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The latest physician jobs brought to you by the NEJM CareerCenter
Dear Physician:

As a 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 is the leading source of information about 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 of NEJMCareerCenter.org.

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Jeffrey M. Drazen, MD

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Demystifying Urban Versus Rural Physician Compensation

Salary Differences Are Minimal, but Incentives and Perks Might Make Rural Opportunities More Attractive

By Bonnie Darves

In physician recruiting, the basic principle of supply and demand has always been a contributing factor in the ultimate compensation package that job-seeking physicians are offered; and the prevailing thinking is that the harder it is to recruit to a location, the more likely it is that newly trained physicians who accept opportunities there will earn more than their urban counterparts.

Even though that might be the case for some opportunities in rural areas — defined variably in the market as either a population of 20,000 or fewer or up to 50,000 and fewer — it’s not that straightforward. And where a differential does exist that positions a rural practice opportunity as more financially lucrative than a comparable urban one, the compensation difference might not be a significant as some young physicians think. Recruiting professionals and consultants who help organizations structure physicians’ compensation packages concur that while physicians who consider rural opportunities will surely be wooed, welcomed, and financially accommodated to the extent that hiring organizations are able, they shouldn’t expect a bonanza.

In other words, urban myths — that physicians who take a rural opportunity in the Plains region will start out earning 25 to 30 percent more annually than their colleagues in Chicago are just that: myths. The reality, according to Patrice Streicher, senior operations manager in Vista Staffing’s permanent search division, is that the difference will be more in the neighborhood of 5 to 10 percent. “I can say on the record that, based on what we’re seeing, the difference will be minimal — maybe 10 percent at the most — between compensation in a rural versus urban or mid-sized community.” And the salary component of the offer is pretty much the same, regardless of the location, said Ms. Streicher, a National Association of Physician Recruiters board member.

“There are certainly differences in terms of how compensation is set,” said Ms. Streicher. “Five years ago, the rural offers might have had much higher salaries and different structures than urban ones, but with the growth of telemedicine and other market developments, that’s no longer the case,” she said.
Survey data from the American Medical Group Association (AMGA) supports Ms. Streicher’s contention, according to Wayne Hartley, MHA, growth and service line development officer for AMGA’s consulting organization and a longtime physician compensation consultant. “It’s not like physicians are getting paid 30 percent more in rural areas,” he said. “It’s more like 5 to 10 percent.”

Tony Stajduhar, president of Jackson Physician Search in Alpharetta, Georgia, which places approximately 40 percent of its candidates in rural practice opportunities, said that his company’s recent data found a difference of an additional 9 to 10 percent in salaries in rural compared to urban starting compensation offers. (His firm defines rural as a population of 20,000 or fewer.) “Some of the survey data shows a differential closer to 5 percent, but we’re seeing about 10 percent, and in some specialties, slightly more than that depending on the community and circumstances,” Mr. Stajduhar said.

He added that rural practicing physicians often have an earnings advantage ultimately over their city colleagues because of a factor that few young physicians consider — the payer mix and associated reimbursement rates. “The payer mix is often better in rural areas because insurers have less leverage there than in urban areas,” he said, that are well supplied with physicians. “This can make a real difference over time.”

Ken Hertz, a principal consultant with the Medical Group Management Association (MGMA), cautions young physicians to avoid being enticed primarily by offers of much higher earnings. “If it sounds too good to be true, it probably is,” he said. “And it’s far more important to take a position because it interests you and you want to be in the community — to build your practice with less competition and to serve that community. The reality is that you’re not going to become a millionaire in three years just because you chose a rural opportunity over an urban one.”

Data extracted from MGMA’s recent national compensation survey showed only minor differences in first-year primary care physicians’ guaranteed compensation for non-metropolitan areas and urban ones — a median of $205,588 in smaller areas versus $200,000 in larger metropolitan ones. Physicians taking the non-urban positions received more generous relocation stipends than their counterparts, however. For surgical specialists as a group, the findings for the same two groups were surprising: first-year guaranteed compensation median was $250,000 in non-metro areas and $320,000 in urban ones. Mr. Hertz noted, however, that because rural practicing specialists have little competition, their earnings might outstrip their urban counterparts’ compensation when productivity structures come into play in subsequent years.

**Incentives enrich rural offers**

The relatively minimal salary difference is hardly dire news, however, for physicians who are exploring rural opportunities. Where they are likely to fare better financially than those pursuing urban opportunities is in the realm of incentives. Ms. Streicher reported that she has seen signing bonuses for non-urban opportunities as high as $100,000 — particularly for primary care positions. “There is not a plethora of these, but they do exist. And I recently encountered a candidate who received multiple six-figure signing bonus offers.” The point, she said, is that rural communities have “more motivation and eagerness to offer signing bonuses, better relocation packages, or other incentives. They’re going to offer those bells and whistles above and beyond what you’ll see in some urban settings.”

The other common area where incentives enrich a starting offer in rural locations is education loan repayment. A secondary analysis of data from the 2018 AMGA Medical Group Compensation and Productivity Survey found that for primary care packages in rural areas, the median loan forgiveness amount offered primary care physicians was $75,000 and the 75th percentile was $100,000. Mr. Hartley cautions that the sample size is small but that based on his consulting experience, such amounts are not uncommon. He also reminds young physicians that any such incentives are generally retention bonuses.

“These dollars are typically linked to a term of service of three to five years, and there are ‘claw-back’ [required repayment] provisions if the term of service is not completed,” Mr. Hartley said. “And as with any contract, all types of recruitment incentives should undergo legal counsel review.”

Ms. Streicher also cautions physicians to thoroughly understand the structure of any incentive they’re offered, as in most cases, there are strings attached. “The signing bonus is usually a retention bonus, and if the physician leaves soon after joining, she’ll likely have to pay it back.” The other consideration, she added, is that leaving an opportunity after just a year or 18 months — when an organization has invested substantially to bring in the physician — doesn’t work out well for anyone involved. “Remember that you’re building a career — your CV is a reputation that you should hold in high regard.”
One financial benefit worth considering, Mr. Stajduhar points out, is that rural locations typically offer a far lower cost of living than urban ones, and the funds saved because of lower housing costs can position prudent young physicians well financially over time. “When I’m speaking to groups of residents, to illustrate this I’ll often compare Atlanta living costs to rural area costs — a house for $400,000 in a rural area might be mansion compared to the fixer-upper that $400,000 will buy in the city,” he said. “That, combined with the fact that a lot of rural employers are willing to help younger physicians with loan repayments, can make a real difference financially over several years.”

All sources mentioned an important reminder about why there’s no such thing as “the sky’s the limit” in rural offers. For one, numerous state and federal laws govern how much hiring health care entities can pay incoming physicians — in salaries and incentives — and all compensation structures must meet the standard for fair market value. In addition, in this age of information transparency, organizations simply cannot (and most would not, for political and ethical reasons) offer incoming physicians a higher salary than their same-specialty colleagues already practicing there.

**Comparing rural areas’ compensation structures**

There is insufficient survey data to determine just where in the country rural offers will be the most financially attractive because samples are small and factors such as the employer’s stability and market position, the payer dynamics, and even the Medicare and Medicaid reimbursement rates may affect the compensation employers offer. All sources concurred, however, that the most lucrative offers are likely to come from rural areas that have historically had great difficulty attracting physicians.

Overall, the 2018 Medscape Physician Compensation Report bears out the regional compensation differences and alludes to the rural added salary differential that physicians newly trained physicians might see in rural offers. Across all specialties, median physician compensation in the North Central region, which includes a lot of rural areas, was $319,000, compared to $275,000 in the far more densely populated Northeast region.

Travis Singleton, executive vice president at the national recruiting firm Merritt Hawkins, notes that payer mix and market conditions account for physician compensation differences to the same extent that location might affect earnings. “The Midwest, the Southeast, and Texas have long been bastions of fee-for-service medicine, which has kept physician incomes relatively high in those areas — which also include a preponderance of rural areas,” he said. He added that these areas typically must pay more to attract physicians. “And since there is less competition among physicians in these areas, their earning potential often is higher than in urban settings,” he said.

Nonetheless, at the hiring juncture, the salary and incentives that different rural locations offer are determined primarily by a factor outside the employer’s control, Mr. Singleton observed. “I wish I could say there’s a complicated algorithm that drives compensation differences that can be calculated and adjusted for, but it’s far simpler: supply and demand,” he said. More physicians want larger, metropolitan areas, putting rural areas at a disadvantage from the start with fewer candidates to pursue. Merritt Hawkins’ recent Survey of Final Year Residents found that only three percent of residents completing their training would prefer to practice in a community of 25,000 people or less. “That causes rural facilities to ‘up the ante’ in compensation,” he said, which historically, has meant 10 to 15 percent higher starting salaries and higher signing bonuses.

Further, like Ms. Streicher, Mr. Singleton has observed that variation among compensation structures is lessening regardless of where the opportunity is offered. Given the consolidation and commoditization in medicine, he said, there isn’t as much variation in compensation and contract structures as there used to be. “Perhaps one myth now is that physicians can heavily negotiate contracts with large integrated health systems,” he said. The chance that a large system will substantively amend a contract to accommodate one physician when they employ thousands, he added, “is relatively small,” he said. “However, there is still some wiggle room when it comes to schedule, and sometimes smaller, rural facilities have more latitude to tailor compensation and practice parameters to a candidate’s needs.”

**Negotiating room might exist in non-monetary perks**

Several sources mentioned that rural employers are both amenable to accommodating incoming physicians’ schedule-flexibility requests and lifestyle considerations where feasible, and some have figured out that marketing of those perks can increase the candidate pool for hard-to-fill positions. Ms. Streicher cites an organization in rural Maine that successfully enticed a highly qualified young psychiatrist by creating a creative schedule. The position is structured so that the psychiatrist works onsite part of the time and treats patients using telemedicine the rest of the
time, allowing greater schedule flexibility. “Technology may offer a real explosion of possibilities in candidates that rural organizations might not have seen otherwise,” she said.

Mr. Hartley cited the example of a rural community that needs a general surgeon but doesn’t have enough volume to keep the physician busy full-time. “Because the hospital might not be able to recruit a part-time surgeon, they might have to hire an FTE [full-time equivalent]. In that case the surgeon might be able to earn median compensation for part-time work,” he said, “even if the schedule includes a lot of call.”

Mr. Hertz points to other potential lifestyle benefits that young physicians who are outdoors enthusiasts or want more time with family — a growing number today cite just such preferences — might find in rural settings. There’s usually no traffic to contend with and the commute might be nonexistent, he said, and proximity to nature can be a draw. He cites the case of a young physician who practices in rural Montana and is a mere 10 minutes from skiing. “She often skis in the morning before coming to work,” he said, and she is able to arrange her schedule so that she can occasionally pop out to compete in a competition during the workday.

Another potential benefit to the smaller setting is the flexibility, for surgeons and primary care physicians, to pursue professional interests in a far less crowded and competitive environment. “It’s like the difference in working in a big versus a small company. In the latter case, you can carve out your niche and pursue your specific interests and wear a lot of different hats without stepping on colleagues’ toes,” Ms. Streicher said. “You can bring a real entrepreneurial spirit to a rural community if you bring a talent and expertise they don’t have. Besides, you get to build your practice on someone else’s dime.”

Finally, physicians who accept offers in rural settings usually find a rather large welcome mat and a willingness to go out of their way to help physicians and their families settle in. “If you're willing to make a commitment, there are places that will make an investment in you because it's really expensive to be reliant on locum tenens or deal with turnover,” Mr. Hartley said. “They have a vested interest in keeping you there.”

Creating a Physician CV That Shines

Simple format, brevity, and absolute accuracy — and avoiding including extraneous details — are musts.

By Bonnie Darves

Physician residents and fellows who start writing their curriculum vitae (CV) usually approach the task expecting that it will be a straightforward matter of letting the world know where they’ve been and what they’ve done, in a document that is about three pages in length. In theory, that’s about right. In practice, however, many young physicians, especially those about to launch their first job search, quickly find themselves sweating the details. They wrestle with how much detail to include and how to structure their CV as the selling tool they intend it to be: a document that sets them apart from the crowd.

Fretting a bit about getting it right is not a bad thing, say recruiters and physicians who are on the receiving end and who review scores of CVs each year. Too often, young physicians don’t take the time to ensure that their CV is not only polished and error-free, but also an accurate reflection of important accomplishments that prospective employers care about.

John D. “Jack” Buckley, MD, vice chair for education in the department of medicine at Indiana University School of Medicine, frequently encounters CVs that leave out the kinds of details that might be differentiators: committee work, quality-improvement initiative involvement, medical student teaching or mentoring, or even assistance on a hospital IT project.

“Ideally, everything that is on your work calendar should be on your CV, and there should be a brief description and timeline of those roles or assignments,” said Dr. Buckley. In his experience, residents usually include their research work but sometimes leave out these kinds of quasi-extracurricular activities, thus missing an opportunity to demonstrate their willingness to go above and beyond what's required of them.

Sapna Kuehl, MD, director of the internal medicine residency at Saint Agnes Healthcare in Baltimore, Maryland, also urges physicians to briefly describe their roles in committee, task force, or initiative work, and associated accomplishments. “People who are hiring physicians out of training are looking for evidence of dedication and persistence,” she said.

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Choosing a CV format is perhaps the easiest aspect of preparing a professional-looking CV. Examples abound online, and most training programs provide a recommended template for physicians seeking structure guidance. The basic content and suggested order of information appearance, for trainees seeking an initial practice opportunity, are as follows:

- **Name and contact information**
- **Education**, undergraduate through internships, residencies, and fellowships — including specific clinical roles and any leadership roles
- **Licensure** (status of applications planned or underway, if any)
- **Board certification or status**
- **Professional experience** (medicine-related only), including procedure and patient volumes, if applicable to the specialty, and administrative roles or duties
- **Activities and committee memberships**, including roles and brief descriptions of associated accomplishments
- **Honors, awards, and professional affiliations**
- **Publications and presentations**

All dated entries should be chronologically arranged on the page from present to past, in a month/year format. Physicians should be prepared to explain any gap of more than three months in a conversation or a cover letter, all sources agreed, and should never attempt to “fudge” or cover up a gap. “A gap can be a red flag to a recruiter, even if the reason is completely understandable,” said Laura Schofield, a recruiter with Boston-based Atrius Health, which employs approximately 950 physicians.

Christopher Shireman, who is chief executive officer of Western Neurosurgery Ltd., in Tucson, Arizona, and has vetted scores of physician candidates over his 20 years in health care leadership, expects physicians to explain any sizable timeline gaps in an accompanying cover letter, not in the body of the CV. “I had one candidate who had a one-year gap before medical school, who spent that year working in an emergency room. In another case, the candidate took off a year during training to take care of his dying mother,” Mr. Shireman said. “Most of the time, it’s just a matter of letting people know why there’s a gap.”

Regarding date and timeline entries, physicians should doublecheck all dates before finalizing the document and ensure that the CV is up to date, according to Jeffery Johns, MD, medical director of the Vanderbilt Stallworth Rehabilitation Hospital in Nashville, Tennessee. “It’s important that your CV is up to date as of the day you send it. If you have an entry that reads ‘2013–present,’ for example, ensure that’s correct,” said Dr. Johns. Failing to address such an important detail reflects poorly on the physician. “When I review CVs, I am looking for meticulous attention to detail.”

The CV should be rendered in a simple sans serif font in an easily readable font size — at least 11 or 12 points — and physicians should stick to a single font and size, and a very simple presentation format. “Remember that this is not an art contest,” Dr. Buckley said.

Brenda Reed, who is director of physician and medical staff recruitment at Atrius Health, considers a “busy” CV — one with several fonts or font sizes, or documents that contain graphics — not only annoying but also cause for mild suspicion. It can give the impression that the physician is trying too hard. “I have seen a beautiful CV hide a candidate who had serious performance issues or other problems, so I am a bit wary when I see a fancy CV,” she said.

In that same vein, Dr. Johns recommends that physicians who are preparing hard copies of their CVs to hand out at conferences or job fairs use a decent-quality paper stock — something slightly heavier than 20 lb. bond copier paper — but nothing dense, elaborate, or textured.

**Keep recipient in mind**

Rita Essaian, DM, MHA, executive administrator, human resources, at the Southern California Permanente Medical Group (SCPMG), which employs more than 9,000 physicians, stresses the importance of ensuring that the CV is error-free and professional in appearance. “The CV should be crisp, clean, and clearly written — no grammar or spelling errors — but also succinct,” Ms. Essaian said. SCPMG hired between 500 and 900 physicians annually in the past three years, and its recruiters receive more than 4,000 CVs in a given year, she explained. A recent cardiology position posting, for example, attracted 100 CVs. Given such volume, a physician whose CV is illegible, error-ridden, or difficult to follow might not make the first cut.

“Physicians should always have their CVs reviewed and proofread before sending them,” Ms. Essaian said. She added that potential candidates
reaching out about a particular posted position should also ensure that the CV and cover letter clearly indicate relevance to the position of interest. The recruiters who do the initial screening, she said, will first match CVs to posted opportunities, and also screen on the basis of criteria the department chief provides before forwarding CVs to reviewing physicians.

Dr. Buckley agreed. “Residents and fellows should always have someone they trust review their CV draft,” he said. Several sources recommended that trainees whose first language is not English should seek professional help crafting and polishing the document if such services are not readily available through their program.

Physicians should also pay attention to seemingly minor formatting details that, if not handled properly, could frustrate potential readers who review scores of CVs as part of their job. Page numbers and an identifying footer including the physician’s name should appear on all pages. Further, ensure that the document's file name isn't cryptic, urges Ms. Reed. “One of my pet peeves is when candidates send a perfectly lovely CV, but then name the file ‘myCV.’ Always think about how something will be received on the other end,” she said, because attachments can and do get separated from the email message. She and other sources gave their votes to file names that start with the physician's last name, followed by first name.

Finally, it's advisable to prepare the CV in PDF format. That's not a guarantee that the CV won't be altered by a recipient — unfortunately, this does happen, recruiters said. Using a PDF is a deterrent, at least, because someone who decides to alter the document for whatever reason would have to first go through the trouble of converting it to another file format.

**What to include, or possibly exclude**

Regarding information that should not be included in the physician CV, sources interviewed for this article had mixed opinions in some cases. Most sources advised against residents including a career statement or job objective at the top, below contact details. That information is usually more appropriate for a cover letter or accompanying email note, unless its inclusion in the CV is requested.

There might be exceptions, however, depending on the employer. The Permanente medical groups’ recruiters and physician reviewers appreciate seeing a brief opening statement in a CV, especially if the physician has been in practice for several years. “In those cases, we really like to see a half-page career summary on the first page,” Ms. Essaian said. Another reasonable exception, several sources acknowledged, might be for internal medicine physicians who know that they only want a hospitalist position, not an outpatient practice job.

Regarding whether cover letters or explanatory notes should be supplied with CVs, the general consensus was that doing so is usually helpful and is definitely in the category of “can’t hurt.” At the very least, the accompanying document provides an opportunity for the physician to state why she or he is interested in either the organization or a posted position.

Dr. Kuehl, who favors a brief personal statement or cover letter, advises that the document should be employer focused. “It shouldn’t be too ‘I’ focused,” she said. “It’s an opportunity to talk about what you would bring to the organization that might distinguish you from other candidates — such as work in population management, IT expertise, patient counseling skills, or practice improvement experience,” she said.

Ms. Essaian noted that her organization also likes to see evidence in the cover letter that the candidate has gone to the effort to learn something about Kaiser Permanente health plan and its medical groups, which are independent entities that care for health plan members.

Sources offered mixed opinions on whether to include test scores. The general consensus was that unless the scores are very high, such as 220 or higher on the USMLE, it’s best not to include them. Some recruiters and physicians favored a final section that lists personal interests and hobbies; others considered such detail extraneous. Ms. Essaian, for instance, said that her organization prefers not to see any personal details. Those who voted for including personal interests stressed the importance of employing brevity — two lines at most — and, of course, using good judgment in choosing what to reveal.

“I appreciate knowing a little bit about physician candidates’ interests — if they like hiking or snorkeling or skiing, for example, because that often helps with icebreakers and gives me a sense of who they are,” said Ms. Reed.

In the hobbies category, short-and-sweet is a must, according to Janet Jokela, MD, MPH, acting regional dean at the University of Illinois College of Medicine at Urbana. “I counsel residents that they don’t need to include their interests. But if they do, it should be a simple, short list,
separated by commas, with no explanatory detail,” she said. “A resident who once asked me to review his CV draft had included three sentences on his basement home-brewing operation—not advisable.”

Mr. Shireman, who has reviewed numerous physician specialists’ CVs, appreciates knowing about candidates’ personal interests for the same reason Ms. Reed cites. “Especially in an intense field like neurosurgery, I want to see that information—just a line or two—because it shows me they’re human and that they have a life outside of medicine,” he said.

The issue of whether to include a photo elicited varying responses, but most sources advised against including one—and definitely not embedded in the CV document—unless a photo is requested. “There is always the possibility of unconscious bias, so I think it’s best to avoid including one,” Dr. Buckley said. Ms. Schofield noted that some training programs encourage their international medical graduates to send photos and that some hospitals seeking candidates may require them, though she herself opposes the idea.

It should go without saying that physicians should never inflate, embellish, or mischaracterize their achievements in an attempt to give a better impression. Besides being dishonest, such tactics are likely to backfire at some point, with potentially career-damaging repercussions. “Honesty and complete accuracy are the most important aspects of a CV. Physicians should never inflate anything,” Dr. Jokela said.

Sources agreed that physicians should keep to the standard order of information appearance while attempting to position potentially distinguishing details on the first page, if possible. “Residents and fellows who have received awards or special recognition should consider moving up that information so that it appears on the first page, if it’s not too awkward to do so,” said Dr. Jokela. At the very least, she added, important awards shouldn’t be buried at the bottom of the document.

There appears to be general agreement that the following information generally should not be included on the physician CV, under most circumstances:

- **Birthdates, Social Security numbers, and any other official identification number.** These should be excluded for both security and bias-avoidance reasons.

- **Marital status.** This detail falls under the category of extraneous information, all sources agreed. Besides, if a candidate proceeds to a site interview or even a formal pre-interview call, that detail will likely emerge in the context of a conversation, even though recruiters and individuals involved in hiring are prohibited by law from asking for such information.

**References.** Including references before they’ve been requested can give a recipient the wrong impression. And besides, Mr. Shireman points out, references usually won’t be checked until a candidate has completed a site interview and the organization is considering setting a second site interview or drafting an offer. “Listing references before they’re asked for can make it look like you’re trying too hard,” he said.

**Extensive publication details.** Ideally, the publication citations should include only the basic details—the article author(s), title, and journal name and publication date.

**Conference attendance.** Several sources mentioned that they have occasionally received residents’ CVs that list conferences attended. This isn’t an important detail, except in cases when the resident gave a presentation or talk at the conference. That information would go under the category of invited speeches/presentations, below publications.

**CV length and ‘version control’**

The ideal length for a physician CV varies depending on the individual and the type of position being sought. In most cases, residents’ CVs can and should be rendered in a few pages (three or fewer) unless the trainee happens to have an unusually extensive research or publishing history.

Most sources thought that a single CV version should suffice in most cases, but several noted that there might be situations that warrant creating a short and long version. Physicians seeking a research position, for instance, might create a short version including the basics and a longer version detailing their research interests and accomplishments, and then offer recipients the opportunity to receive the longer one. Likewise, physicians seeking an administrative position or one in which special skills in health care IT are a plus, for example, might craft an additional document or addendum that describes their related experience.

“In most cases, a longer-version CV is really more appropriate for senior faculty members than for young physicians,” Dr. Jokela said.
Clinical Practice

Obstructive Sleep Apnea in Adults

Siegfried C. Veesey, M.D., and Ilene M. Rosen, M.D., M.S.C.E.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various categories is then presented, followed by a review of formal guidelines, when they exist. The article ends with the authors’ clinical recommendations.

A 56-year-old woman reports fatigue and sleepiness. Despite sleeping 7 to 8 hours nightly, she wakes unrefreshed. She has been told by her husband that she snores. She awakens nightly to urinate and typically falls promptly back to sleep. Recently, she has noted sleepiness while driving home from work. Her medical history includes obesity, hypertension, and type 2 diabetes mellitus. Her physical examination is notable for a body-mass index (BMI, the weight in kilograms divided by the square of the height in meters) of 35 and a large tongue partially obscuring the soft palate. How would you evaluate and treat this patient?

The Clinical Problem

Obstructive sleep apnea is characterized by episodic sleep-state-dependent collapse of the upper airway, resulting in periodic reductions or cessations in ventilation, with consequent hypoxia, hypercapnia, or arousals from sleep. Many patients are unaware that their breathing is affected and may not visit a physician for evaluation. In addition, patients may not consider sleepiness a relevant topic to discuss with health-care providers. Yet, the prevalence of obstructive sleep apnea is conservatively estimated to be 3% among women and 9% among men 50 to 70 years of age,2 including an estimated 24 million persons in the United States who have not received a diagnosis.

Risk factors for the disease are conditions that reduce the size of the resting pharynx or increase airway collapsibility. Obesity is the most important risk factor for obstructive sleep apnea.3 Increased adipose tissue within the tongue and pharynx compromises upper-airway dimensions and makes the airway more prone to collapse during sleep. Obstructive sleep apnea has been reported to be present in more than 40% of persons with a BMI of more than 30 and in 60% of persons with metabolic syndrome.4 Male sex is another important risk factor, although the scientific bases for the differences between sexes are unknown. Progesterone stimulation of upper-airway muscles and ventilation may contribute to the lower prevalence of obstructive sleep apnea among premenopausal women than among older women, whereas higher androgen levels (e.g., as with use of androgen supplementation and polycystic ovarian disease) may increase muscle mass in the tongue and worsen obstructive sleep apnea.5,6 The prevalence of obstructive sleep apnea is also substantially increased among persons with hypothyroidism or acromegaly.7,8 Increased tonsillar and adenoid tissue and certain craniofacial abnor-

malities (retrognathia and maxillary insufficiency) may also confer a predisposition to obstructive sleep apnea.9

Strategies and Evidence

The clinical approach to patients with obstructive sleep apnea should begin with an assessment of the likelihood of the disease, symptomatology, and relevant coexisting conditions in order to direct diagnostic testing. Once a diagnosis is made, treatment is guided by the severity of disease, symptoms, coexisting conditions, and the presence of exacerbating factors.

Evaluation

Obstructive sleep apnea should be considered in all patients who report sleepiness. Because chronic sleepiness is common in the general population, other findings, as specified in Table 1, support pursuing evaluation for obstructive sleep apnea. It is important to note that not every patient with obstructive sleep apnea perceives sleepiness or has been told of snoring. Although higher BMIs markedly increase the risk of obstructive sleep apnea, some patients have an AHI of 5 or more events per hour. The AHI is used to categorize disease severity; persons with an AHI of 5 to 15, 16 to 30, or more than 30 events per hour are considered to have mild, moderate, or severe obstructive sleep apnea, respectively.

Collectively, the number of apneas and hypopneas per hour of sleep is termed the apnea-hypopnea index (AHI), in which the presence of obstructive sleep apnea is defined as an AHI of 5 or more events per hour. Therefore, there are inherent limitations with using the AHI calculated from one night of sleep to categorize disease severity and long-term risks; measures of oxygen desaturation, such as the time spent with oxyhemoglobin...
bin saturations of less than 90% and the lowest value of oxyhemoglobin saturation during sleep, may provide additional important information in this regard.

To meet the increased demands to diagnose obstructive sleep apnea and to reduce costs, simple diagnostic tools that can be performed at home have been developed and validated. Home sleep apnea tests, the most commonly used portable in-home studies, do not measure sleep and thus cannot determine the AHI. Instead, these devices measure the respiratory-event index (REI), calculated as the frequency of breathing events (all apneas and any hypopneas with oxyhemoglobin desaturation of ≥4%) per hour of monitored time. The apnea–hypopnea index (AHI) is the number of apneas and hypopneas per hour of sleep. The respiratory-event index (REI) is the number of respiratory events (e.g., minor pauses in ventilation) per hour. The AHI is associated with several coexisting conditions that confer a predisposition to nonobstructive sleep apnea and to reduce costs, simple diagnostic tools that can be performed at home have been developed and validated.

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Obstructive sleep apnea is associated with an increased risk of cardiovascular disease. Among a population-based cohort of more than 6000 participants (age, >40 years), those with an AHI in the upper quartile (>31 events per hour) were more likely than those in the lower quartile (<1.4 events per hour) to have histories of hypertension, stroke, coronary artery disease, or heart failure, even after adjustment for BMI and other cardiovascular risk factors.28 In a follow-up study, the AHI predicted incident hypertension.29 Patients with obstructive sleep apnea, particularly those with an AHI of more than 30 events per hour, are at an increased risk for sleep-related dysrhythmias (e.g., sinus bradycardia and atrioventricular block) and nonsustained ventricular tachycardia.30 Furthermore, hypomenorrhea in patients with obstructive sleep apnea probably drives parasympathetic activation and bradycardia31 and is a predictor of cardiovascular outcomes, including sudden cardiac death.32,33 An AHI of 20 or more events per hour has been associated with an increased in an adjusted risk of stroke by a factor of four in men and a factor of two in women.34 In addition, obstructive sleep apnea is associated with an increased risk of diabetes and glucose dysregulation, independent of obesity,35 as well as increased levels of total cholesterol, low-density lipoprotein cholesteroles, and triglycerides and decreased levels of high-density lipoprotein cholesterol.36 In a 20-year longitudinal study, the presence of moderate-to-severe obstructive sleep apnea was associated with an increased adjusted risk of incident diabetes.37 This same study also showed an increase in cancer mortality and all-cause mortality among men 40 to 70 years of age with an AHI of more than 30 events per hour.38

**TREATMENT OPTIONS FOR OBSTRUCTIVE SLEEP APNEA**

Currently, treatment is recommended for all patients with an AHI or REI of 15 or more events per hour, as well as for persons with an AHI or of more than 15 events per hour is associated with a decrement in psychomotor speed equivalent to 5 years of aging.38 In addition, an inverse relationship exists between subjective measures of quality of life and the severity of the AHI.39 Persons with untreated obstructive sleep apnea have three times the risk of motor vehicle accidents as the general population.40 Obstructive sleep apnea is also associated with an increased risk of cardiovascular disease.

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**Figure 1. Diagnostic and Therapeutic Decision Making for Obstructive Sleep Apnea.**

Obstructive sleep apnea should be considered in persons presenting with a strong clinical picture (upper left) and in those who have some symptoms suggestive of obstructive sleep apnea along with coexisting conditions that heighten the risk of obstructive sleep apnea or who have a disease or condition that has been associated with an increased prevalence of obstructive sleep apnea (upper right). Consideration of the likelihood of clinically significant disease and the absence of diseases that may confound the diagnosis is imperative to select the most appropriate diagnostic assay for obstructive sleep apnea. In patients with high clinical suspicion and without these conditions, a home sleep apnea test may be appropriate. Positive airway pressure (PAP), including continuous positive airway pressure (CPAP), is the frontline therapy for all patients with symptoms and those with moderate-to-severe disease. Patients who are unable to use PAP therapy may be candidates for oral mandibular-advancement splints, hypoglossal-nerve stimulation, or other surgical procedures. All patients must be regularly evaluated for effectiveness of therapy, weight loss, and risk of drowsy driving. The respiratory-event index (REI) is the number of respiratory events (all apneas and any hypopneas with oxyhemoglobin desaturation of ≥4%) per hour of monitored time. The apnea–hypopnea index (AHI) is the number of apneas and hypopneas per hour of sleep.

**Table 1. Signs and Symptoms That Should Trigger Suspicion of Obstructive Sleep Apnea.**

<table>
<thead>
<tr>
<th>Sign or Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load or irregular snoring</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Daytime sleepiness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Unrefreshing sleep regardless of sleep duration</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Increased fatigue when patient is sedentary</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nouria</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Choking and gasping in sleep</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dry mouth on awakening</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Morning headaches</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Body-mass index &gt;30</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Crowded oropharynx</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Increased neck circumference (men, &gt;17 in. [43.2 cm]; women, &gt;15 in. [38.1 cm])</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Table 1. Signs and Symptoms That Should Trigger Suspicion of Obstructive Sleep Apnea.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
frequency-reducing surgery of the tongue and soft palate has minimal effects on the AHI in controlled trials.18 A systematic review, largely involving case series, suggests that uvulopalatopharyngoplasty, and, in particular, maxillomandibular advancement surgical procedures may be beneficial in patients with mild or moderate obstructive sleep apnea and favorable anatomy.29,30 Patients with mild obstructive sleep apnea who remain unable to use PAP therapy may be candidates for an oral appliance to advance the mandible, positional therapy (avoiding a supine sleep position), or surgical correction of a collapsible pharynx. In a randomized, controlled trial, CPAP was shown to be more effective than a mandibular-advancement splint in reducing the AHI, but adherence was greater with the oral appliance.31 Adjustable mandibular-advancement splints are recommended in patients with mild-to-moderate obstructive sleep apnea who are unable to use PAP; however, long-term use of the devices may alter dental occlusion.32 Surgical options have expanded for obstructive sleep apnea in the past several years. Radio-
CONCLUSIONS AND RECOMMENDATIONS

The woman described in the vignette has a history of obstructive sleep apnea syndrome and a recent diagnosis of obstructive sleep apnea. She has no medical conditions that preclude the use of home sleep apnea testing (e.g., chronic obstructive pulmonary disease) or the use of medications (other than those used to treat obesity). This approach may be used to confirm the diagnosis, preserving polysomnography for a negative study. Because she is sleepless, she should be treated with an REM of greater than 5 events per hour and treated with CPAP as first-line therapy. She should be advised regarding the importance of therapy and the benefits of weight loss. In addition, she should be counseled regarding the dangers of drowsy driving and to avoid sedating medications and alcohol. Close follow-up after initiation of PAP is warranted to maximize adherence to therapy, long-term assessment of improvements in the AHI and sleepiness with therapy should be evaluated at all follow-up visits, because both outcomes may change with age, weight fluctuations, and the status of associated conditions.

Dr. Vasey reports holding an issued patent (8,569,374) on NADPH oxidase inhibition pharmacotherapeutics for obstructive sleep apnea syndrome and associated conditions licensed to the Trustees of the University of Pennsylvania; and Dr. Kosek, receipt of potential financial interest in Jazz Pharmaceuticals, ResMed, and Merck. No other potential conflict of interest relevant to this article was reported.

Disclosures: The forms for the authors are available with the full text of this article at NEJM.org.

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The National Cancer Institute (NCI) is seeking candidates with a medical degree and experience in cancer immunotherapy for the Immuno-Oncology Branch (IOB) of the Division of Cancer Treatment and Diagnosis (DCTD). The IOB manages and coordinates all functions of the branch including planning, designing and executing preclinical research and clinical development of immunotherapy agents through a cross-functional collaboration within DTP and DCTD. As a senior advisor to the Division Director and Institute Director, the candidate will set priorities for federal investment in the development of new methods, technologies, and treatment paradigms that integrate immunomodulation strategies into clinical studies. The candidate is expected to manage and coordinate a system of grants and contracts to discover, investigate, develop and bring to initial clinical trials novel immuno-oncology products.

This is an exploratory ad to gauge interest and develop a possible candidate pool. A vacancy announcement to fill the position will be posted on www.usajobs.gov at a later date.

This is a full-time government position. Compensation for this position will be commensurate with the individual’s qualifications and experience as permitted within Federal government appointments. Individuals who apply must be U.S. citizens.

Please submit your resume, a statement of interest, and contact information for three references to:

Dr. Rosemarie Aurigemma, Developmental Therapeutics Program, National Cancer Institute at aurigemr@nih.gov or at (240) 276-5465 to address questions regarding this position.

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**For more information contact:**
- Heather Mamos
  - Physician Recruitment Specialist
  - Phone: (609) 580-7131
  - Email: hmamos@bjhehr.org
  - www.CorePhysicians.org

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**Jiahui International Hospital - Opportunities in China**

Jiahui Health is an international integrated system that is dedicated to providing world-class, comprehensive care, and advancing clinical education and research.

Jiahui International Hospital is the first general hospital compliant with international standards. Located in Shanghai’s downtown Xuhui District, the hospital launched its first phase in October 2017 with 246 of its total 500 beds. Jiahui International Hospital has three specialty centers: oncology, women & pediatric health and sports medicine.

In order to achieve a truly international standard of healthcare service, Jiahui formed a collaboration with Massachusetts General Hospital in 2012. This collaboration includes the hospital’s overall planning, operations management, and clinical research, even extending to cover training for physicians and nurses, and oncology and medicine research. On April 13, 2017, Jiahui and Massachusetts General Hospital formally and publicly announced their strategic collaboration. Jiahui International Hospital has co-branding with Massachusetts General Hospital.

Jiahui International Hospital is recognized as the currently only LEED Gold Green Building among medical institutions in mainland China. From overall planning to daily operations, Jiahui International Hospital leverages MediQual's quality improvement initiatives in a healthcare organization.

**For more information contact:**
- Jiahui Health
  - Website: www.jiahui.com

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**NIH/VHA Opportunities in China**

NIH/VHA is seeking experienced physicians in specialty areas.

**For more information contact:**
- Jiahui Health
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The Associate Medical Director has both administrative and clinical (primary care) responsibilities.

**The ideal candidate will be:**
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- Board Certified in Internal/Family Medicine or Mel/Peds
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- Experienced in leading quality improvement initiatives in a healthcare organization
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  - www.CorePhysicians.org

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**NEJMCareerCenter.org — Opportunities in China**

NEJMCareerCenter.org is a job search website for healthcare professionals.

**For more information contact:**
- NEJMCareerCenter.org
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**Jiahui International Hospital — Shanghai**

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**For Career Opportunities:**
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**NEJMCareerCenter.org — Opportunities in China**

NEJMCareerCenter.org is a job search website for healthcare professionals.

**For more information contact:**
- NEJMCareerCenter.org
  - Website: NEJMCareerCenter.org
Interested candidates should have a passion for making a change and delivering excellent patient care in China. Strong English language proficiency, spoken and written, is required; fluency in Chinese language is desirable but not required. Experience in an accredited university medical center preferred. Must have excellent leadership and communication skills, and a willingness to relocate to Shanghai, China.

**Director of Surgery:** Responsible for establishing, directing, inpatient, and ambulatory surgical services at JICC. This position will recruit, train, and mentor surgical professionals, lead care teams to provide team-based patient care, and lead the development of evidence-based surgical practice policies. This candidate will work closely with the JIH Executive team and JICC directors to develop international standard services and assist the Executive Director of the Cancer Center in building a world-class center for Shanghai and China.

**Chief of Pathology:** Responsible for the development of the Department of Pathology at JICC. The Chief will also be responsible for the education of junior faculty and for establishing a robust clinical and translational research program. The leader is expected to build modern, state-of-the-art Surgical and Clinical Pathology laboratory.

**Director of Medical Oncology:** Responsible for establishing, directing, and running solid tumor inpatient and ambulatory clinical services at JICC. The Director of Medical Oncology will recruit, train, and mentor clinical professionals, lead care teams to provide team-based patient care, and lead the development of evidence-based clinical practice policies. Candidate must be board-certified in Medical Oncology and Hematology.

**Director of Radiation Oncology:** Responsible for establishing, directing, and running the Radiation Oncology clinical services at JICC. Must be board-certified in Radiation Oncology.

**Interested Candidates**

Interested candidates should have a passion for making a change and delivering excellent patient care in China. Strong English language proficiency, spoken and written, is required; fluency in Chinese language is desirable but not required. Experience in an accredited university medical center preferred. Must have excellent leadership and communication skills, and a willingness to relocate to Shanghai, China.

**Director of Hematology/Oncology Opportunity: Jiahui International Cancer Center, Shanghai**

**Position Description**

**Director of Hematology/Oncology:** This role will be responsible for setting up, directing, and running hematologic malignancies and benign hematologic inpatient and ambulatory clinical services at Jiahui International Cancer Center in Shanghai, China. The Director of Hematology/Oncology will recruit, train, and mentor clinical professionals, lead care teams to provide team-based patient care, and lead the development of evidence-based clinical practice policies. Candidate must be board-certified in Hematology and Medical Oncology. Experience at an accredited university medical center preferred.

**Interested Candidates**

Interested candidates should have a passion for making a change and delivering excellent patient care in China. Strong English language proficiency, spoken and written, is required; Chinese speaking is a plus. Must have good leadership and communication skills, and a willingness to relocate to Shanghai, China. Position reports directly to the Executive Director of Jiahui International Cancer Center. For more information on this position, contact:

Lisa Parker
T +1 214 888 6839
clinical.careers@jiahui.com

**About Jiahui International Hospital**

Jiahui provides a full spectrum of health care services to help people live a better life, driven by a strong mission to change China’s medicine landscape and to deliver high-quality clinical care, groundbreaking clinical research, and exceptional professional training. Our healthcare network includes a brand new Jiahui International Hospital (a 500-bed tertiary care facility), Jiahui Clinics outpatient care centers and the Jiahui Wellness Center for advanced health management. Jiahui International Cancer Center has a strategic collaboration with the Massachusetts General Hospital Cancer Center, an international healthcare industry leader. www.jiahui.com

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Trinity Health Of New England is proud of its history of provider collaboration. Our practice model empowers our physicians to work at their highest level, while allowing time for professional development and family life. Whether you are focused on providing outstanding patient-centered care or driven to grow into a leadership role, you will thrive at Trinity Health Of New England.

For additional 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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