, a board member of the Association of Physician Staff Recruiters (ASPR). He and other recruiters interviewed indicated that residents might not receive sufficient coaching from their program staff on this aspect of the site visit.

Act — and be — prepared for the interview

Ideally, physicians planning for an onsite interview should prepare for the visit a week or two in advance. This preparation process should be fairly straightforward, depending on the practice opportunity. There is an abundance of information available online today about many health care organizations and the geographic areas and markets in which they operate. This means that physicians should arrive reasonably well informed. “It’s pretty easy now to do research on a practice, facility, or organization, and the prospective employer will expect the resident or fellow to have done that research,” said Craig Fowler, immediate past president of the National Association of Physician Recruiters and vice president of training, recruiting, and public relations for Pinnacle Health Group in Atlanta, Georgia. “There’s no excuse for being unprepared for this aspect of the site visit, and I often remind residents that being uninformed could give the impression that they’re not highly interested in the opportunity, even when they are.”

The most efficient way to obtain a basic grounding on a practice, facility, or academic institution is to first review the organization’s website and ask the recruiter to provide background information. If candidates aren’t familiar with the geographic region or the health care environment within the area in question, they might find it helpful to look at both business and general-interest publications websites.

If possible, residents should reach out through professional channels to learn more about the organization or facility before the visit. This might entail asking training program faculty members if they have any contacts in the region, or tapping into the medical school or residency alumni networks to identify physicians who might have a helpful perspective.

The star candidates, Mr. Kram, a veteran recruiting professional, points out, “are those who show me and our [interviewing] physicians and administrators that they’ve done some checking — and that they’ve networked enough to know about the organization’s history, and its physicians or its research.” Knowing in advance, for example, that a health care system operates six hospitals and a large clinic network, or is well known for its cardiac care, will help the candidate steer the conversation toward how any of the attributes might affect the opportunity.

Ms. Hennessey observed that being prepared is also ultimately a matter of courtesy. Organizations have generally gone through considerable time and expense to prepare for a candidate’s visit and schedule meetings with very busy physicians and administrators. As such, showing up unprepared or acting as if the site visit is just a casual opportunity to meet and greet could offend the hosting institution. It also could waste the candidate’s time, if doing some homework might have ruled out a less-than-ideal opportunity.

“Young physicians should keep in mind that the number of site visits they can make is a finite number, and they should choose accordingly,” Mr. Kram said. He and other sources stressed that candidates should never accept the offer of a site visit if they’re not truly interested in exploring the opportunity.

Answer — and ask — the important questions

When candidates prepare for onsite interviews, they should first be ready to answer questions succinctly and professionally. At the same time, candidates should also be ready to ask questions of the physicians and administrators who participate in the interviews.

Of course, it’s not always possible to predict the questions that will be asked. However, physicians should have a ready, ideally rehearsed answer to two all-important ones they’re likely to hear: What do you think you would bring to our organization, and why are you interested in this opportunity?

The recruiters who contributed to this article reported nearly unanimously that most candidates can readily speak to how they’re qualified to succeed clinically in the position. That’s not necessarily the case when candidates are asked why they are interested in the position, recruiters said.

“Physicians should not answer the question by just saying ‘my family lives in New Jersey,’” Mr. Kram advised. “In my experience, the smart candidates really do their homework before they come for the site visit, and they come because they’re interested in our organization or their prospective colleagues,” Ms. Hennessey said.

It’s also advisable for the candidate to ask specific questions during onsite interviews and conversations. “I sometimes think there’s a misunderstanding
among residents about this,” said Ms. Peterson. Prospective colleagues and other interviewers are in fact expecting questions from candidates, and they might be disappointed if those questions aren’t posed, she said.

It is recommended, for example, that candidates ask specific questions about practice scope, procedure expectations, patient volumes and scheduling practices, operating room availability, organizational culture, and the organization’s position in the marketplace and plans for growth, to name a few important ones. “Asking questions demonstrates a level of engagement and interest on the candidate’s part. The key is to ask the questions respectfully,” Ms. Peterson said.

On a deeper level, physician candidates are also encouraged to ask strategic questions during the interviews. Candidates might ask about the organization’s perceived strengths and weaknesses, for example, with an eye to how their own qualifications might help the practice or facility address the latter. In this climate of consolidation in health care, it’s also appropriate to ask whether the organization is contemplating a purchase, merger, or affiliation — or the prospective addition or removal of a particular clinical service — that might affect the candidate’s own professional future.

Recruiters agree that candidates should reserve the formal interview forum primarily for addressing position-related questions, not to ask about things like recreational opportunities or schools. The community tour or conversations with real estate professionals is the appropriate time and place for those inquiries.

“If you’re not sure what to ask during the interview, go to your program faculty leaders and ask them what they might ask, if they were getting ready for that particular site visit,” said Ms. Peterson. “Their guidance can be very helpful.”

“Candidates who have done research on the compensation in their specialty and who are concerned about ensuring they receive a certain salary level actually should ask questions of the recruiter before they schedule the site visit,” Ms. Peterson said. “At the very least, it’s OK for candidates to ask whether the expected compensation range is competitive with the range in their specialty and in that region, before proceeding.”

Candidates who have a successful site visit and are very interested in the position should let their key interviewers know that right away, said Nahry Minars, president and chief executive officer of ProMedical Staffing, LLC, in Washington, D.C. “Candidates should always send a thank you to the prospective colleagues and the recruiter, ideally soon after they leave town and before they get back to their busy lives,” she said, adding that she advises sending that note within 48 hours, to all key individuals. “That thank-you note is the perfect vehicle for letting the people you met know that you’re very interested in the opportunity — and asking if they need anything else from you, so that your note requires a response. Waiting too long to let them know your interest can give the wrong impression.”

**Other site-visit do’s and don’ts: the short list**

Physicians who accept the offer of a site visit should plan ahead. To that end, the recruiters offered these additional tips:

- **Do request “downtime” — a few hours or an entire day, if needed — to check out the area alone.** Most organizations will arrange a community tour of some sort if the site visit will be more than a single day (some organizations, as a rule, use a two-visit model, and reserve that return visit for seeing the community). Physicians who really want some time alone or with a significant other to explore the community should ensure that’s set aside ahead of time.

- **Don’t forget that everyone you encounter onsite is important, and treat all with the same degree of respect.** A candidate’s inappropriate or discourteous behavior to anyone may raise questions about the candidate’s suitability for the position. Behaving inappropriately can “sink the opportunity quickly,” as one recruiter put it.

- **Do ask if a spouse or partner can accompany you.** Although most organizations are willing to accommodate a candidate’s significant other, it’s still a good idea to clear that person’s prospective presence (and be clear about any associated expenses) ahead of time with the recruiter.
Seeking Work-Life Balance in Physician Practice Opportunities

Whether you are a Gen-Xer about to leave training or already in practice and considering a change in venue, establish a realistic set of essential work-life priorities before you negotiate with employers. Become familiar with the fiscal outlook, reimbursement models, staffing patterns, caseload, and coverage requirements. Communicate with other physicians who have recently been hired and keep your requests in line with the real or perceived norm for salary, benefits, and defined work time. Once you’ve established yourself as an indispensable member of the medical staff, it will be easier to attain your ideal work-life balance.

—John A. Fromson, MD

Young physicians can — and increasingly do — ask for preferred schedules or other accommodations, but there’s a time and place and way to broach the subject.

By Bonnie Darves

It’s understandable that physicians coming out of training want to find a practice opportunity that not only suits their clinical interests and skill sets but also offers the potential for a reasonable balance between work requirements and their personal and family life. It’s also understandable that the practices, hospitals, and health systems seeking to hire new graduates are eying balance as well. Ideally, they want candidates who are highly skilled and committed to providing good care and willing to help the organization meet its operational and financial requirements.

The issue — or challenge, in many cases, today — for employers is finding a way to structure and offer practice positions that meet their own and candidates’ needs. And that’s no small feat, in an environment where, particularly in primary care, demand for physicians far exceeds supply.

The recruiters who frequently find themselves in the middle of this equation report that they sometimes see a bit of a disconnect between the kinds of lifestyle accommodations and concessions physicians want and what the employing entities can reasonably offer. “What candidates ask in terms of schedule preferences or work week [structure] depends largely on whether there’s a shortage in their specialty,” said Chris Kashnig, a lead physician recruiter for Dean Medical Group in Madison, Wisconsin, part of SSM Health. “What I am seeing is that young physicians, in pediatrics, for example, want ‘bounded’ work — a strictly outpatient practice with a defined schedule. The problem is there aren’t enough of those positions around.” In primary care, he added, his organization is experiencing an increasing amount of requests for part-time positions, particularly from women and candidates with young children.

Some candidates these days, particularly in primary care, have no qualms about asking for special accommodations across the board, recruiters report. Here’s an example: Residents in internal medicine or family medicine asking for a fairly substantial list of work-life balance accommodations — a four-day work week with flex time, loan repayment, a signing bonus, and relocation expense coverage. And on top of that, by the way, they would also like top-dollar compensation and no call duty.

What’s wrong with that picture? For one thing, it doesn’t imply — or leave — much room for give and take. Secondly, such an exhaustive set of requirements doesn’t take into account the fact that the newly graduating physician is just that: a medical professional new to her or his career and the real-world practice environment, who’ll require significant training and a substantial investment on the part of the hiring organization. Further, accommodating a wish list that’s out of sync with what the organization’s other physicians receive, expect, or experience might be politically untenable and is not particularly conducive to supporting collegiality.

“What candidates need to be reasonable with their expectations, and realize that they’re going to be part of a team — that they’ll have to make some concessions,” said Patrice Streicher, a professional development coach and director of Vista Staffing Solutions’ search division in Wisconsin. “Yes, we can get you a four-day work, but you should be prepared to give and take. It’s also important, I think, for candidates to separate their needs vs. wants, before they talk to recruiters.”

Understanding practices’ needs

Another area of potential disconnect between graduates and hiring organizations is a limited understanding, on physicians’ part, of the constant balancing act that practices face. They must staff to guarantee adequate care coverage for patients while ensuring that they don’t pay more than they can afford for physician services. All recruiters interviewed for this article said that most young physicians they encounter have little understanding of the operational realities of managing practices, and staffing...
hospitals and health systems. And residents likely aren’t aware of the market realities and legal issues organizations contend with when they recruit.

That’s understandable, perhaps, because most residents have not been exposed to such business concepts and have been focused on clinical skill-building. Nonetheless, this lack of awareness is a likely contributing factor to unreasonable expectations, some recruiters pointed out.

“Most young physicians don’t have a clue about how staffing a practice works, so they don’t have a sense of what they can reasonably ask for and what practices can actually do,” said Regina Levison, vice president of client development for Jordan Search Consultants. “We’re constantly educating clients about this.” Ms. Levison said that the tenor of opportunity advertisements that detail the upsides but not the job requirements, fueled by the residency rumor mill, exacerbate the expectation disconnect. “When candidates hear that a colleague got a part-time primary care position that pays $250,000 and requires no call, they think they can ask for that too,” she said, pointing out that such positions are rare and likely won’t be in desirable urban areas.

“It would be helpful to all of us—residents and recruiters—if residency directors were a bit more in touch with the market and could share that information with young physicians,” said Bruce Guyant, regional director of physician recruitment for LifePoint Health’s western region. “I think that medical leadership needs to understand better what goes on in smaller communities and rural areas, from the business and market standpoint, because that’s where the bulk of the jobs and patients are.” Mr. Guyant noted that many of the rural hospital positions he recruits for offer high compensation and financial incentives, but can’t be highly flexible in the schedule arena.

The ‘Gen-X’ factor

It’s hard to pinpoint what is driving what appears to be a palpable shift in young physicians’ expectations, but it’s likely multiple factors. On the positive side, medical residents, like their fellow “Generation X” age peers in other fields, surveys show, appear more aware generally of the importance of avoiding job burnout and jeopardizing their feelings about their work. This particular generation, recruiters and residency directors report, places a commensurately higher value than their older counterparts on having a “quantifiable” work life and reserving defined time for non-work pursuits.

“The duty-hour restrictions [imposed in 2003] probably contributed to this shift,” said Gopal Yadavalli, MD, director of the internal medicine residency program at Boston University. “Before, there was this expectation that you ‘stay until the work is done,’ but people graduating over the last decade have been in a different environment with the 80-hour work weeks and 16-hour shifts. This mindset influences the trainees, and perhaps colors their expectations too.” Anecdotally, Dr. Yadavalli notes, he isn’t hearing reports from recent graduates about mismatched workload expectations once the physicians get into practice. Those he has heard from, most of whom are in academic positions, “seem quite happy with their schedules,” he said, even if some struggle to obtain protected time for non-clinical activities.

The case might be different for internal medicine graduates going into community practice settings, Dr. Yadavalli acknowledged, noting that graduates who choose hospitalist positions appear less satisfied with their schedules and associated demands than those in academic practice.

One upside of the new generation’s quest for balance in their work and personal lives — young physicians want to be more available to spouses and children than perhaps their own parents were, and keep a routine workout schedule — might contribute to untenable expectations, observed Craig Fowler, immediate past president of the National Association of Physician Recruiters. “To their credit, this group of young physicians want to be all things to all people. They want to be high-performing clinicians but also show up at their child’s soccer games, and be around most nights for dinner,” said Mr. Fowler, senior vice president for the recruiting firm Pinnacle Health Group in Atlanta. “That’s commendable, but it might not be ideal for the community or organization the physician wants to join.”

Several recruiters reported that residents in the specialties generally don’t request, or expect, as much in the way of work-life balance accommodations as those in primary care. This might be attributable to the culture in their residencies regarding work expectations, some recruiters ventured, or because they’ve had more exposure to practice-life realities because of the additional time they spend in training. And in specialties where supply does not outstrip demand, savvy residents might be less inclined to ask for concessions, some sources said.

“We see this more in primary care — physicians starting the conversation with questions about call and the work schedule, and the amount of compensation — than among specialists. The primary care physicians know
that because of the market, they can be very choosy,” said Kathryn Zimmerman, MBA, director of physician network development with Adventist HealthCare in the Maryland region near Washington, DC. “At the same time, I see a lot of passion in these young PCPs and a commitment to good clinical care and outcomes. Still, it is a bit of a cutoff when people lead with special considerations.”

The picture appears to be somewhat different in certain small specialties, where clinical practice and setting specifics might take higher priority than life-style considerations for job-seeking physicians. In child psychiatry, for example, even though the shortage is perennial, physicians might hold out for a type of practice structure, observed Eugene Beresin, MD, a professor of psychiatry at Harvard Medical School and senior medical educator in child and adolescent psychiatry. “Our trainees are seeking positions that enable them to achieve what they went into this field for — to help children and families, and to be able to do some psychotherapy. They’re not wooed by positions that offer no call or high compensation,” Dr. Beresin said. “At the same time, they’re extremely aware of and concerned about the challenges they’ll face in balancing their professional and personal lives.”

What the ads don’t say
The shortages in primary care and some specialties, often underscored by the barrage of communication residents receive about practice opportunities and the tenor of associated advertisements, might be skewing physicians’ expectations about how flexible positions (and employers) might be. Several other sources mentioned the “sky’s-the-limit” advertisements that are becoming commonplace in primary care and the specialties.

“For locations that are challenging to recruit to, we see advertisements that offer not only large sign-on bonuses and inflated starting salaries but also numerous life-style perks,” said Katie Cole, head of Harlequin Recruiting in Denver, which specializes in the neurosciences. “Candidates coming out of training are bombarded by these offers and think that they’re able to hold out for every item on their wish list. But that’s not the case when the opportunities are in high-demand, desirable areas.”

How and when to ask
While most physicians are gracious in making their requests, even if their “wish list” is a tad extensive, some are too aggressive and demanding, some recruiters maintain. Recruiters, and likely employers too, take issue with candidates who lead with the money card — asking for compensation above the median — but don’t appear willing to perhaps work extra hours in exchange or let go of other work-life balance requests such as preferred work-week or call schedules.

A more appropriate approach to requesting work-life balance accommodations, Ms. Levison advises, is for candidates to first state what they bring to the table and in skills and qualifications, before divulging the wish list. Then, she added, physicians should be prepared to offer something to counter their request. “If a candidate doesn’t want to work five days because she wants the fifth day for family, but is willing to work three or four long days, that will get the attention of groups that want to staff longer on weeknights or flex their staffing,” she said.

What doesn’t work, all recruiters interviewed agreed, is when candidates propose a lopsided arrangement with no give and take, from the start. Even worse, perhaps, is a candidate who goes through several conversations and a site interview before dropping a laundry list of work-life balance requirements on the table when an offer is imminent. In any conversation with a recruiter or prospective employer, physicians should be gracious, first and foremost, and should err on the side of appearing flexible, not rigid. “It’s best to leave your demanding attitude at home,” Ms. Levison said. (See “Do’s and don’ts” at the end of the article.)

“When I recruit for internal medicine and family practice positions, many candidates today tell me exactly what they want in terms of work-life balance,” said Mr. Kashnig. “So sometimes I have to counter by letting them know what we can accommodate and what we can’t — and that we’ll adapt within reason.” For example, Dean Medical Group has structured its primary care practices to allow for part-time practice (a minimum of three-quarters time) and job sharing, where feasible. However, all physicians must work some evening or Saturday hours, and take very limited call.

What the medical group won’t accommodate, Mr. Kashnig points out, are patently unreasonable requests — such as four-day work weeks, with Friday off, and no evenings or call. “Most physicians are civil, but we do occasionally run into graduates who want more [compensation] than we can
pay or aren't willing to work with our schedules. And if their expectations are unreasonable, we tell them," he said, adding that a demanding attitude in a new graduate is a definite "red flag."

**Work-life balance requests: Do’s and don’ts**

Most medical practices and health care organizations will try to grant highly qualified physician candidates’ requests for part-time schedules or other accommodations, within reason and to the extent feasible, provided the physician is willing to give something in return and the request doesn’t conflict with established culture.

In these discussions, as in anything that involves potentially complex or sensitive negotiation, there’s an etiquette of sorts. Recruiters who shared their perspectives for this article offered additional guidance for candidates on how to navigate these discussions.

**Share your strengths before asking for accommodations.** "What recruiters want to hear, before making concessions, is that you’re highly qualified and committed to your specialty but also willing to put down roots, grow the practice, and cultivate patient loyalty," said Ms. Zimmerman.

**Articulate what’s important.** Decide what’s most important — is it a three-day work week or very limited night call because of family considerations? — and lead with that, Mr. Guyant advises. "Many candidates, when I ask what’s most important or less important besides compensation, and why, can’t always tell me."

**Broach the big-picture or “must-have” needs early, before interviews start.** Timing is important, Ms. Streicher reminds candidates, to avoid wasting anyone’s time. "It’s best to be open, early on, particularly if you want a part-time schedule, so that the recruiter can make a good match. And do ask questions about the job’s fixed requirements, before you talk to any one in leadership," she said.

**Be prepared to pare your wish list — and keep it short.** “You won’t get 100 percent of what you want in schedule or life-style accommodations, so don’t shoot for the moon. And do rate and rank your priorities, ideally before you start exploring opportunities,” Mr. Fowler advises.

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**Initial Treatment of Hypertension**

Sandra J. Taler, M.D.

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

The article ends with the author’s clinical recommendations.

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A 56-year-old woman presents for elevated blood pressure, which was noted at a job-site screening. She has gained 20 lb (9.1 kg) during the past 5 years and takes naproxen sodium at a dose of 220 mg daily for joint pain. She has never smoked, and she consumes one or two alcoholic drinks daily. Both of her parents received a diagnosis of hypertension in their 50s. On examination, the blood pressure is 162/94 mm Hg in both arms while the patient is seated and 150/96 mm Hg while the patient is standing. The body-mass index (the weight in kilograms divided by the square of the height in meters) is 29. Her examination is notable only for abdominal obesity without bruises or masses. The serum level of sodium is 138 mmol per liter, potassium 3.8 mmol per liter, calcium 9.4 mg per deciliter (2.35 mmol per liter), fasting glucose 105 mg per deciliter (5.8 mmol per liter), and creatinine 0.8 mg per deciliter (71 μmol per liter). Urinalysis is negative. How would you further evaluate and treat this patient?

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**Hypertension, the elevation of systolic blood pressure, diastolic blood pressure, or both above normal levels, is common in developed and developing countries and increases in prevalence with age.** The threshold blood pressure for the diagnosis has declined over time on the basis of trials showing benefits of treatment to incrementally lower blood-pressure targets in reducing mortality and cardiovascular-event rates.1 Although in recent years hypertension has been defined as a blood pressure of 140/90 mm Hg or more, the 2017 American College of Cardiology–American Heart Association (ACC–AHA) Hypertension Guideline adopted a lower threshold, in which hypertension is defined as a systolic blood pressure of 130 mm Hg or more or a diastolic blood pressure of 80 mm Hg or more (Table 1).1 Among adults in the United States, the overall preva-

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**THE CLINICAL PROBLEM**

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Clinical Practice

**Initial Treatment of Hypertension**

- The 2017 ACC–AHA Hypertension Guideline redefines hypertension as a systolic blood pressure of 130 mm Hg or more or a diastolic blood pressure of 80 mm Hg or more and lowers the blood-pressure target to less than 130/80 mm Hg.

- This blood-pressure target is supported by the SPRINT trial, which showed lower hypertension-associated morbidity and all-cause mortality with a systolic blood-pressure target of less than 120 mm Hg than with a target of less than 140 mm Hg; electrolyte abnormalities, syncope, and acute kidney injury were more common in the lower-target group.

- The initial assessment should consider coexisting conditions, including cardiovascular disease, diabetes mellitus, chronic kidney disease, and elevated risk of cardiovascular disease, in determining when to start blood-pressure–lowering medication.

- Recommended lifestyle modifications include restriction of dietary sodium intake, weight loss if the patient is overweight, exercise, moderation of alcohol intake, and increased consumption of potassium-rich foods.

- The initial antihypertensive agent should generally be selected from one of four drug classes shown to reduce cardiovascular events: ACE inhibitors, angiotensin-receptor blockers, calcium-channel blockers, and thiazide-type diuretics.

- Repeat visits are required to ensure ongoing hypertension control.

**Signs and Symptoms**

- The diagnosis of hypertension is based on the average of two or more readings taken on two or more occasions.

- Measurements should be made with the use of a standardized measurement technique and validated equipment, including a cuff of correct size. Measurements should be made with the back supported, legs uncrossed, feet on the floor, and the measurement arm supported on a table at heart level after the patient has sat quietly for 5 minutes. Current methods rely on aneroid sphygmomanometers or oscillometric devices in which blood pressure is calculated from maximal oscillations of the blood-vessel wall during cuff deflation (defined as mean arterial pressure), with systolic and diastolic pressures calculated with the use of proprietary algorithms. Automated devices that take two to six serial measurements and determine the mean are increasingly used in outpatient clinics, and the readings correlate closely with those of ambulatory blood-pressure monitoring while the patient is awake. These devices allow an attendant to place the cuff and leave the room, minimizing the “white coat” effect (i.e., blood pressure elevated in the office but normal outside).

**Masked Hypertension**

- Masked hypertension should be considered when office blood pressures are controlled but the patient has elevated home measurements or a greater severity of hypertension-associated target-organ damage than expected. Ambulatory blood-pressure monitoring is useful in assessing these possibilities; if such monitoring is unavailable or for measurements obtained over several days, home blood-pressure monitoring is an alternative.

- One of the diagnoses is confirmed, a careful history taking should assess coexisting conditions and contributing factors, including lifestyle practices, other cardiovascular risk factors that are associated with hypertension, and features to suggest a secondary cause of hypertension. A gradual rise in blood pressure that is associated with weight gain, in combination with a positive family history, supports primary hypertension, whereas severe or resistant hypertension, accelerated target-organ damage, or other symptoms or signs suggest a secondary cause that merits further testing and referral (Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org). The physical examination should include cardiac and vascular evaluation and assessment of target-organ damage (Fig. 1). A thigh blood-pressure measurement is recommended for adults younger than 30 years of age to exclude aortic coarctation, and blood-pressure measurement while the patient is standing is recommended for older adults to assess orthostatic blood-pressure changes. Initial laboratory testing should assess for coexisting conditions that may affect the patient’s response to medication and assess for target-organ damage. Such testing includes assessment

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**Table 1. Classification of Blood Pressure in Adults.**

<table>
<thead>
<tr>
<th>Blood-Pressure Category</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Normal</td>
<td>Systolic pressure of &lt;120 mm Hg and diastolic pressure of &lt;80 mm Hg</td>
</tr>
<tr>
<td>Elevated</td>
<td>Systolic pressure of 120–129 mm Hg and diastolic pressure of &lt;80 mm Hg</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Systolic pressure of 130–139 mm Hg or diastolic pressure of 80–89 mm Hg</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Stage 2</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Systolic pressure of ≥140 mm Hg or diastolic pressure of ≥90 mm Hg</td>
</tr>
</tbody>
</table>

**STRENGTHS AND EVIDENCE**

**Evaluation**

The first step is to confirm the diagnosis of hypertension. Guidelines recommend at least two blood-pressure measurements on at least two occasions with the use of a standardized measurement technique and validated equipment, including a cuff of correct size. Measurements should be made with the back supported, legs uncrossed, feet on the floor, and the measurement arm supported on a table at heart level after the patient has sat quietly for 5 minutes. Current methods rely on aneroid sphygmomanometers or oscillometric devices in which blood pressure is calculated from maximal oscillations of the blood-vessel wall during cuff deflation (defined as mean arterial pressure), with systolic and diastolic pressures calculated with the use of proprietary algorithms. Automated devices that take two to six serial measurements and determine the mean are increasingly used in outpatient clinics, and the readings correlate closely with those of ambulatory blood-pressure monitoring while the patient is awake. These devices allow an attendant to place the cuff and leave the room, minimizing the “white coat” effect (i.e., blood pressure elevated in the office but normal outside).

**Masked Hypertension**

Masked hypertension should be considered when office blood pressures are controlled but the patient has elevated home measurements or a greater severity of hypertension-associated target-organ damage than expected. Ambulatory blood-pressure monitoring is useful in assessing these possibilities; if such monitoring is unavailable or for measurements obtained over several days, home blood-pressure monitoring is an alternative.

One of the diagnoses is confirmed, a careful history taking should assess coexisting conditions and contributing factors, including lifestyle practices, other cardiovascular risk factors that are associated with hypertension, and features to suggest a secondary cause of hypertension. A gradual rise in blood pressure that is associated with weight gain, in combination with a positive family history, supports primary hypertension, whereas severe or resistant hypertension, accelerated target-organ damage, or other symptoms or signs suggest a secondary cause that merits further testing and referral (Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org). The physical examination should include cardiac and vascular evaluation and assessment of target-organ damage (Fig. 1). A thigh blood-pressure measurement is recommended for adults younger than 30 years of age to exclude aortic coarctation, and blood-pressure measurement while the patient is standing is recommended for older adults to assess orthostatic blood-pressure changes. Initial laboratory testing should assess for coexisting conditions that may affect the patient’s response to medication and assess for target-organ damage. Such testing includes assessment

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**Figure 1. Pathophysiology of Hypertension.**

GFR denotes glomerular filtration rate, and NSAIDs nonsteroidal antiinflammatory drugs.
of serum levels of sodium, potassium, calcium, uric acid, creatinine (with estimated glomerular filtration rate), hemoglobin, and thyrotropin; a lipid profile; urinalysis; and electrocardiography. Patients with diabetes mellitus, chronic kidney disease, or chronic kidney disease. For patients with stage 1 hypertension and without these conditions, the 2017 ACC–AHA guideline recommends calculation of the estimated 10-year risk of cardiovascular disease (http://tools.acc.org/ASCVD-RiskEstimator). If this risk is less than 10%, it is reasonable to implement lifestyle modifications alone for a period of 3 to 6 months. For those with stage 2 hypertension or with preexisting cardiovascular disease, diabetes mellitus, chronic kidney disease, or a 10-year risk of cardiovascular disease of 10% or higher; or both; lifestyle modifications alone are recommend ed. For all patients with hypertension, a blood-pressure target of less than 130/80 mm Hg is advised.

Lifestyle Changes

Recommended strategies include restriction of dietary sodium intake below 1500 mg per day,15,16 weight loss (if overweight or obese),17 aerobic or resistance exercise for 90 to 150 minutes per week,15,16 moderation of alcohol intake (2 drinks daily for men and 1 drink for women),17,18 and increased intake of potassium-rich foods.19 Each of these strategies is likely to produce, whole grains, and low-fat dairy products and which limits sodium intake, was associated with a reduction of 11.4/5.5 mm Hg in blood pressure, as compared with a control diet.20 Patients should be encouraged to minimize the use of NSAIDs, decongestants, and amphetamines (as used for attention deficit–hyperactivity disorder). Other behaviors that are associated with cardiovascular risk, including tobacco use and a sedentary lifestyle, should also be addressed.

Evidence Supporting Pharmacologic Therapy

Multiple clinical trials — including (but not limited to) the Veterans Administration Cooperative Study21–23 (focusing on diastolic hypertension), the Systolic Hypertension in the Elderly Program (SHEP) trial,24 and the Systolic Hypertension in Europe trial25 — have shown that blood pressure can be effectively reduced by medications and that doing so may benefit in a reduced incidence of target organ events.

Other trials have compared first-line therapies with the use of different drug classes.20–27 The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) randomly assigned more than 40,000 patients at high cardiovascular risk to initial therapy with chlorthalidone, amiodipine, lisinopril, or doxazosin and allowed additional medications to achieve a blood pressure of less than 140/90 mm Hg.27 The doxazosin group was stopped early owing to a higher incidence of heart failure. Chlorthalidone and amiodipine were effective in reducing pressure levels than the other agents, fewer heart- failure events than amiodipine, and fewer combined cardiovascular events, strokes, and heart-failure events than lisinopril.

More recently, the Systolic Blood Pressure Intervention Trial (SPRINT) randomly assigned 9361 persons with a systolic blood pressure of 130 to 180 mm Hg and normal or low normal left ventricular ejection fraction to a systolic blood-pressure target of either less than 120 mm Hg or less than 140 mm Hg.29 The trial was stopped early after 3.3 years for demonstration of greater benefit of the lower pressure target with respect to the primary composite outcome (myocardial infarction, other acute coronary syndromes, stroke, heart failure, or death from cardiovascular causes) (hazard ratio, 0.75; 95% confidence interval [CI], 0.64 to 0.89) and all-cause mortality (hazard ratio, 0.73; CI, 0.60 to 0.90). Patients in the intensive-treatment group required an average of one additional medication (2.8 drugs, as compared with 1.8 for standard treatment).

The Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial, with a trial design nearly identical to that of SPRINT but involving 4733 participants with type 2 diabetes, showed no significant benefit for the lower blood-pressure target with respect to the primary outcome, although there was a significant difference in the incidence of stroke that favored the lower target.24 A possible contributor to the negative results of the ACCORD trial was the power of the trial, with fewer events than predicted in the group with a higher blood-pressure target.

Drug Selection

The initial agent can be selected from one of four drug classes: angiotensin-converting enzyme (ACE) inhibitors, angiotensin-receptor blockers (ARBs), calcium-channel blockers, and thiazide-type diuretics; each class has been shown to reduce cardiovascular events (Table 2).28 The patient’s lifestyle, coexisting conditions, and clinical characteristics should be considered in selecting an agent. For example, patients with a high salt intake (e.g., eating primarily processed foods) may have a greater blood-pressure reduction with diuretic therapy, whereas those restricting salt intake may have a greater response to blockade of the renin–angiotensin system. This approach has in some cases been successful in lowering the patient’s age and race as predictors of blood-pressure response29 and by others to use renin profiling for drug selection,30 although data are not conclusive.

Caution is advised with thiazide use in patients 65 years of age or older, particularly in women31 and in patients of either sex who have hypokalemia, the elderly, or those with renal dysfunction.32,33 Some providers have used for add-on therapy if blood pressure remains uncontrolled. (Table S2 in the Supplementary Appendix). For example, sustained-release beta-blockers are indicated in patients with congestive heart failure, after myocardial infarction, for arrhythmias, and for migraine prophylaxis and will also treat the patient’s hypertension. An ACE inhibitor or ARB should be prescribed for most patients with chronic kidney disease with albuminuria, with referral to a nephrologist for advanced chronic kidney disease (stage 3b or higher).

If the first agent that is selected has unacceptable side effects, it should be discontinued (if lower-based therapy) and a second agent should be started. If the selected agent has an acceptable side-effect profile but is not effective, the dose may be increased or a second agent with a different mechanism of action can be added. In a recent meta-analysis, dual therapy involving at least one agent at a low dose had similar efficacy to that of higher-dose monotherapy.34 If combination therapy is used for add-on therapy if blood pressure remains uncontrolled. (Table S2 in the Supplementary Appendix). For example, sustained-release beta-blockers are indicated in patients with congestive heart failure, after myocardial infarction, for arrhythmias, and for migraine prophylaxis and will also treat the patient’s hypertension. An ACE inhibitor or ARB should be prescribed for most patients with chronic kidney disease with albuminuria, with referral to a nephrologist for advanced chronic kidney disease (stage 3b or higher).
adherence rates decline as the number of medications and overall pill burden rises: 79% for one daily dose, 69% for two doses, 65% for three doses, and 52% for four doses. Nonpharmacologic therapy requires a strong ongoing commitment to be effective. Ultimately, the best strategies combine lifestyle efforts with medical therapies to achieve greater effect with the use of fewer medications and lower doses. Dose adjustment is recommended until blood-pressure goals are achieved, with interval laboratory testing to monitor for electrolyte disturbances or decline in renal function. Home blood-pressure measurements should be encouraged, although data are lacking to show that they improve blood-pressure control. Home monitors should be checked annually for accuracy, and the technique for their use should be reviewed regularly. Inclusion of a nurse or pharmacist in the care team may facilitate more timely addition of new agents or adjustment of the dose when indicated.

**AREAS OF UNCERTAINTY**

There is continued debate regarding preferred blood-pressure targets and the benefits and risks of lower targets. In SPRINT, it was necessary to treat 61 patients to prevent one additional cardiovascular event and to treat 90 patients to prevent one additional death over a period of 3.26 years. Such estimates will vary with the absolute individual level of cardiovascular risk. Attendant costs of tight blood-pressure control warrant consideration, including higher rates of serious adverse events (hypotension, electrolyte abnormalities, syncope, and acute kidney injury) with intensive treatment than with standard treatment in SPRINT and additional pill burden. There is particular concern about harms of tight control in elderly persons, although a SPRINT substudy involving patients 75 years of age or older showed significant benefit with the systolic blood-pressure target of less than 120 mm Hg, with absolute rates of and relative risks of hypotension, syncope, and electrolyte abnormalities that were similar to those in the overall SPRINT population; this substudy extended the benefits seen in an earlier trial involving elderly persons with a systolic blood-pressure target of less than 150 mm Hg. Failure to measure blood pressure correctly may produce higher office readings and limit achievement of blood-pressure targets. In addition, evidence is lacking to show that tight control prevents the progression of chronic kidney disease. Studies of blockers of the renin–angiotensin system have shown slowing of diabetic nephropathy, but not slowed the progression of chronic kidney disease in patients without albuminuria, a finding that suggests the need for new approaches for this patient population.

**GUIDELINES**

In 2013, the National Heart, Lung, and Blood Institute transferred the development of hypertension guidelines to the ACC and the AHA. The 2017 ACC–AHA guideline replaces the 2014 guideline of the Eighth Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, which was completed before the publication of SPRINT. (Blood-pressure targets of these and other guidelines are summarized in Table S3 in the Supplement.) Recommendations in the present article are generally concordant with the 2017 ACC–AHA guideline.

**CONCLUSIONS AND RECOMMENDATIONS**

The patient in the vignette probably has primary hypertension, with a positive family history and contributing lifestyle factors, including weight gain and NSAID use. Her alcohol intake, at more than one drink per day, may be a contributor. I would initiate single-agent therapy for her stage 2 hypertension and encourage lifestyle changes, including sodium restriction, weight reduction, and discontinuation of contributing medications; attention to the lipid profile and glucose level is also warranted. A thiazide-type diuretic or ACE inhibitor is a reasonable first agent to prescribe, with follow-up blood-pressure and electrolyte measurements in 3 to 4 weeks. Dose increases and additional medications may be needed. I would recommend regular visits during dose adjustment, combined with home blood-pressure measure-
ments; lifestyle factors and medication adherence should be assessed at each visit. Once her blood pressure is at goal (<130/80 mm Hg), I would recommend follow-up at 6-month intervals.

References


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Who can guide me through the process?
Who provides the best support?
The Department of Medicine at the University of Mississippi Medical Center (GMMC) is seeking an experienced board certified gastroenterologist at associate professor or full professor level to lead the Division of Digestive Diseases. As part of our strategic growth, we are also hiring additional gastroenterologists, including for the areas of hepatology and endoscopy. For Director, the department is searching for an individual who is energetic and collegial with an established record of leadership and scholarship, and vision for strategic expansion of an academic division across the spectrum of tertiary care, education of trainees at all levels, and development of a robust research program.

Located in Jackson, MS, GMMC is the state’s only academic health science center with the mission to improve the lives of Mississippians by educating tomorrow’s healthcare professionals, by conducting health sciences research, and by providing cutting edge patient care. A major goal of the Medical Center is the elimination of differences in health status of Mississippians based on race, geography, income, or social status.

Considerable opportunities exist for the right candidate to develop an internationally reputable division. Opportunities also exist for providing a full spectrum of gastroenterology services including inpatient and outpatient consultative services, liver transplants, and interventional procedures in a free-standing endoscopy suite. The UMMC physiology department, ranked in the top 10 in the United States for NIH funding, has extensive basic and translational research opportunities. UMMC is the home of two NIH cohort studies that provide opportunities for epidemiologic, including genetics, and translational research. The new clinical trials center will provide facilities for Phase I to IV studies. The Center for Telehealth extensively links rural communities in Mississippi, providing novel opportunities for clinical care and implementation science research. The UMMC Patient Experience Data Warehouse has data on over 650,000 patients and 19 million encounters including hospitalizations, clinic visits, medications, and laboratory data that are available for outcomes research, big data analysis, or preliminary/feasibility data for other projects. Many other opportunities also exist.

Resources include competitive compensation and benefits, generous start-up package, ability to hire more faculty, strong support staff, and excellent career growth opportunities.

Interested candidates may send CV and cover letter to:
Javed Butler, MD
MPP MBA
University of Mississippi Medical Center
Department of Medicine
2500 N. State Street
Jackson, MS 39216

Telephone: #601-984-5600, Fax: #601-984-5608

jbutler4@umc.edu

GMMC is an Equal Opportunity/Affirmative Action Employer and does not discriminate on the basis of race, sex, religion, color, national origin, age, ethnic origin, disabilities, either military or non-military related, veteran status, or political affiliation. Applications and/or content may be referred to the Director of Equal Employment Office, 2500 North State Street, Jackson, MS 39216-4505.

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Cassandra Dombrowski
Physician Recruitment
Phone: 508-862-7882
Email: cdombrowski@capcodhealth.org

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We're expanding in Northern Colorado locations to enhance our ability to deliver our nonprofit mission of making healthcare easier so that life can be better.

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For more information on Primary Care opportunities please contact: Liz Mahan, Physician Recruitment Specialist Berkshire Health Systems (413) 395-7866 Mdrecruitment@bhs1.org www.berkshirehealthsystems.org

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**Memorial Sloan Kettering Cancer Center**

**Associate Professor or Professor Level Faculty Position – Lymphoma Service**

Memorial Sloan Kettering Cancer Center (MSK) is one of the world’s premier cancer centers, committed to exceptional 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 Lymphoma Service in the Division of Hematologic Oncology, Department of Medicine, is seeking a full-time Associate Professor or Professor Level faculty member who specializes in the treatment of lymphomas. The successful candidate will participate in a large and growing clinical and translational research program, which is supported by an NCI-SPORE grant and an LLS-SCOR grant. Ideally, the candidate should possess expertise and/or interest in the area of ctDNA, biomarker-based trials, and immunotherapy, including CAR T cells.

- Experience in the care of patients diagnosed with lymphoma
- Completed a fellowship and be either board-eligible or board-certified in Medical Oncology
- Requirements for licensure in New York State
- Track record of peer-reviewed publications in hematologic malignancies
- Interest in teaching medical students, house staff, and medical-hematology/oncology fellows

Please send CV, bibliography, brief statement of interests, and names of 3 references via email to:

Anas Younes, MD, Chief Attending, Lymphoma Service, 1275 York Avenue, New York, NY 10065
Email: younesa@mskcc.org
CC: Tangee McBride: McBrideT2@mskcc.org

**Banner Health**

- Hard work is rewarded generously
- Supportive Administration team
- True work-life balance
- Light call schedule
- Flexible schedule, 4-day work week

**Berkshire Health Systems**

- Paid CME plus allowance
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- Relocation assistance
- Generous salary plus incentives

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Anas Younes, MD, Chief Attending, Lymphoma Service, 1275 York Avenue, New York, NY 10065
Email: younesa@mskcc.org
CC: Tangee McBride: McBrideT2@mskcc.org

**Banner Health**

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- Supportive Administration team
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- Light call schedule
- Flexible schedule, 4-day work week

**Berkshire Health Systems**

- Paid CME plus allowance
- Paid malpractice
- 401k retirement plan with 4% match after one year of service
- Relocation assistance
- Generous salary plus incentives
THE PATIENT HAS BEEN, AND ALWAYS WILL BE, OUR PRIORITY.

One thing sets North Shore Physicians Group, near Boston, MA, apart—our singular focus on the patient. From the beginning, our practice was founded on the principle of physicians, administrators and the community working together to provide better health care. Today, that focus continues to drive us to be innovators, collaborators and trusted care providers.

While practicing at North Shore Physicians Group you’ll enjoy:
- a collaborative team-based care environment
- reasonable, telephone-based call coverage
- opportunities to teach residents and/or grow into leadership roles
- leadership that values your input and understands the importance of work-life balance
- living in a community that features excellent educational opportunities, cultural experiences and an overall outstanding quality of life.
- working in a practice that has received Level 3 NCQA Patient-Centered Medical Home status

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Florida International University seeks an energetic, visionary, and collaborative leader with a commitment to innovation, scholarly and research excellence, diversity, and community to serve as Dean of the Herbert Wertheim College of Medicine (HWCOM) and Senior Vice President for Health Affairs. FIU is a vibrant comprehensive university offering 180 bachelor’s, master’s and doctoral programs in 12 colleges and schools. FIU is Carnegie-designated as both a research university (R1) and a community engagement university. Located in the heart of the multicultural South Florida urban region, FIU’s multiple campuses serve over 54,000 students, placing FIU among the ten largest universities in the U.S. FIU is also one of the top 100 research institutions in the nation. Annual research expenditure engagement have made FIU the go-to solutions center for local to global issues alike. FIU leads the nation in awarding undergraduate and graduate degrees, including in the STEM fields, to minority students. FIU’s students reflect Miami’s diverse population, earning FIU the designation of Hispanic-Serving Institution.

Since its authorization by Florida statute in 2006, HWCOM has grown to an enrollment of 480 students and graduated five classes of students. The only public college of medicine socially accountable, community-based medicine, HWCOMembraces physicians, scientists, and health professionals who are uniquely qualified to transform the health of patients and communities. HWCOM has the mission of its inclusive, central-nation curriculum, and Harvey productively with one another to meet the diverse needs of society, from the United States Medical Licensing (USMLE) Step testing and Step 2 Clinical Knowledge Examinations, and in the National Resident Matching Program, in which they match into residency programs in all specialties at prestigious institutions throughout the U.S. Fully accredited by the Liaison Committee on Medical Education (LCME), HWCOM has been recognized by the Association for Medical Education in Europe (AMEE) for its focus on social accountability and the social determinants of health. HWCOM’s mission is to be a national leader in transforming the health of communities through the purposeful integration of education, research, and clinical care. HWCOM’s operations are driven by the values of scholarship, innovation, inclusion, integrity, and service. One of the most diverse medical schools in the county, HWCOM ranks in the percentage of Hispanic graduates.

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- Neurology
- Neurosurgery
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- **Emergency Medicine**
- **Family Medicine**
- **Internal Medicine/Pediatrics**

If you would like more information please contact:

Diane Forte
dforte@emersonhospital.org
phone: 978-287-9002
fax: 978-287-3600

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**Location, Location, Location**

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Emerson Hospital Opportunities

Located in Concord, Massachusetts Emerson is a 179-bed community hospital with satellite facilities in Westford, Croton 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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- **Family Medicine**
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dforte@emersonhospital.org
phone: 978-287-9002
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