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Physician Employment Benefits See Some Shifts

In some areas, benefits are becoming richer; in others, they're stagnating or declining

By Bonnie Darves

Many young physicians who are evaluating compensation packages — or if they're fortunate, comparing two attractive offers — focus primarily on the cash salary component and how competitive that number is. That's an important consideration, of course, but looking at salary outside the context of the entire compensation package is short-sighted. Benefits, those humdrum components of the picture, are much more important from a financial perspective than some physicians might realize, experts say, in both the short term and the long term.

“To compare two compensation packages, you have to really look at the details of the benefits and the monetary value of the benefits,” said Mary Heymans, managing director and senior advisor for physician services at Integrated Healthcare Strategies in Minneapolis, which advises health care organizations and physician groups on physician compensation plans. “One plan might have a cash component that's $10,000 higher, but if the other plan has much richer benefits, the physician might lose as much as $35,000 by taking the higher-salary position.”

As example of the potential difference, Ms. Heymans notes, is in employers' 401(k) retirement plan offerings. If one organization offers a 5% employer-paid match for plan contributions and the other has no matching provision, the difference over even a 10-year period could be substantial. Likewise, if one organization picks up the tab for 90% of health care premiums and covers dependents, and another organization pays only 80% and requires a higher cost-sharing expense for family members’ coverage, the difference might significantly affect the physician's annual finances.

Full employer-paid health insurance coverage, as in 100% of premiums and no cost-sharing, is pretty much gone, as is the case in most industry sectors today because of the rising expense. The data from SullivanCotter & Associates, a national health care workforce consulting firm, illustrates the new reality. The firm’s 2018 compensation survey found that typical health coverage cost sharing is now an 80%/20% employer/employee split, and a 70/30 split for dependent coverage.

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“From a design perspective, physicians are usually eligible for the same basic health coverage, dental coverage, and qualified retirement plans as other employees,” said Mark Rumans, MD, chief medical officer and a managing principal at SullivanCotter. “Most organizations offer several different coverage options, from a PPO to an HMO or a high-deductible plan.”

On a countering note, health care employers are increasingly incorporating wellness programs that might qualify the physician — or any employee — for a discount on premiums. “Approximately 80% of physician employers offer wellness programs now,” Ms. Heymans said, “and 75% of those will reduce your premium if you participate in the program.”

Benefits’ dollar value rising

The thing to keep in mind is that the value of employer-paid benefits is a big-ticket item that easily tops $30,000 annually and might even be double that amount. Benefits’ value is likely to be the equivalent of between 10% and 20% of total cash compensation, depending on the physician specialty. Data from the American Medical Group Association’s 2018 Medical Group Compensation and Productivity Survey found that employer-sponsored benefits’ value commonly ranges from 12% to 18% of cash compensation.

“Specialties with higher cash compensation usually have a lower benefits expense as a percentage of compensation,” said Wayne Hartley, MHA, chief operating Officer of AMGA Consulting. That means that the percentage is less meaningful across specialties than within them, because benefits will account for a higher percentage of a pediatrician’s salary than a neurosurgeon’s.

Ms. Heymans cites, as an example, a typical primary care physician compensation range. Her company’s 2017 Integrated Healthcare Strategies/Arthur J. Gallagher & Co. National Physician Survey Report found that median benefit expenditures for a physician earning $250,000 is 18.92%, which equates to $47,300. “This is the amount the employer pays on the physician’s behalf,” she said. For comparison purposes, the benefits component typically includes medical, dental, and vision coverage, life insurance, short-term and long-term disability coverage, a retirement plan, and payroll taxes including Social Security and Medicare.

Jennifer Moody, an associate principal with the ECG Management Consultants in Dallas, reports that her firm has seen a continuing increase in the dollar value of physician benefits packages in recent years. The average in 2015, per ECG research, was $47,780; last year, it was $50,626. “We’re seeing a lot of benefits going from ‘nice to have’ to ‘must have,’” she said, citing the example of more employers offering and subsidizing both short- and long-term disability, including private groups. “Those groups have had to step up their benefits to compete in this market.”

What’s up, what’s down, and what’s changed?

From a big-picture perspective, physicians considering hospital or health system employment can expect comprehensive benefits coverage across the board, from health and disability insurance to retirement benefits, paid vacation, and payroll taxes. Life insurance is frequently offered as a benefit, and like health insurance, its value varies. A competitive life insurance benefit would be at least as much as but ideally two times the physician's salary (or provide the ability to buy up to that amount), in Ms. Heymans’ view. “I’ve seen some packages where employers are offering only $50,000, and that’s definitely too low,” she said.

On the perks side, sign-on bonuses and education-loan repayment remain common and can be generous, especially in hard-to-recruit-to locations. Both tend to have serious strings attached. The bonus might be repayable if the physician leaves employment before a specified time; likewise for the education-loan repayment. “Loan forgiveness is more common in very rural markets than in urban ones,” Mr. Hartley, said noting that it “usually includes a ‘claw-back’ or pay-back period of several years of service — typically three to five years.”

The recent Merritt Hawkins survey of physician incentives found that loan forgiveness offerings ranged from $10,000 to a high of $260,000 for physicians, with a three-year payout term most common (72%) and one-year payout almost unheard of (5%).

Angie Caldwell, a principal with the health care consulting and accounting firm PYA in Tampa, Florida, advised job-searching physicians to expect that a signing bonus will be predicated on the contract term or a specified period, typically three to five years, and that the money will likely have to be paid back proportionally if the physician leaves early. “That bonus is essentially ‘earned’ through the contract,” she said, “so it’s important to look at the payback terms.” For example, if a physician receives a $30,000,
three-year signing bonus and leaves at the end of two years, she or he might have to repay the employer $10,000.

Overall, Mr. Hartley observed, there is continued movement toward using benefits as a retention tool. For example, retirement or pension options might include five-year or longer vesting periods, he said. “Many organizations have continued to add wellness benefits such as gym memberships,” he added.

Paid CME and relocation-expense allocation remain prevalent, too, but both are generally flat — with CME topping out in the $4,000-annually range and relocation increasingly subject to a cap of around $10,000 in many organizations. It’s worth noting that relocation reimbursement is now taxable to the physician, regardless of the amount. In evaluating CME benefits, physicians should ask whether the benefit includes associated paid time off and travel expenses.

In terms of new or relatively new benefits, many physician employers now offer Section 125 flexible-spending plans for managing health and child-care expenses through payroll deductions. There’s also a trend toward offering long-term disability coverage at reduced group rates if it’s not fully employer paid — rare these, several sources said.

The AMGA survey data found that typical long-term disability protection covers 60% to 66% of the physician’s salary, Dr. Rumans noted, and that only 28% of organizations offer full salary continuation.

PTO: More generous but less flexible

One area where things are shifting is paid time off, or PTO. “PTO has become much more clearly defined in recent years,” Ms. Caldwell said. Organizations today are stating the exact number of permitted days off (four to six weeks annually is the common range now), defining what constitutes paid vs. unpaid leave, and being firm on what happens with accrued leave that isn’t taken.

Things used to be more negotiable in the PTO area, but that’s no longer the case with most large physician employers, Ms. Caldwell observed. “Fewer employers are offering PTO buyout anymore,” she said, referring to the option of converting unused PTO days to cash. She added that the current generation of millennial physicians also tend to want to use their PTO, not bank it.

“It’s more common to see ‘use it or lost it’ PTO systems now,” Ms. Heymans said.

Several sources cautioned that rich PTO benefits are less common in independent physician groups than in hospital- or health system-employment models. Mr. Hartley noted that AMGA has seen some movement away from PTO or vacation pay for physicians who work in production-based compensation plans.

Another area where there’s potentially wide variation among employers or groups is physician retirement plans. Although most organizations that employ physicians offer some defined-contribution (employee funded through deferrals) retirement plan — 76%, according to SullivanCotter survey data — employer matching might be either rich or nonexistent, depending on the organization. Last year, 22% of organizations SullivanCotter surveyed provided an employer-funded nonqualified benefit of between 3% and 7% of salary.

Physicians who work in government-employed positions for county, state, or national organizations will have access to potentially richer retirement benefits than their private-sector counterparts, possibly including a defined-benefit plan, which is effectively a pension plan. However, physicians in academic centers generally earn lower salaries — sometimes far lower — than those working for hospitals, health systems, or large physician groups.

At the outside, most financially attractive end of the retirement-plan spectrum, Mr. Hartley pointed out, are employer-sponsored deferred-compensation options or supplemental retirement benefits, designed to help earners reduce their tax burden. “Those are still available in some organizations and can be very valuable over the long run,” he said. Ken Sammut, vice president of recruiting at Cekja Search, a national firm, noted that such options are far more common in private groups than in health systems.

Comparing packages? Be thorough, and ask questions

Young physicians who are evaluating and ultimately comparing practice opportunities’ compensation packages tend to be too focused on the cash component and too casual about the benefits, all sources agreed. That’s inadvisable for two reasons. First, the total value and availability of benefits might vary significantly from one employer organization to another.
In addition, the details and minutiae matter, and can make a big difference in areas such as health coverage and retirement plans.

Although few prospective employers provide complete financial details on benefits unless they're prepared to make an offer, organizations should be willing to provide a comprehensive listing of all benefits, according to Ms. Moody. “If they’re not, that’s a potential red flag,” she said.

Mr. Sammut advises physicians to be somewhat assertive, ideally toward the end of a successful onsite interview, about obtaining an opportunity to review benefits. “A good way to handle this is to say, ‘should things go well, is there someone who can walk me through the benefits that you offer?’” he said. He cautioned that the first site visit is not the time to try to negotiate benefits.

Following are other issues physicians should keep in mind when they review or compare benefits in the context of an employment offer:

**Request a pro forma document that details the benefits’ monetary value.** This document, Ms. Moody explains, should provide full details on the value of the individual benefits and any out-of-pocket costs that physicians will or might have to absorb. “If the physician is expected to assume high costs for health insurance or other benefits, that usually means the organization isn’t competitive,” she said.

**Understand how much employers would pay on your behalf.** Even if an organization offers a wide array of benefits, it’s important to look at the employer’s outlay for those benefits. That amount might vary considerably from one organization to another, Ms. Heymans said.

**Keep employers’ constraints and economic considerations in mind.** In a highly competitive market, physicians might be tempted to request benefits adjustments or more perks, but that might not be feasible. For one, employers might be prohibited legally from offering anything deemed above fair market value. Also, employers don’t want to risk political fallout from an arrangement that smacks of unequal treatment or favoritism.

Mr. Sammut urges young physicians to keep in mind that benefits’ total value and, to some extent, composition, tend to be very regionally based and driven by market factors. In the Northeast, where large numbers of physicians train and many want to remain, benefits packages, like cash compensation, are generally less rich than in rural areas, for example, or the Southeast. The same goes for incentives. A signing bonus of $10,000 to $20,000 is a common range, but he has seen bonuses as high as $50,000 in recruitment-challenged areas.

Finally, Mr. Hartley reminds physicians that groups, hospitals, and health systems operate in a somewhat volatile revenue and reimbursement environment, and they don’t necessarily have the “deep pockets” that some physicians might think they have. “There is cost pressure everywhere. Employers attempt to be competitive for their local and national market, but they have limits on what they can offer physicians,” he said.

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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?

“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, one who can help you with career planning, and another mentor for life planning.”

— Dr. Pereira

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

“How should young physicians approach 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

“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?

“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. Pereira

“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.”

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

“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 time to you.”

— Dr. Best

“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

For the past month, a 75-year-old woman with polymyalgia rheumatica has received prednisone at a dose of 20 mg daily. The treatment plan is to try to taper the dose to 5 mg daily within 6 months. Given typical durations of treatment, the expectation is that she will continue to receive prednisone for 2 years. She is otherwise healthy and has no personal or family history of fracture. She does not smoke or drink alcohol.

Bone mineral density T score is −1.2 at the femoral neck. Her bone mineral density T score is ~1.2 at the femoral neck. What would you advise to prevent glucocorticoid-induced osteoporosis and fracture?

CLINICAL PRACTICE

Caren G. Solomon, M.D., M.P.H., Editor

Glucocorticoid-Induced Osteoporosis

Lenore Buckley, M.D., M.P.H., and Mary B. Humphrey, M.D., 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.

The Clinical Problem

Approximately 1% of all adults and 3% of adults older than 50 years of age receive glucocorticoids for allergies, inflammatory conditions, or cancer. Long-term use of glucocorticoids is associated with clinically significant toxic effects. Fracture is the most common serious and preventable adverse event associated with these agents. The risk of fracture increases with age and with the dose and duration of glucocorticoid use (Table 1). Vertebral fractures are the most common fractures associated with glucocorticoids; the risk of vertebral fracture increases within 3 months after initiation of treatment and peaks at 12 months. The relative risk of clinically diagnosed vertebral fracture doubles and the risk of hip fracture increases by approximately 50% among patients who receive 2.5 to 7.5 mg of prednisolone daily. In a study with a follow-up of 6 months to 10 years, glucocorticoids taken at very high doses significantly increased the risk of vertebral fractures; among adults who received 30 mg per milliliter (74 nmol per liter). Her bone mineral density T score is ~1.2 at the femoral neck. What would you advise to prevent glucocorticoid-induced osteoporosis and fracture?

Bone loss results from increases in expression of receptor activator of nuclear factor-κB ligand (RANKL), which lead to increases in the number of bone-resorbing osteoclasts. Osteocyte apoptosis induces osteolysis, which results in an early increase in expression of receptor activator of nuclear factor-κB ligand (RANKL), which lead to increases in the number of bone-resorbing osteoclasts. Osteocyte apoptosis induces osteolysis, which results in an early
increased risk of fracture even before bone mineral density decreases. Bone formation also decreases early in glucocorticoid treatment because of a decrease in osteoblast recruitment and accelerated apoptosis. Indirect glucocorticoid effects that also predispose patients to an increased risk of fracture include reduced muscle mass leading to an increased risk of falls, decreases in renal calcium resorption and levels of sex hormones, and alterations in parathyroid hormone pulsatility.10

The risk of fracture rapidly decreases when glucocorticoids are discontinued. A large retrospective study showed an increased risk of major osteoporotic fracture among patients with recent prolonged glucocorticoid use but not among those with intermittent or past use of these agents.11 Treatment of the underlying conditions for which glucocorticoids are prescribed often requires multiple medications, tests, and medical visits. The underlying condition (e.g., rheumatoid arthritis), as well as clinically evident glucocorticoid-associated adverse effects (e.g., muscle weakness and decreased skin integrity), are typically the focus of treating clinicians. Moreover, patients are frequently resistant to the administration of medications to prevent osteoporosis, a condition that does not currently affect their quality of life, and many are concerned about rare potential adverse effects of antiosteoporosis medications. Thus, assessment and treatment of osteoporosis are frequently postponed or missed.

**STRATEGIES AND EVIDENCE**

Prevention of glucocorticoid-induced fractures requires identification of patients who should receive preventive treatment. The fracture risk assessment tool (FRAX) (www.shef.ac.uk/frax/) combines many risk factors for osteoporosis (including glucocorticoid use) with the bone mineral density to provide an estimate of the 10-year risk of major osteoporotic fracture and hip fracture among patients who are at least 40 years of age.12 Although the risk of fracture can be calculated when the bone mineral density T score is not available, bone mineral density testing and the fracture risk assessment tool (FRAX) (www.shef.ac.uk/frax) should be performed soon after the initiation of glucocorticoid treatment. The risk of fracture among patients who are 40 years of age or older can be estimated with the use of bone mineral density testing and the fracture risk assessment tool (FRAX).

**Table 1. Risk Factors for Fractures in Patients Receiving Glucocorticoids.**

<table>
<thead>
<tr>
<th>Category of Risk</th>
<th>Risk Factors</th>
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<tbody>
<tr>
<td>Related to glucocorticoid use</td>
<td>High daily dose of glucocorticoid (e.g., &gt;7.5 mg of prednisone daily), cumulative dose of glucocorticoid &gt;5 g, current or recent (&lt;3 mo) use of glucocorticoid, glucocorticoid-associated myopathy that increases the risk of falls, glucocorticoid-induced hyperglycemia</td>
</tr>
<tr>
<td>Related to underlying condition</td>
<td>Rheumatoid arthritis, ankylosing spondylitis, inflammatory bowel disease, biliary cirrhosis</td>
</tr>
<tr>
<td>Related to risk of osteoporosis</td>
<td>Age &gt;55 yr; white race; female sex; menopause; smoking; excess alcohol use (&gt;2 units per day); bone mineral density T score below &lt;−1.5; increased fall risk; endocrine disorders: hypogonadism, hyperparathyroidism, or hypoparathyroidism; malabsorption; BMI &lt;18.5; previous fracture</td>
</tr>
</tbody>
</table>

* The body-mass index (BMI) is the weight in kilograms divided by the square of the height in meters.
† According to the U.K. National Health Service, a standard glass of wine (175 ml) is 2.1 units (www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/).
estimates. When glucocorticoid use is added as a risk factor in the FRAX tool, the fracture estimates reflect the risk associated with prednisone use at a dose of 2.5 to 7.5 mg per day; however, analysis of data from the U.K. General Practice Database suggests that among patients who receive more than 7.5 mg of prednisone daily, the FRAX-predicted risk of major osteoporotic fracture varies to be increased by 15% and the risk of hip fracture to be increased by 20%. However, among patients who receive very high doses of prednisone (>30 mg per day or cumulative doses to >8 g per year), this adjustment may underestimate the risk of fracture. Another limitation of the FRAX score calculation is the use of bone mineral density at the hip instead of at the lumbar spine, since glucocorticoids have the greatest negative effect on trabecular bone in the spine.

Currently, tools to estimate the risk of fracture among patients who are younger than 40 years of age are lacking. The risk of fracture increases and the time to fracture decreases considerably with increasing age among patients who receive glucocorticoids.

TREATMENT

NONPHARMACOLOGIC OPTIONS

Given the potential to recover bone mass, minimizing glucocorticoid use is the most important intervention to prevent fractures. For patients who receive glucocorticoids, routine lifestyle recommendations that are based on observational data are largely from patients who have not received glucocorticoids include weight-bearing exercise, maintenance of normal weight, smoking cessation, limitation of alcohol consumption, and the assessment and management of fall risks.

CALCIUM AND VITAMIN D

Adequate dietary intake of calcium (1000 mg per day) and vitamin D (600 to 800 IU) is routinely encouraged in patients who receive glucocorticoids. Calcium and vitamin D may be more important for patients who receive glucocorticoids than for the general population because glucocorticoids increase the excretion of urinary calcium. A Cochrane meta-analysis estimated that the bone mineral density (measured in grams per square centimeter) at the lumbar spine was significantly higher among patients who received calcium and vitamin D supplementation than among those who received placebo (weighted mean difference, 2.6%; 95% CI, 0.7 to 4.5). Randomized trials have shown that calcium and vitamin D supplementation prevented decreases in bone mineral density in the spine during long-term use of low-dose prednisone (mean dose, 7.1 mg per day) but did not completely prevent bone loss in patients who were beginning to receive high-dose treatment (mean dose, 23 mg per day). Calcium alone is not effective in preventing bone loss in patients who are receiving glucocorticoids, but the effect of calcium and vitamin D on rates of fracture among patients who receive glucocorticoids is lacking.

PHARMACOLOGIC TREATMENT

The 2017 guidelines of the American College of Rheumatology recommend pharmacologic treatment to prevent additional fractures in any patient with a previous osteoporotic fracture who is receiving glucocorticoids (prednisone dose ≥2.5 mg per day). Among patients who are receiving glucocorticoids and have a bone mineral density T score ≤−2.5 or less at either the bone mineral density of the spine or the femoral neck, pharmacologic treatment is also recommended for men who are 50 years of age or older and for postmenopausal women. Among adults who are 40 years of age or older and who do not meet the above criteria, pharmacologic treatment is recommended if the 10-year risk of major osteoporotic fracture is at least 20% or if the risk of hip fracture is at least 5% according to the FRAX tool (after increasing the risk by 15% and 20%, respectively, for prednisone dose >7.5 mg daily). Table 2 lists these indications and other recommendations that should be considered for adults 40 years of age or older who are at moderate risk for fracture and for adults younger than 40 years of age.

Bisphosphonates

Numerous randomized trials have shown that bisphosphonates (alendronate, risedronate, zoledronate, and ibandronate) increase bone mineral density in patients who receive glucocorticoids. In a 2016 Cochrane review that included 12 randomized trials and involved 1343 participants, participants who received bisphosphonates had a 48% (95% CI, 9 to 65) lower risk of new vertebral fractures than participants who received calcium, vitamin D, or both; the estimated number needed to treat to prevent one glucocorticoid-induced vertebral fracture was 31.3. Randomized trials have shown that denosumab treatment for osteoporosis for 3 to 5 years, serious adverse events, including atypical femoral fractures and osteonecrosis of the jaw, have been reported to be rare (0.003% and 0.006%, respectively). Given their low cost and good safety profile, oral bisphosphonates are recommended as first-line agents to prevent glucocorticoid-induced fractures unless there are drug contraindications or unacceptable side effects. Intravenous bisphosphonates may be preferred in patients who are not adherent to oral bisphosphonates or in those who cannot safely take the oral formulation.

Other Recommended Agents

Teriparatide and alaboparatide are anabolic and increase bone formation. In a trial involving 428 patients who were receiving glucocorticoids, patients received either teriparatide or alendronate for 36 months. Teriparatide was associated with greater increases in bone mineral density at the spine than alendronate (11% vs. 5.3%, P=0.001) and a lower rate of radiographic vertebral fractures (1.7% vs. 7.7%, P=0.007); however, there was no significant difference in rates of nonvertebral fracture between the two treatment groups. Hyperparathyroidism was present in 21% of patients in the teriparatide group, as compared with 7% of those in the alendronate group. In a recent smaller trial involving middle-aged men who were receiving glucocorticoids, the bone mineral density was higher and the rate of fracture was lower among patients who received teriparatide than among those who received risedronate. However, bone loss and fractures occur rapidly after teriparatide is discontinued; therefore, after discontinuation, an antiresorptive agent such as bisphosphonates or denosumab should be initiated. Initial treatment with an anabolic agent such as teriparatide or alaboparatide, followed by an antiresorptive agent, may be considered for treatment of severe osteoporosis (bone mineral density T score below −2.5 in patients with a history of fracture).

Denosumab inhibits bone resorption by binding to RANKL and interfering with the development of osteoclasts. A noninferiority trial comparing denosumab with risedronate in patients who were beginning to receive glucocorticoids and in those who had received these agents longer-term showed superiority of denosumab with respect to increases in bone mineral density at the spine at 12 months and noninferiority with respect to rates of fracture. Some but not all studies have shown a higher risk of fractures with denosumab than with bisphosphonates.

Given the limited available safety data, denosumab is generally not recommended as the first-line treatment in patients taking multiple immunosuppressive drugs or a biologic treatment.

At doses of denosumab that are used to treat osteoporosis, the risks of osteonecrosis of the jaw (0.001% to 0.15%) and atypical fractures are low. However, rates of vertebral fracture increase rapidly after denosumab is discontinued, especially among patients with a previous vertebral fracture, and an alternative antiresorptive therapy is recommended after discontinuation.

Third-Line Agents

Treatment either with raloxifene (a selective estrogen-receptor modulator) in postmenopausal women or with calcitonin, another antiresorptive agent, should be reserved for patients in whom other treatments are contraindicated or in whom such treatments have failed. Raloxifene is approved by the Food and Drug Administration for the prevention and treatment of glucocorticoid-induced osteoporosis in postmenopausal women; it also increases the absolute bone mineral density (measured in grams per square centimeter) at the lumbar spine by 1.3% from the baseline measure, as compared with calcium and vitamin D supplementation, which decreased the absolute bone mineral density. However, there was no difference in bone mineral density at the femoral neck between the treatment groups, and trials assessing rates of fracture among patients who have received both glucocorticoids and raloxifene are lacking. Although raloxifene has been shown to reduce the risk of estrogen-receptor–positive breast cancer, potential adverse effects include hot flashes, leg cramps, venous thromboembolism, and fatal stroke.
**Table 2. Recommendations from Recent Guidelines for the Prevention and Treatment of Glucocorticoid-Induced Osteoporosis.**

<table>
<thead>
<tr>
<th>Variable</th>
<th>American College of Rheumatology*</th>
<th>European League Against Rheumatism†</th>
<th>International Osteoporosis Foundation and European Calcified Tissue Society‡</th>
<th>National Osteoporosis Guidelines Group§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients warranting intervention on the basis of dose and duration of glucocorticoid treatment</td>
<td>All adults taking ≥2.5 mg of prednisone daily for &gt;3 mo</td>
<td>All adults taking any dose of prednisone daily for &gt;3 mo</td>
<td>Any adults with previous fracture, age ≥70 yr or taking ≥7.5 mg prednisone daily; for all other adults are based on intervention thresholds that differ according to country</td>
<td>All adults taking any dose of prednisone daily for &gt;3 mo</td>
</tr>
<tr>
<td>Wominoes test and monitor for changes in BMD</td>
<td>All adults ≥40 yr of age and adults &lt;40 yr with a history of fragility fracture or other risk factors, tested within 6 mo after initiation of glucocorticoids, repeated every 2–3 yr and every 1–3 yr in adults ≥40 yr receiving glucocorticoids without treatment for osteoporosis</td>
<td>Premenopausal women or men &lt;70 yr of age; not recommended for postmenopausal women and older men, since they will receive treatment for osteoporosis regardless of BMD</td>
<td>Patients without previous fracture, &lt;70 yr of age, &lt;7.5 mg of prednisone daily; monitor patients receiving glucocorticoids at appropriate intervals thereafter (not specified)</td>
<td>Not specified</td>
</tr>
<tr>
<td>Correction used with the FRAX tool to adjust risk estimate for prednisone dose &gt;7.5 mg</td>
<td>Risk of major osteoporotic fracture is increased by 15% and risk of hip fracture is increased by 20%; if receiving &lt;2.5 mg of prednisone daily, FRAX risk of major osteoporotic fracture is decreased by 20% and risk of hip fracture is decreased by 35%</td>
<td>Supplement if receiving ≥2.5 mg of prednisone daily; no recommended dose of calcium and vitamin D</td>
<td>Supplement if receiving glucocorticoids for &gt;3 mo; do not recommend dose of calcium and vitamin D</td>
<td>Supplement if level of dietary calcium and vitamin D is inadequate</td>
</tr>
<tr>
<td>Calcium and vitamin D supplementation</td>
<td>800–1000 mg of calcium daily and 600–800 IU of vitamin D daily</td>
<td>Supplement if receiving ≥2.5 mg of prednisone daily; no recommended dose of calcium and vitamin D</td>
<td>Supplement if receiving glucocorticoids for &gt;3 mo; do not recommend dose of calcium and vitamin D</td>
<td>Supplement if level of dietary calcium and vitamin D is inadequate</td>
</tr>
<tr>
<td>Threshold for pharmacologic treatment</td>
<td>All adults with a previous fragility fracture; adults ≥30 yr with BMD T score of −2.5 or less or FRAX risk ≥20% for major osteoporotic fracture or ≥3% for hip fracture; adults ≥40 yr with BMD T score of −1.0 to 1.9; adults &lt;40 yr with BMD T score ≤−2.5 or FRAX risk ≥20% for major osteoporotic fracture or ≥3% for hip fracture; adults ≥40 yr with BMD T score &lt;−2.0; adults &lt;40 yr with BMD T score &lt;−2.0 and risk of hip fracture is increased by 20%</td>
<td>Adults with previous fracture or taking ≥7.5 mg of prednisone daily, postmenopausal women and men &gt;70 yr, taking &gt;7.5 mg of prednisone daily, premenopausal women and men &gt;70 yr, and adults ≥40 yr with a high-risk BMD T score (not specified)</td>
<td>Adults with previous fracture or age ≥70 yr or taking &gt;7.5 mg of prednisone daily; adults with no previous fracture, age &gt;70 yr, or taking &lt;2.5 mg of prednisone daily; FRAX risk of major osteoporotic fracture is decreased by 20% and risk of hip fracture is decreased by 35%</td>
<td>Adults with a previous fragility fracture or taking ≥7.5 mg of prednisone daily; women and men ≥70 yr</td>
</tr>
</tbody>
</table>

* BMD denotes bone mineral density, and FRAX fracture risk assessment tool. † This guideline predates approval of teriparatide and denosumab. ‡ This guideline predates approval of denosumab. § This is a conditional recommendation because of poor quality of data or lack of data about benefits, harms, or both.

**Pharmacologic interventions**

<table>
<thead>
<tr>
<th>First-line therapy</th>
<th>Second-line therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral bisphosphonates</td>
<td>Infusion bisphosphonates, teriparatide, denosumab, raloxifene (only in postmenopausal women when other listed second-line medications are not appropriate)</td>
</tr>
</tbody>
</table>

**Duration of pharmacologic intervention**

- If continuing to receive glucocorticoids ≥5 yr, continue treatment if moderate to high risk of glucocorticoids discontinued before 5 yr, continue treatment for osteoporosis for 5 yr if moderate to high risk; discontinue treatment for osteoporosis when glucocorticoids are discontinued if low risk.

**Areas of Uncertainty**

- Long-term use of glucocorticoids is common and may be associated with significant musculoskeletal adverse effects.
- Although data on the effects of medications on bone mineral density are generally consistent with observations in experimental models, the clinical implications of these findings have not been clearly established.
- Many medications have been shown to decrease bone density, and it is generally recommended that studies in animals be interpreted with caution.

**TREATMENT IN WOMEN OF CHILDBEARING AGE**

- Bisphosphonates are generally recommended. Studies in animals have shown that denosumab has teratogenic effects and should be used with caution in women who are pregnant or breastfeeding.

- Calcitonin, which can be administered subcutaneously or by nasal spray (with less absorption), may cause nausea or vomiting.

- A meta-analysis of trials comparing zoledronic acid and risedronate showed that the bone mineral density at the femoral neck and lumbar spine was increased in women who received bisphosphonates. Among those who were receiving glucocorticoids at the time of the randomized trials, osteoporotic fractures occurred at a similar rate in those who received glucocorticoids alone and those who received a bisphosphonate in addition to their glucocorticoids.
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9. Van Staa TP, Leufkens HG, Ahmadin

CONCLUSIONS AND RECOMMENDATIONS
The 75-year-old woman with polyalygna rhea-
matic descripte in the vignette is currently re-
ceiving prednisone at a dose of more than 7.5 mg per day and is expected to receive a lower dose for the foreseeable future. On the basis of her bone mineral density T score of use of high-
dose prednisone, the FRAX 10-year risk of major osteoporotic fracture is 18% and the risk of hip fracture is 3.8% (after increases of 15% and 20%, respectively, for the risk because of use of high-dose prednisone). This level of risk meets American College of Rheumatology guideline criteria for pharmacologic treatment (2.0% risk of major osteoporotic fracture or 2.4% risk of hip fracture). In keeping with these guidelines, we would recommend bisphosphonates (e.g., oral alendronate at a dose of 70 mg once weekly) as first-line treatment. The prednisone dose should be tapered as much as possible according to disease activity. We would continue to recom-
bend bisphosphonate treatment for 5 years as long as the patient is taking prednisone at a dose of at least 2.5 mg per day. When the prednisone dose is reduced below 2.5 mg per day, we would reassess the risk of fracture and discontinue bisphosphonate treatment if the predicted risk no longer meets the criteria for pharmacologic treatment. Optimization of calcium and vitamin D intake, weight-bearing exercise, and strategies to prevent falls should be encouraged.

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

Clinical Practice
The New England Journal of Medicine
Data to guide assessment of the risk of glucocorticoid–associated fractures among adults who are younger than 40 years of age are lacking. Tools to estimate short-term and long-term risks of fracture are needed for this population. The natural history of bone loss attributable to glucocorticoids differs from that related to meno-

pause and aging. glucocorticoid use is typically a transient factor, the rate of bone loss varies over the course of glucocorticoid treat-
ment, and bone strength improves with the discontinuation of glucocorticoids. Despite these differences, patients who receive glucocorticoids often receive the same regimens used to treat osteoporosis in postmenopausal women. Data on the effectiveness and safety of alternative regimens that may be more acceptable to patients are lacking. Such regimens include targeting anti-
osteoporosis therapy to periods of higher-dose glucocorticoid use, followed by calcium and vita-
min D supplementation during periods of low-dose glucocorticoid use.

Guidelines
Several professional societies have published guid-
elines for the prevention and management of glucocorticoid-induced osteoporosis.22,23,24 Owing to limitations in high-quality data to inform screening and treatment guidelines, guidelines vary with respect to the glucocorticoid doses warranting intervention, the need for bone mineral density testing and calcium and vitamin D supplemen-
tation, the thresholds and duration of osteo-
porosis treatment (Table 2). The recommendations in this article are consistent with the guidelines of the American College of Rheumatology;


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HOW TO APPLY: Submit electronic resume or curriculum vitae (CV) and supporting documentation to CBEREmployment@fda.hhs.gov. Supporting documentation may include: educational transcripts, medical license, board certifications. Applications will be accepted through June 30, 2019, although applicants will be considered as resumes are received. Please reference Job Code: OTAT-18-0012-NEJM.

NOTE: This position may be subject to FDA’s strict prohibited financial interest regulation and may require the incumbent to divest of certain financial interests. Applicants are strongly advised to seek additional information on this requirement from the FDA hiring official before accepting a position. A probationary period for first-time supervisors/managers may be required for supervisory positions.

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5. Participates in rotational daily and night on-call services, for all skilled nursing & rehabilitation facilities.
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7. Supervises physician extenders, including physician assistants and nurse practitioners.
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Senior Scientific Officer Position Available at NIDDK

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) is seeking exceptional candidates to serve as Director of a Program in Human Pathophysiology and Clinical Kidney Disease in the extramural Division of Kidney, Urologic, and Hematologic Diseases (DKUHD).

The incumbent will serve as a Program Director and a Senior Scientific Officer within and outside the NIDDK. The successful candidate will join a group of highly interactive scientists and clinicians directing research programs in all areas of nephrology, urology, and hematology diseases. S/he will be expected to evaluate and administer extramural research with the goal of building and implementing a cutting edge clinical and translational research portfolio on the pathophysiology and clinical manifestations of human renal diseases (including AKI).

The position involves initiating research activities and providing advice to the Director, DKUHD on current and future kidney disease studies and in other areas of nephrology, managing multi-center cooperative agreement clinical studies, and administering a portfolio of nephrology clinical and translational research grants focusing on human kidney injury and disease. In addition to these activities, the incumbent identifies areas of innovation and priorities for development and application of research initiatives. He/she participates in the planning of meetings and workshops involving members of the NIH and general research community. The position has substantial trans-NIDDK and trans-NIH programmatic opportunities that requires frequent interactions with other federal agencies and diverse groups of professional and lay organizations, as well as advocacy groups.

The NIDDK seeks candidates who have a significant track record of scientific research achievement and outstanding communication skills. Applicants must possess an M.D., Ph.D., or equivalent degree, with sub-specialization in nephrology, and national recognition for kidney research.

Individuals interested in learning more about opportunities to serve as a Senior Scientific Officer in DKUHD are invited to contact:

Robert Star, M.D., Director, DKUHD
starr@niddk.nih.gov
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Baystate Health (BH), our extensive and experienced primary care network is the foundation on which our health system is built. Comprised of Baystate Primary Care Practices (academic and community), Baystate Medical Center, a 716-bed tertiary care hospital and the region's only level-1 trauma center, 3 community hospitals and Baystate Children's Hospital, we have practice settings that fit your career goals. Baystate Health is a well-established and growing organization which has the resources and support to start or advance your career.

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For more information please contact Liz Mahsa, Physician Recruitment Specialist Berkshire Health Systems (413) 439-7886
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NEJM Career Center

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- Infectious Disease
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Trinity Health Of New England Medical Group is seeking board-certified/board-eligible Family Medicine and Internal Medicine physicians to join our expanding primary care teams throughout our service areas in Springfield, Massachusetts and in Hartford and Waterbury, Connecticut.

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For more information, please call Daniele Howe, Senior Physician and Advanced Practitioner Recruitment Specialist, Trinity Health Of New England, at 413-523-0824 today, or email your CV and letter of interest to daniele.howe@sphs.com.

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Primary Care opportunities available with Trinity Health Of New England Medical Group.

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Primary Care opportunities available with Trinity Health Of New England Medical Group.
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