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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.

We've included a reprint of the January 28, 2021, article, “Clinical Practice: Atrial Fibrillation.” 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 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 working out.

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

Sincerely,

Eric J. Rubin, MD, PhD
The Medical Group Management Association’s annual Provider Compensation and Production Report, which included data from more than 168,000 physicians and nonphysician providers, found an average increase of 2.6% in primary care total compensation from 2018 to 2019, to $273,437. Here’s that breakdown, from MGMA’s 2020 Datadiive Provider Compensation Report:

**MGMA—family medicine average total compensation:** $258,947, down slightly from $268,954 in 2018

**MGMA—internal medicine average total compensation:** $268,658, up from $258,323 in 2018

**MGMA—pediatrics (general) average total compensation:** $232,409, essentially flat compared with $232,701 in 2018

Although regional compensation variations are generally less pronounced than they were five or 10 years ago, because most organizations consider national data when setting their compensation structures, the MGMA survey did find some notable differences between the Eastern region (with a median of $257,757) compared to the other regions: $273,578 in the Midwest, $276,654 in the Southern region, and $279,626 in the Western region.

“Compensation for primary care providers is pretty consistent across each of the regions,” said Andrew Swanson, MBA, vice president of industry insights for MGMA. “The difference between the highest paying region (Western) compared to lowest paying region (Eastern) is just over $20,000.”

The Medscape 2020 Physician Compensation Report, based on survey responses obtained from 17,000 physicians before the pandemic, found a 2.5% average increase in primary care compensation compared to 2019, from $237,000 to $245,000. In the breakdown, family medicine average compensation was $232,000, internal medicine $251,000, and pediatrics $232,000. Interestingly, 88 percent of PCPs surveyed reported receiving incentive bonuses over the year, at an average of $26,000.

**Productivity mostly flat in primary care**

The trend toward rising work relative value units (W-RVUs), the primary measure of how hard physicians work, appears to be leveling off. The MGMA’s most recent survey found RVUs essentially unchanged from 2018 to 2019 across all primary care specialties. Median W-RVUs sector wide were 4,847 in 2019, a negligible difference of -0.27% from the previous year. The breakdown was 4,714 median W-RVUs in family medicine with obstetrics (and 4,936 without), 4,804 in internal medicine, and 4,879 in pediatrics.

The AMGA survey’s findings were similar. Median W-RVUs came in at 4,740 in family medicine, 4,861 in internal medicine, and 5,246 in pediatrics. From a regional standpoint, W-RVUs were highest in the South and East (in both regions, median W-RVUs topped 5,000 in all three primary care specialties) and lower (below 5,000) in the West and North. The exception was pediatrics, where median RVUs were the highest of all the primary care specialties in all four regions, topping out at 5,676 in the South. “The West was highest in every metric, from total cash compensation to total RVUs,” Mr. Horton said. “That’s not surprising, really, because the region includes some of the highest cost-of-living ZIP codes in the country and that environment also has more capitation — covered lives and risk contracts — than the other regions. In addition, in many of those organizations, [physician] positions are salaried,” Mr. Horton said.

As an indicator of overall primary care physician productivity to organizations’ revenues, it’s worth noting, Mr. Horton pointed out, that while compensation per W-RVU was up 2.6% in 2019, compared to the prior year, collections per RVU dropped by 1.6%. “This is the biggest gap that we saw in all of the specialties, which clearly puts some pressure on organizations going forward,” he said.

The MGMA’s survey found essentially the same trend: For most primary care specialties, compensation increases appear to be outpacing increases in productivity. “There have been concerns about physician shortages, which could be one explanation for higher compensation rates compared to productivity,” said Andrew Swanson, MBA, vice president of industry insights for MGMA.

What was surprising in AMGA’s findings, is that the long-expected significant shift from paying physicians on value rather than predominately on volume still isn’t gaining much traction in the marketplace. In fact, the percentage of physician compensation paid out based on value actually declined slightly in 2019, to 7.6% from 7.8% in 2018. “There’s been a lot of focus on getting more value in [physician care], but that shift is occurring more slowly than we anticipated,” he said.

**Gauging pandemic’s effect on compensation**

Although the MGMA declined to predict the effects of the pandemic and associated economic conditions and the drop in health care organizations’ revenues effects on PCPs (and other physicians’) compensation in the next few years, citing fluctuating economic conditions, the organization...
is following the situation closely. In MGMA’s 2020 Monthly Survey, which captures compensation and productivity-level information on a monthly basis, preliminary findings showed dips in compensation in April and a slow rebounding in the following months. Not unexpectedly, the drops in provider productivity in April were much more significant than the drop in compensation, MGMA data analysts reported, and rebounding of productivity has been slower as well. Overall, according to MGMA’s recent COVID-19 financial impact report, practices reported an average 55 percent decline in revenue in the early months of the pandemic and many were forced to furlough medical staff.

“COVID-19 has had a dramatic impact on the health care industry with productivity halting for many medical practices. Compensation models will look different in the near future based on shifting productivity and demands on physicians and the industry overall,” said Halee Fischer-Wright, MD, MGMA’s president and chief executive officer.

In a July 2020 Hospital Finance Podcast on the effects of the pandemic on physician compensation, Zachary Hartshell, a principal at SullivanCotter, which conducts annual surveys on physician compensation, reported that relatively few — less than 10 percent — of organizations surveyed had actually implemented wholesale furloughs or layoffs. Instead, SullivanCotter found that organizations making adjustments to address revenue declines were instead reducing compensation, shrinking benefit plans, or opting for temporary furloughs to ride out the drop in patient volumes.

Of course, it’s not all doom and gloom out there, Mr. Horton reminds physicians. The pandemic will pass, organizations will always need skilled PCPs, and physicians will still command good incomes. He noted that the starting salaries for PCPs reported in the latest AMGA survey illustrate the high demand for physicians in that sector. Compared to 2018, starting compensation for internists was up 5.7%, and for family medicine physicians, 3.7%, and pediatricians, 5.1%. Even if the pandemic puts downward pressure on PCP compensation for a while, and organizations will have to adjust accordingly, he said, PCPs should be optimistic overall about their important role in health care delivery, regardless of economic conditions.

In the interim and going forward, to enable flexibility in physician pay structures, Mr. Horton urges organizations to set a component of compensation based on organizations’ financial performance, and he strongly recommends that PCPs get involved in financial decision-making where they practice. “Physicians should focus on organizations that will include them in financial decision-making, not insulate them from financial reality,” he said.

When they’re considering primary care practice opportunities during this uncertain time, Mr. Horton added, physicians shouldn’t be afraid to ask pointed questions about the organization’s financial foundation and its ability and approach to weathering potentially significant upheaval, as the country experienced this year. “Physicians might ask, for example, what happened with patient volumes and how compensation was handled during the first wave of the pandemic and what the organization’s compensation committee has planned in the event of another major disruption,” Mr. Horton said.

Although PCP hiring also took a downturn in the wake of the pandemic, not surprisingly, there’s a general sense that the overall hiring market remains strong because of the underlying factors, according to Merritt Hawkins, one of the country’s largest physician recruiting firms. “The continued impact of COVID-19 makes looking into the future a difficult proposition. However, it’s clear that most of the fundamental supply and demand factors driving compensation in primary care remain in place,” said Tom Florence, an executive vice president at Merritt Hawkins. He cites the aging US population and high prevalence of chronic disease, as well as the growing need for preventive care that’s been sidelined temporarily during the pandemic. “Sooner or later, a backlog of sick patients will need to be addressed. In the short term, COVID-19 reduced demand for primary care doctors and therefore inhibited salary offers, but the underlying factors that drive demand for primary care physicians remain intact,” he said. “I think that primary care physicians can be optimistic that practice offers will remain abundant and compensation levels will hold.”

**Urgent care’s boom spurs substantial compensation increases**

One of the bright spots on the compensation horizon in recent years has been urgent care, a relatively new specialty that’s seen a big increase in earnings as the model’s prevalence grows. As health systems have newly implemented or expanded their urgent care presence and a slew of newcomer standalone organizations have entered the urgent care market, the specialty has become a darling of sorts in the health care sector. And that is increasing demand for those physicians and, in turn, higher compensation.
In the 2020 MGMA survey, urgent care physicians were No. 2 in terms of their compensation increase year over year, with a jump from a median of $259,661 in 2018 to $277,393 in 2019, a 6.83% increase. It’s worth noting the urgent care physicians worked hard to get the pay hike, with an 8.26% increase in W-RVUs compared to the previous year. According to MGMA data analysts, the compensation and productivity increases, 15.44% from 2015 to 2019 (compensation) and 12.44% (W-RVUs) might be attributed primarily to market dynamics in recent years. “We’ve seen sizable increases in both physician compensation and productivity in urgent care, which could be indicative of its wider use,” Mr. Swanson said.

The AMGA’s survey found even higher compensation levels in urgent care. Median compensation came in at $295,605 in the 2020 survey, up from $283,787 in the 2019 survey — a substantial increase that occurred without an increase in W-RVUs, which remained flat at 4,895 in 2019. Since 2017, median urgent care compensation has increased by nearly $30,000, far more than for many other nonsurgical specialties.

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

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

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

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

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

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

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

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

Of course, your final step is how you actually feel after you’ve interviewed at a job.

As straightforward as this may sound, most graduating trainees don’t take the time to go through this process, and it’s probably a big contributor to why job turnover is so high in the first few years into practice. Many people jump on job offers for the wrong reasons - the job is prestigious, recommended to them by a mentor, it’s in the town they’ve always pictured themselves living in but not the right practice setting, or simply because they’re afraid that they won’t find another job. Although some practicalities will always factor into your job search, don’t start from that point. Start with that list you put together above, and it’ll give you criteria to judge each opportunity that comes your way, and hopefully land that job that’s right for you. While no job is perfect, making sure that your major goals are fulfilled by it will go a long way towards both personal and professional happiness.

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Symptoms of atrial fibrillation, when present, range from minimal to incapacitating. Atrial fibrillation may cause fatigue, decreased exercise tolerance, and palpitations. Rapid heart rates may cause hypotension, syncope, angina, or pulmonary edema, and emergency treatment may be warranted. Severe manifestations are often associated with acute illness or surgery that leads to increased sympathetic tone and a rapid ventricular rate. Atrial fibrillation can cause a depressed left ventricular ejection fraction that improves or completely reverses after adequate rate control or restoration of sinus rhythm. Although this atrial fibrillation–induced cardiomyopathy usually occurs when the ventricular rate is persistently faster than 110 beats per minute, it may occur at slower rates in some patients.

An ECG recording that is required for diagnosis reveals QRS complexes that occur at irregular intervals, with variable oscillation of the baseline between beats and no discrete P waves (Fig. 1 and 2). Depending on the frequency of symptoms, ambulatory ECG recording may be preferred.

Mimics, but additional structural and electrophysiological changes allow atrial fibrillation to persist once it is initiated. Electrical isolation of pulmonary veins alone is less likely to prevent the recurrence of persistent atrial fibrillation than to prevent the recurrence of paroxysmal atrial fibrillation.

More than two thirds of patients with recently discovered atrial fibrillation have a paroxysmal pattern, but 5 to 10% per year have progression to persistent atrial fibrillation. Among patients who present with persistent atrial fibrillation and successfully undergo cardioversion, up to 20% have recurrent atrial fibrillation such that it becomes difficult to maintain sinus rhythm.12,13

**Strategies and Evidence**

**Diagnosis and Evaluation**

Symptoms of atrial fibrillation, when present, range from minimal to incapacitating. Atrial fibrillation may cause fatigue, decreased exercise tolerance, and palpitations. Rapid heart rates may cause hypotension, syncope, angina, or pulmonary edema, and emergency treatment may be warranted. Severe manifestations are often associated with acute illness or surgery that leads to increased sympathetic tone and a rapid ventricular rate.1 Atrial fibrillation can cause a depressed left ventricular ejection fraction that improves or completely reverses after adequate rate control or restoration of sinus rhythm.1 Although this atrial fibrillation–induced cardiomyopathy usually occurs when the ventricular rate is persistently faster than 110 beats per minute, it may occur at slower rates in some patients.1

An ECG recording that is required for diagnosis reveals QRS complexes that occur at irregular intervals, with variable oscillation of the baseline between beats and no discrete P waves (Fig. 1 and 2). Depending on the frequency of symptoms, ambulatory ECG recording may be preferred.
warfarin therapy reduced the risk to 1.4% per year. Several randomized trials have established that direct-acting oral anticoagulants are noninferior to warfarin. A meta-analysis showed that in trials with follow-up ranging from 12 weeks to 2.8 years, the risk of stroke or embolic events was 11% lower among patients who received direct-acting oral anticoagulants than among those who received warfarin; the risk of major bleeding was also reduced (from 5% to 4%) as was the risk of intracranial hemorrhage (from 1.3% to 0.6%). The risk of stroke among patients who received a direct-acting oral anticoagulant was 1.3% to 1.5% per year. In observational studies, apixaban has been associated with less bleeding risk than rivaroxaban. The major route of elimination is renal for all direct-acting oral anticoagulants, with substantial hepatic elimination for apixaban; dosing adjustment is generally needed in patients with renal dysfunction. Unlike warfarin, direct-acting oral anticoagulants do not require repeated laboratory testing to guide dosing and are generally preferred when their greater cost is not prohibitive. Warfarin therapy reduced the risk to 1.4% per year.

Warfarin

Rivaroxaban

Dabigatran

Apixaban

Edoxaban

Warfarin

Figure 3. Stroke Prevention in Patients with AF.

Scores on the CHA2DS2-VASc scale range from 0 to 9, with higher scores indicating a greater risk of stroke. Points are summed to generate the score. The mean CHA2DS2-VASc scores and stroke rates in large randomized trials are shown for patients receiving direct-acting oral anticoagulants and for those receiving warfarin. Historical data are from January et al.2 In other trials, the annual stroke rate has ranged from 1.2% to 1.3% among patients who received direct-acting oral anticoagulants, and 1.5% to 2.2% among those who received warfarin.20,21 Anticoagulation is indicated in patients with a CHA2DS2-VASc score of 2 or more (shaded area) and may be considered in patients with a score of 1. TIA denotes transient ischemic attack.

Maintenance of Sinus Rhythm

The decision regarding whether to pursue maintenance of sinus rhythm is shared between the patient and physician; this decision is informed by the effect of anticoagulation on the patient’s quality of life and by the risks and toxic effects of therapies. Many patients with paroxysmal atrial fibrillation or recently recognized persistent atrial fibrillation have symptoms and want to receive therapy, but some patients with persistent atrial fibrillation adapt without realizing that the rhythm is changing in their activity. For newly recognized asymptomatic atrial fibrillation, an attempt at cardioversion and maintenance of sinus rhythm is often reasonable to achieve a reduction in their activity. For newly recognized asymptomatic atrial fibrillation, an attempt at cardioversion and maintenance of sinus rhythm is often reasonable to achieve a reduction in their activity. For newly recognized asymptomatic atrial fibrillation, an attempt at cardioversion and maintenance of sinus rhythm is often reasonable to achieve a reduction in their activity. For newly recognized asymptomatic atrial fibrillation, an attempt at cardioversion and maintenance of sinus rhythm is often reasonable to achieve a reduction in their activity. For newly recognized asymptomatic atrial fibrillation, an attempt at cardioversion and maintenance of sinus rhythm is often reasonable to achieve a reduction in their activity.
nosed within 1 year before enrollment and other cardiovascular disease or stroke risk factors. The early rhythm-control strategy was associated with a significantly lower rate of the composite of death from cardiovascular causes, stroke, or hospitalization for heart failure or acute coronary syndrome (by 1.1 events per 100 person-years; a 22% reduction), without an increase in the number of nights spent in the hospital. Serious adverse events related to treatment occurred in 4.9% of the patients in the early rhythm-control group; the most common serious adverse event in that group was drug-induced bradycardia (in 1.0% of the patients).

Continued therapy with a beta-blocker may reduce episodes of atrial fibrillation in some patients, but it is less effective than antiarrhythmic drugs; atrial fibrillation has been reported to recur in 43 to 67% of patients who receive beta-blockers. Reductions in the frequency and duration of atrial fibrillation episodes are often reasonable goals if they improve symptoms. Adverse effects and contraindications (Table 1) are important considerations in drug selection. Several agents have been linked to an increased risk of death among patients with structural heart disease (e.g., flecainide, propafenone, and d-sotalol) or heart failure (dronedarone). Flecainide, propafenone, sotalol, and dofetilide are options for patients who do not have structural heart disease. Patients who receive sotalol and dofetilide must be monitored closely for prolongation of the corrected QT interval, which can lead to potentially fatal ventricular tachycardia (torsades de pointes). This risk is increased among women (because the QT interval is longer in women than in men), among patients with renal insufficiency or bradycardia, and among those who are taking other drugs that prolong the QT interval or alter antiarrhythmic drug absorption or elimination.

Amiodarone is a highly effective antiarrhythmic drug; however, owing to several potential long-term toxic effects, long-term use should be avoided if possible. Catheter ablation that is performed with the use of radiofrequency or cryotherapy is more effective than antiarrhythmic drug therapy for maintaining sinus rhythm in patients with paroxysmal atrial fibrillation. Two recent randomized trials compared cryoballoon with antiarrhythmic medication in patients with primarily paroxysmal atrial fibrillation. Symptomatic atrial fibrillation recurred by 1 year after a 90-day “blanking period” (i.e., the first 90 days after the index ablation) in 11.0% of the patients who underwent ablation and in 26.2% of those who received antiarrhythmic drugs in one trial. The percentage of patients with treatment success at 1 year was 74.6% in the ablation group and 45.0% in the drug-therapy group in the other trial. Therapies for maintenance of sinus rhythm are generally less effective in patients with persistent atrial fibrillation than in those with paroxysmal atrial fibrillation. In the randomized Catheter Ablation Versus Antiarrhythmic Drug Therapy for Atrial Fibrillation (CABANA) trial, 57% of the patients had persistent atrial fibrillation at trial entry; after 48.5 months of follow-up, only 16% of the patients in the ablation group had persistent atrial fibrillation, as compared with 26% in the drug-therapy group. The most common procedure-related adverse events were associated with vascular access (in 3.9% of the patients); serious complications included cardiac perforation with tamponade (in 0.8%), phrenic-nerve injury (in 0.1%), and transient ischemic attacks from cerebral emboli (in 0.3%). An expert consensus statement noted that procedure-related death occurs in fewer than 1 in 1000 patients. Uncommon late complications include pulmonary-vein stenosis and left atrial esophageal fistula (in 0.02 to 0.11% of patients). The latter manifests 1 to 4 weeks after ablation with a clinical syndrome resembling endocarditis and is fatal without prompt recognition and emergency surgery. During the first 3 months after ablation of atrial fibrillation, atrial tachycardia or atrial flutter occurs in up to 50% of patients and often resolves spontaneously, although antiarrhythmic drug therapy or cardiovascular version may be warranted. During longer follow-up, atrial fibrillation recurs in 15 to 50% of patients owing to lack of durability of the ablation lesion or the development of a new source of atrial fibrillation. Patients with reductions in atrial fibrillation burden and symptoms do not necessarily have to undergo a repeat procedure.

Maintenance of sinus rhythm is improved by the treatment of modifiable risk factors. A randomized trial involving 150 patients with atrial fibrillation showed that the addition of an intensive weight loss program to other therapies (including treatment and counseling for hypertension, sleep apnea, alcohol consumption, hyperlipidemia, and diabetes mellitus) resulted in weight loss as well as less atrial fibrillation and
fewer symptoms of atrial fibrillation than the standard treatment.46 A randomized trial involving patients with atrial fibrillation who consumed more than 10 standard drinks (with 1 standard drink containing approximately 12 g of pure alcohol) per week showed that those assigned to abstain from alcohol (average consumption, ≤2 drinks per week) had a lower atrial fibrillation burden during the following 6 months than those assigned to the control group.47 A recent scientific statement by the American Heart Association suggested a goal of 10 reduction in weight in patients with a BMI of 28 or higher, along with routine exercise and management of diabetes, hyperlipidemia, and sleep apnea and moderation of alcohol consumption.18

GUIDELINES

Guidelines for the management of atrial fibrillation have been written collaboratively by the American College of Cardiology, American Heart Association, and Heart Rhythm Society,38 the European Society of Cardiology,39,40 and the Canadian Cardiovascular Society.41 Our recommendations are generally consonant with these guidelines.

AREAS OF UNCERTAINTY

Data on the effects of strategies to maintain sinus rhythm on the overall risk of death are lacking. Recent randomized trials have suggested that the risk of death may be decrease in patients among whom the sinus rhythm is maintained early after the diagnosis of atrial fibrillation and in those with depressed left ventricular function who are candidates for and who undergo ablation.18

Among some patients with atrial fibrillation

CONCLUSIONS AND RECOMMENDATIONS

For a patient such as the one described in the vignette who has newly recognized atrial fibrillation, we would obtain estradiol, creatinine, and thyroid-stimulating hormone to identify reversible risk factors, and institute treatment with a direct-acting oral anticoagulant and therapy with a beta-blocker (adjusting the dose to achieve rate control). Further evaluation would include a careful medical assessment of possible coronary artery disease with stress testing or angiography. We would perform direct-current cardioversion after a 4-week course of anticoagulation. If cardioversion fails, additional decisions regarding further therapy would be guided by symptoms, risks, and benefits and would include consideration of catheter ablation to maintain sinus rhythm.18,48

Dr. Krämer reports receiving consulting fees and lecture fees from Bayer Schering, Abbott Medical, and Biosense Webster and lecture fees from Biotronik and Medtronic; and Dr. Tziveloglou reports receiving consulting fees from Boston Scientific and Abbott Medical. No other potential conflict of interest relevant to this article was reported. Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Clinical Practice

Functional nature of electrogram fractionation demonstrated by left atrial high-den- sity atrial mapping: Circ Arrhythm Electrophysiol 2018; 11: e005151.
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Urology, Pediatric
Urology, Female
Urology, Male
Veterinary Medicine
Vascular Surgery
Women's Health

Classified Advertising Rates

We change $9.95 per word per insertion. A 2- to 4-line frequency discount rate of $7.40 per word per insertion is available. A 5-line frequency discount rate of $7.10 per word per insertion is also available. In order to earn the 2-to4-line or 3-line discounted word rate, the request for an ad to run in multiple issues must be made initial upon publication. The issues do not need to be consecutive. Web fees: Classified line advertisers may choose to have their classifieds appear online at NEJM CareerCenter for a fee of $12.00 per issue per advertisement. The web fee must be purchased for all dates of the print schedule. The choice to place your ad online must be made at the same time the print ad is scheduled. Note: The minimum charge for all types of line advertising is equivalent to 30 words per ad. Purchase orders will be accepted subject to credit approval. For orders requiring prepayment, we accept payment via Visa, MasterCard, and American Express for your convenience, or a check. All classified line ads are subject to the consistency guidelines of NEJM.

How to Advertise

All orders, cancellations, and changes must be received in writing. Email your advertisement to us at ads@nejmcareercenter.com, or fax it to 781-893-1053 or 781-893-5003. We will contact you to confirm your order. Our clos- ing date is typically the Friday 20 days prior to publication date; however, please consult our reply box rate card online at nejmcareercenter.com or contact the Classified Advertising Department at 1-888-643-6991. Be sure to tell us the classification heading you would like your ad to appear under (see listings above). If no classification is offered, we will determine the most appropriate classification. Cancellations must be made 20 days prior to publication date. Send all advertisements to the address listed below.

Contact Information

Classified Advertising

The New England Journal of Medicine
800 Winter Street, Waltham, MA 02451-1412
Email: ads@nejmcareercenter.com
Fax: 1-781-893-5003
Phone: 1-888-643-6991
Phone: 1-781-893-3800
Website: nejmcareercenter.com

How to Calculate the Cost of Your Ad

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

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

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

MEDICAL DIRECTOR — A dynamic, growth-oriented family health care company is looking for a full-time Medical Director in greater New York. Ideal candidate should be board certified in internal medicine with subspecialties in oncology or gastroenterology. Willing to visit patients at home. Good verbal and written skills required. Attractive salary and benefits. Send CV and email address to NEJM. This advertisement is 56 words. At $9.95 per word, it equals $537.20. This amount would be placed under the Chiefs/Directors/Department Heads classification.

Classified Ads Online

Advertisers may choose to have their classified line and display advertisements placed on NEJM CareerCenter for a fee. The web fee for line ads is $12.00 per issue per advertisement and $200.00 per issue per advertisement for display ads. The ads will run online for two weeks prior to their appearance in print and one week after the print publication date. For online-only recruitment advertising, please visit nejmcareercenter.com for more information, or call 1-800-654-6991.

Policy on Recruitment Ad

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

As a civilian physician with the Defense Health Agency, you ensure that those who serve our country get the quality care they need and deserve. That’s why you become a doctor to care for people and have a meaningful career. If you’re ready for a job that gives you the work-life balance you need with all the benefits you deserve, then discover the opportunities waiting for you at the Defense Health Agency.

- COMPETITIVE SALARY
- GENEROUS PAIN-TIME OFF
- RECRUITMENT BONUSES
- FLEXIBLE SCHEDULES
- JOB SECURITY
- SUPPORTIVE WORK ENVIRONMENT
- WORLDWIDE LOCATIONS

We offer what matters most.

HEROES CARING FOR HEROES

Be seen as a person, not just a solution to COVID

With everything going on, it’s easy to become a faceless cog in the machine of healthcare. If you’re looking to reconnect with your passion for medicine, we can help you find the perfect job that’s tailored to who you are, not just what you are.

From locum tenens to permanent placements, let’s find the change that’s right for you.

comphealth.com | 844.217.9193

Visit NEJMCareerCenter.org.

Greater Boston – Primary Care
Internal Medicine/Family Medicine

Atrius Health, a well-established, physician-led, nonprofit multispecialty group practice, is nationally recognized for transforming healthcare through clinical innovations and quality improvement. At Atrius Health, we are working together to leverage technology to develop best practices. Our organization is renowned for providing exceptional value based care to our patients in over 30 practices in eastern Massachusetts.

We are an affiliate of Harvard Medical School/Tufts University School of Medicine and offer both teaching and research opportunities through our Academic Institute. You would be joining a practice of compassionate colleagues who provide outstanding, evidenced based, preventive medicine in a collaborative, team environment.

We are expanding primary care and have multiple opportunities at most of our practices. These positions are outpatient only, minimal call, 1:1 MA support, and have staff embedded in our primary care model to manage our most complex patients. Our organization recognizes the importance of primary care and it has been in the forefront of our mission; prominent in all of our strategic initiatives and robustly staffed.

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

Opportunities exist across NH, VT and NY including:
• Concord, NH
• Keene, NH
• Lebanon, NH
• Manchester, VT
• Pownal, VT
• Hoosick Falls, NY
• Windsor, VT
• Manchester, VT
• New London, NH

Dartmouth-Hitchcock offers an exceptional compensation and benefits package that includes vacation, CME allowance and relocation assistance. Academic rank at the Geisel School of Medicine at Dartmouth may be commensurate with experience.

Dartmouth-Hitchcock is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, veteran status, gender identity or expression, or any other characteristic protected by law.

Find your next locum tenens assignment today!
Visit NEJMCareerCenter.org.

Visit www.atriushealthproviders.org, or send confidential CV to: Laura Schofield 275 Grove Street, Suite 3-300, Newton, MA 02466-2275
E-mail: Laura_Schofield@atriushealth.org

THE PRIMARY CARE CAREERS

Locum Tenens Jobs at NEJM CareerCenter

Find your next locum tenens assignment today!
Visit NEJMCareerCenter.org.
Baystate Health (BH) is Western Massachusetts’s premier healthcare provider and home to the University of Massachusetts Medical School—Baystate.

At Baystate Health we know that treating one another with dignity and equity is what elevates respect for our patients and staff. It makes us not just an organization, but also a community where you belong. It is how we advance the care and enhance the lives of all people.

ChooseBaystateHealth.org

**Baystate Health offers:**

- Supportive Work Environment
  - Nurse Triage - Daytime, Nighttime, first call after hours & weekends
  - Scrubs
  - 1:1 Medical Assistant
  - Direct access to a large multispecialty group including Behavioral Health network integration
  - Lab and practice specialty scheduler onsite
  - State of the art EHR system with technology support

- Work Life Balance
  - Flexible work schedules
  - Full time 4 day work week

- Built in administration time and ramp-up time for new physicians
- Very reasonable patient volume expectations

- Academic & Nonacademic Positions
  - Faculty appointments UMass school of medicine (dependent on practice setting)

- Outstanding Benefits Package
  - Up to $4500 sign-on bonus (paid within first 30 days of EMPLOYMENT); specific dollar amount will be dependent on experience & site of employment
  - Generous compensation package
  - CME Allowance and time, high quality, low cost medical/dental, robust paid time off

**FOR SOME ELITE SOLDIERS, THIS IS ADVANCING.**

As a general surgeon and officer on the U.S. Army health care team, you will work in cutting-edge facilities as you see and study cases that are not usually encountered in civilian practices. You will also receive benefits that ensure you are taken care of, including student loan repayment programs, paid continuing education, retirement plans and much more. Joining this team will allow you to advance your career and focus on why you became a physician in the first place—to care for your patients.

To see the benefits of being an Army medical professional call 800-431-6717 or visit healthcare.goarmy.com/rapl6

**ChooseBaystateHealth.org**
Primary Care
Internal Medicine • Family Medicine • Urgent Care Medicine
Join Billings Clinic at one of our beautiful locations! Montana’s largest health system offers a collegial network of regional physicians and strong multi-specialty support.

Stipend and generous loan repayment
- Leadership & teaching opportunities
- Virtual care, specialty outreach clinics, telemedicine
- On-site lab and radiology
- Mayo Clinic Care Network provides clinical resources and direct access to Mayo Clinic specialists
- In Montana, you’ll find extraordinary outdoor recreation, friendly communities, excellent schools, and abundant family activities.
Four seasons of sunshine!

Contact: Billings Clinic Physician Recruitment
E-mail: physicianrecruiter@billingsclinic.org
billingsclinic.com/physicianopportunities

Even the Opportunities are Sunnier
The region’s largest and most comprehensive primary care network, located one of the nation’s most sought after destinations, is seeking FAMILY MEDICINE PHYSICIANS.

Baptist Primary Care is a hospital affiliated physician group and an integral component of the Baptist Health system, ranking highest in the categories of best doctors, best nurses, best quality and best reputation.

World-Famous Quality of Life and Regional Appeal
Northeast Florida serves as home to some of the Sunshine State’s best cost of living and the nation’s most sought after quality of life.
- Top ranked schools
- No state income tax
- Recently ranked by Forbes Magazine as the second most desirable city for relocation in the United States

Ideal Place to Practice
- Physician and patient-centric organization
- Work-life balance
- Financially and structurally strong
- Robust hospitalist team providing 24/7 extension of your care

Interested to learn more? Call 904.376.3727 or email your CV to PhysicianCareers@bmcjax.com.

What Kind of Doctor Works in Corrections? Doctors Just Like You.

JOIN DOCTORS JUST LIKE YOU IN ONE OF THESE LOCATIONS:
- California Correctional Center – Susanville
- Mule Creek State Prison – Ione*
- Pelican Bay State Prison – Crescent City
- Salinas Valley State Prison (Psychiatric Inpatient Program) – Soledad*
- Doctors at these institutions receive 15% additional pay.

CCCHCS OFFERS A COMPETITIVE COMPENSATION PACKAGE, INCLUDING:
- 40-hour workweek (affords you true work-life balance)
- Generous paid time off and holiday schedule
- State of California retirement that vests in 5 years (visit CalPERS.ca.gov for retirement formulas)
- Robust 401A and 457 savings plans (tax deferred up to $39,000 – $52,000 per year)
- Paid CME, with paid time off to attend
- Paid Insurance, license, and DEA renewal
- And much more

The answer: Weatherby Healthcare.
Northeastern Vermont Regional Hospital is proud to offer you the chance to enhance your passion and live your dreams in an encouraging & supportive environment!

We are currently recruiting PRIMARY CARE PHYSICIANS in Family Medicine to join our hospital-owned group. New grads are welcome and encouraged to apply. NO nights or weekends!

Excellent specialty support - Urology, Women’s Health, Neurology, Cardiology, Orthopaedics just to name a few!

NVRH offers a competitive salary and a generous benefits package including student loan reimbursement, 401k, relocation reimbursement, CME, medical/dental/vision, membership to local gyms, and more!

Please contact Heather Spinney:
802-748-7312
h.spinney@nvrh.org

To learn more about physician jobs, email CAREERS AT NVRH.

THE UNIVERSITY OF NEW MEXICO
Department of Surgery, Division of Pediatric Surgery

The Department of Surgery, Division of Pediatric Surgery, at the University of New Mexico (UNM), is recruiting a Pediatric Surgeon. UNM is the tertiary referral center for the entire state of New Mexico and also attracts patients from neighboring states as well. UNMH has 6,296 bed for adult, pediatric and psychiatric care. There were 9,060 ED visits, 2,500 trauma admissions (3,280 at the highest activation level, with >20% penetrating trauma), and 16,040 surgical procedures. This position is being recruited at open rank.

This is an excellent opportunity for a pediatric surgeon interested in an academic practice with a wide range of clinical opportunities. Research opportunities are readily available. Appointment and salary will be commensurate with level of experience.

Minimum Qualifications:
- Candidate must be board-certified/eligible in Pediatric Surgery
- Eligible for licensure in New Mexico

Preferred Qualifications:
- Academic experience
- Experience in minimally invasive surgery
- Experience in Pediatric trauma surgery

Interested applicants must apply for this position via UNM’s website, www.jobs.unm.edu, Posting #41397. Please attach a current CV and letter of interest to the application.

For more information please contact David Lemson, M.D., at dlemson@salud.unm.edu

The UNM School of Medicine is an Equal Opportunity/Affirmative Action Employer and Educator. This position may be subject to criminal records screening in accordance with New Mexico state law. UNM is an EEO/AA employer, “Prohibits Discrimination due to Disability or Status as a Protected Veteran.” UNM Board of Regents’ Policy Manual 6.7, which includes information about public disclosure of information about personnel, is located at www.unm.edu/docal.mo.../reg601.pdf

South County Health We’re Growing!
South County Medical Group – Family Medicine

We are currently seeking a Family Medicine Physician to join these other providers at our primary care practice in our East Greenwich Medical & Wellness Center.

Our new physician will see patients within a patient-centered medical home model offering strong collaboration with a pharmacist and nurse case manager to support high-risk patient populations. The center allows our physicians to coordinate care with specialists within the group, which includes cardiology, nephrology, and general surgery. Practice patients include children, adolescents, and adults. We support specialty services including endoscopy, breast surgery, urology, ENT, dermatology, and extended care centers in our own building. You may be wondering what locum tenens can do for your career. Quite a lot, actually. Especially if you’ve been overworked. Or underworked. It even works out for physicians who have been medium-worked. All in all, you’ll be surprised what locum tenens can do for you.

You may be wondering what locum tenens can do for your career. Quite a lot, actually. Especially if you’ve been overworked. Or underworked. It even works out for physicians who have been medium-worked. All in all, you’ll be surprised what locum tenens can do for you.

Even healthy careers can be revived with locum tenens.

To learn more about physician jobs, email prpsearch@theusoncology.com

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South County Health We’re Growing!
South County Medical Group – Family Medicine

South County Health is an Equal Opportunity Employer.
Email: mbailey@southcountyhealth.org

PHYSICIAN CAREERS AT
The US Oncology Network

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

To learn more about physician jobs, email prpsearch@theusoncology.com

The US Oncology Network
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New name, new look, more opportunity.

For over 30 years, Cross Country Search (formerly Cejka Physician Search) has served as a trusted recruitment partner to thousands of healthcare organizations. Now, with even more resources, we continue to work with the country’s leading healthcare systems, hospitals, single and multi-specialty medical groups, managed care and more.

Whether you're looking to further your career, explore new cities or just finishing up your residency, or fellowship training, let Cross Country Search open the door to the healthcare’s best physician and APP opportunities.

We're ready to match your expertise to the ideal job today. Visit us at crosscountrysearch.com or give us a call at 800.678.7858.

New name, new look, more opportunity.

Hartford HealthCare offers first-class Primary Care opportunities located in state-of-the-art, multi-provider, multi-specialty facilities throughout Connecticut.

Our primary care positions offer:

- **Flexibility** – no weekends, no eves, 4 day work week options and infrequent call
- **Support** – New Physician Orientation and Mentorship Program
- **Stability** – Loan repayment support, market-leading compensation and benefits
- **Care continuity** – Our network includes one of the largest, physician-led, multi-specialty medical groups in New England, a vast Behavioral Health Network, and seven acute care hospitals
- **Operational excellence** – EPIC electronic medical record and robust support staffing

This all means MORE OPTIONS to propel your career to new heights and all within a deeply embedded culture of inclusion, innovation, and focus on the highest quality of care.

Located within two hours of Boston and New York City, Connecticut offers a lifestyle that is second to none. Enjoy some of the finest schools in the nation, four beautiful seasons of recreation, and options to live at the shore, in leafy suburbs, or in vibrant urban areas.

Get MORE from your Primary Care career with Hartford HealthCare.

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

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

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

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

**Emerson Hospital Opportunities**

- Cardiology
- General Surgery
- Internal Medicine – Outpatient Practice
- Neurology
- Nocturnist

If you would like more information please contact:

Diane Forte Willis
dfortewillis@emersonhosp.org
phone: 978-287-3002
fax: 978-287-3600
Cambridge Health Alliance (CHA) is an award-winning health system based in Cambridge, Somerville, and Boston’s neighborhoods. We provide compassionate, skillful, and safe care to our diverse patient population through our established network of outpatient clinics, two full-service hospitals and urgent care center. As a Harvard Medical School and Tufts University School of Medicine affiliate, we offer ample teaching opportunities for medical students and residents. We utilize fully integrated EHR and other competitive compensation packages and comprehensive benefits for our employees and their families.

CHA is committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment

We are currently recruiting for the following departments and positions:

- **Psychiatry**
  - Chief, Department of Pediatrics
  - Division Chief, Child & Adolescent Psychiatry
  - Division Chief, Geriatric Psychiatry
  - Director, Adult/Inpatient Psychiatry
  - Medical Director, Outpatient Psychiatry
  - Urology
  - Vascular Surgery
  - Neurology
  - Hospitalist/Outpatient
  - Pulmonary/Critical Care
  - Endocrinology
  - Physician Assistant
  - Primary Care
  - Internal Medicine
  - Family Medicine
  - Pediatrics
  - Emergency

To apply please visit www.CHAHealthProviders.org. Candidates may submit CV confidentially via email to ProviderRecruiter@hbanus.org

CHA Provider Recruitment: Tel: 617-665-3555/Fax: 617-665-0033

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

Job Description
This position provides major support for University of Toledo College of Medicine’s strategy to become the regional market leader in state-of-the-art and innovative cancer services in Northwestern Ohio and Southeast Michigan. The Division Chief of Hematology and Oncology will be responsible for all academic and clinical programs related to medical oncology and hematology and will be a key member of the Division of Hematology/Oncology at the University of Toledo College of Medicine.

Academically, the Division Chief will be responsible for all the educational programs relating to Hematology and Medical Oncology, including medical education for preclinical and clinical undergraduate, and residency and fellowship graduate programs. The Chief will be expected to significantly expand the number of Phase I/II clinical trials. The Chief will also be expected to develop an independent, externally funded clinical/translational or laboratory research program in an area of their choosing. Further, the Chief will create a fertile environment that facilitates the expansion of research within the Division, as well as collaboration with other Divisions and Departments, for example Cancer Biology, Surgery, and Radiation Oncology.

Clinically, the Chief is expected to continue building a market leading, next-generation academic, patient-centered hematology-oncology program, across multiple regional sites and in cooperation with multiple independent health care systems. In this role, the Chief will be responsible for directing physician, nurse practitioner, and other clinical services within the Division of Hematology/Oncology as well as developing associated services and recruiting clinical professionals for all clinical service locations. This individual will maintain a clinical practice to complement their leadership duties.

The successful candidate will have an MD or DO degree from an accredited school of medicine and be Board-Certified in Medical Oncology and/or Hematology. It is also necessary to currently be licensed to practice medicine in the United States and to be in good standing with the medical board(s) in all states which issued license to practice medicine.

Prior experience in a successful clinical practice having a strong patient-centered focus is required. Also required is a verifiable record at the highest standards of medical practice in Hematology-Oncology, accomplishment in hematology and medical oncology education development for medical students, residents, and fellows, and leadership and relationship-building skills. Proven success with recruitment and management of Phase I and II clinical trials is a high priority. A proven track record of success as an independent investigator and a physician scientist is desirable. The Chief will report to and be expected to work with the Chair of the Department of Medicine in faculty and ancillary staff recruitment, strategic planning, and business plan development.

For further information, please contact:
Dr. Juan Jaume/Chair, Search Committee
Department of Medicine/University of Toledo
3000 Arlington Ave./MS 1186/Toledo, OH 43614
Telephone: 419-383-3707/Email: Juan.Jaume@utoledo.edu

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At SSM Health, clinical excellence is the inevitable result of brilliant minds and compassionate providers working together with a shared purpose. We have become a preferred destination for visionary leaders and talented clinicians seeking to practice in an inclusive culture — unified by a purposeful and healing Mission — to advance medicine and healing to the communities we serve. Here, we empower compassionate hearts and brilliant minds to pursue medical advancements that will transform health care. With our unwavering clinical drive, dedication to diversity, and shared commitment to reveal the healing power of God, there are no limits to what we can achieve.

Join the healing ministry of SSM Health and discover what practicing with purpose can mean for your career.

To learn more, visit JoinSSMHealth.com