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Sincerely,

Eric J. Rubin, MD, PhD

April 15, 2020

Physician Employment Contracts: Strategies for Avoiding Pitfalls

By Bonnie Darves

As physicians increasingly opt for practice opportunities in employed-model arrangements, and hiring entities move toward standardizing employment contracts to simplify matters and ensure equitable treatment of existing and incoming physicians, it might appear that there’s scant room for negotiating contract terms.

That’s not a prudent attitude to take about such an important document, contract lawyers maintain. That employment agreement not only dictates the next year or two of a physician’s career but also could potentially adversely affect his or her personal and professional life for years into the future. Benjamin J. Mayer, JD, MBA, a Denver lawyer whose firm specializes in physician contracts, advises physicians to take the position that any terms that aren’t favorable can — and should — be made more reasonable. “The physician might not be able to get a higher starting salary or a larger signing bonus but definitely should negotiate anything that’s explicitly unfair or clearly intentionally ambiguous,” Mr. Mayer said.

Key examples he cites are contracts with onerous non-compete provisions that would prevent a departing physician from working within, say, a 60-mile radius of any of the employer’s locations, or contracts that contain little detail about weekly work hours and schedules, or call requirements. Essentially, anything that is vague or an overreach should be modified or clearly defined. “The physician needs to require reasonable boundaries on his or her personal and professional life for years into the future,” Mr. Mayer said.

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Michael Schaff, cochair of health law for Wilentz, Goldman & Spitzer, P.A. in Woodbridge, New Jersey, suggests that young physicians in surgical and other call-intensive specialties should determine whether practice culture or bylaws issues might translate into an inordinate call burden that they’re not willing to assume. For example, Mr. Schaff noted, some practices enable physicians who reach a certain age — 55 or 60 is common — to opt out of call altogether. If several senior doctors stop taking call, younger physicians’ “equally divided duties” might be unmanageable. To be safe, the contract should specify a “not to exceed” number of call days per week or month, Mr. Schaff and other sources advised.

Emerging “super groups” affect contracts

On a global scale, practice acquisition and management trends — specifically, the growing influence of private equity on physician practice and facility management and the creation of huge organizations that operate scores of groups — are affecting physician employment. Rebecca Gwilt, a Richmond, Virginia, lawyer and partner in Nixon Law Group, said she is witnessing a “trickle-down effect” on contracts as private equity–operated super groups emerge.

“We’re seeing a more sophisticated framework for physician contracts,” Ms. Gwilt said, as well as a trend toward both shorter employment terms and slimmer benefits. “Legally, these companies aren’t permitted to influence the delivery of services, but in general, they’re non-physician companies, which means that the MBAs are making contract decisions, not physicians,” said Ms. Gwilt, who frequently speaks on physician contract issues. “So, as this [model] becomes more common, market salaries and benefits could change.”

Although the trend toward super-group formation isn’t inherently negative — such groups have more bargaining power regarding physicians’ reimbursement rates than smaller ones do, generally — it does call for due diligence and research on the part of physicians who consider interviewing with such entities. “You first should find out who runs the company, because you will have less room to negotiate a contract than with a physician-owned practice,”Ms. Gwilt said. “You want to know what it’s like to work there, so I advise clients to ask for the name of the last physician hired — someone who’s been there for a year — and then talk to that physician.”

The movement toward “corporatization” of medicine, in tandem with the fluctuating health care economic, reimbursement, and policy environment, is prompting employers to reduce their financial risk wherever possible.

One example is instituting shorter contract employment terms, which enables employers to more easily let go of poor-performing physicians. Another recent development is the setting of limits on how much individual physicians can earn, regardless of their productivity, according to Kyle Claussen, CEO of Resolve Physician Agency, a Missouri-based firm that counsels physicians on contract issues.

“It’s becoming more prevalent to see clauses with caps on compensation, such as the 75th or 90th percentile in a major national survey such as the Medical Group Management Association survey,” Mr. Claussen said. Although such caps aren’t likely to affect most physicians coming out of residency because starting salaries are rarely set at those percentiles, the caps could penalize high-income specialties such as neurosurgery and orthopedic surgery as those physicians move into their second and third years of practice. “I’ve seen some high-income specialists walk away from those potential jobs,” he said. He added — and other sources concurred — that sign-on bonuses are less common now than they were a few years ago, possibly for some of the same economic reasons.

Another contract area where shifts are occurring involves bonuses and productivity-based compensation, several sources mentioned. As employers, as well as government and commercial insurers, move toward providing monetary incentives to physicians for performance on measures ranging from patient satisfaction to hospital readmissions, it’s important to know how such payments are handled on the employer side. This is particularly the case with any bonuses or incentive payments that may be due a physician, Mr. Schaff pointed out.

For example, if the contract states that incentives and bonuses are paid only through the employment period or only at the end of a calendar year, the physician might lose out on a substantial sum if he or she leaves the job on, say, Dec. 22, rather than Jan. 1 of the following year. Ideally, the contract should call for payment of “all bonuses earned through the time of termination.”

Ditto for accounts receivable monies that physicians might be due. It’s very common for such monies to continue flowing to the practice for several months after a physician departs, so ideally, Mr. Schaff suggested, the contract should call for reporting on such funds for a specific period after termination and ultimately paying out what’s due at, say, 60, 90, or even 180 days post-termination of employment. “This is all over the map in contracts I’ve seen,” Mr. Schaff said. “I’ve even seen contracts that state that the physician only receives payments through the last day of employment. This is something that should be negotiated.”
At the other end of the spectrum, physicians whose contracts set minimum or expected productivity or quality performance targets in order to continue the base salary beyond year one should understand not only what those requirements are but also — and more importantly — whether they’re achievable and reasonable. That means talking to other physicians at the prospective practice to see how they’ve fared in year two in productivity. It’s also helpful to find out how much personal effort is required to track the performance metrics that underlie performance payments, several sources advised. Mr. Mayer said that when a base salary arrangement converts to a totally productivity-based one at the end of the first year, he often negotiates for something less dramatic, such as continuation of the base salary for an extended period or and perhaps a part-based/part-productivity structure.

“The point is that your contract governs how your money works, and compensation structures are becoming increasingly complicated,” Ms. Gwilt said. “That’s why it’s really important that physicians understand those structures and obtain legal review.” It’s not uncommon for compensation methodologies to incorporate a half-dozen components beyond base salary, such as incentive bonuses or “clawbacks” (monies returned to the employer for underperformance or other reasons) based on quality measures, cost metrics, patient-specific clinical measure reporting, compliance, and shared-savings, to name a handful. On a final note, all sources stressed the importance of physicians reading every word of the contract and obtaining expert review. The point is to make sure that physicians understand what the contract entails and what its provisions would look like in their daily lives, by requesting specific examples of not only what’s expected of them but also what might happen should they leave the position prematurely. “One thing that physicians need to think about but are reluctant to ask is this: What happens if they want to get out or if the employer wants to terminate the contract?” Ms. Gwilt said. “If there’s a penalty clause, that should be highly negotiated.”

Contract pitfalls to watch for

Contract language that’s vague and highly employer favorable. Such language might show up in any area of the contract, but it’s especially problematic when it comes to physician schedules and duties, according to Ms. Gwilt. “You want to beware of anything that states, ‘X will be determined by the practice at its discretion,’” she said. That leaves the physician open to whatever the employer decides at any time during the contract period. At the least, physicians should negotiate to add that the terms be “fair and reasonable, and in accordance with [requirements] for all like colleagues.”

Mr. Mayer provides an example of where “at the practice’s discretion” could have a serious lifestyle effect: unspecified practice locations. As organizations merge and/or add satellite facilities, a vague location clause might mean that physicians could be required to commute to or travel among four different clinics or hospitals. Mr. Mayer suggests that physicians ask prospective employers to specify locations and limit their number contractually, or at least give the physician the opportunity to decide if she or he is willing to expand the number.

Highly restrictive non-compete clauses. Syracuse, New York, attorney Andrew Knoll, JD, MD, cautions physicians to beware of and negotiate onerous non-compete terms when employers aim to keep physicians from working for a slew of specific competitors. “I’ve seen clauses that state, ‘Within two years of leaving the practice, the physician cannot work for health system Y or hospitals A, B, or C.’ That’s overly broad. Others might restrict the employee from going to a particular large health system, but not to smaller hospitals or systems in the same urban area,” Mr. Knoll said. “These clauses should always be reviewed.”

Unreasonable benefit start dates. One pitfall with benefits is not ensuring that they commence at a reasonable time, Mr. Schaff observed. For example, if a contract stipulates that health insurance benefits start on the first day of the month following hiring or 90 days hence, he said, “The physician could be on the hook for paying the premiums for COBRA [continued coverage from the previous employer]. At the least, if the benefits start date can’t be modified, the incoming physician might try to negotiate that the employer pay the COBRA premiums until the coverage starts.”

Onerous — or unspecified — indemnification or liquid damages clauses, especially regarding malpractice claims. The first order of business here is to understand any limitations that employer-paid malpractice coverage might have, and then ensure that the employed or contracted physician isn’t on the hook fully for additional damages that the policy doesn’t cover, Mr. Mayer advised. For example, if the malpractice coverage tops out at $1 million and the judgment comes in at $1.25 million, some contracts might shift the entire shortfall to the physician, explicitly or not so explicitly. “Such a provision might say that ‘the practice and the doctor agree to indemnify and hold each other harmless for any liability caused by the other,’” Mr. Mayer said. “It sounds and seems fair, but in practice, the malpractice claim will usually follow the physician, not the practice. This is something that requires careful review and possibly negotiation.”
Eyeing Physician Career Boost Via Formal Business Education

Getting a business degree can be highly rewarding, but planning and foresight are essential

By Bonnie Darves

Physicians pursue formal business education for a whole host of reasons, but there are some common threads. For many, it’s a desire to effect change within their organizations or even health care delivery as a whole. For others, a master of business administration (MBA) or master of medical management degree (MMM), or the Certified Physician Executive (CPE) credential, is viewed as a way to better position themselves as credible participants in big-picture discussions about organizational direction or in decisions that affect their professional lives or their specialty’s future.

Increasingly, especially in large organizations, the business degree may be a requirement for seeking a senior leadership position. Some physicians have a specific reason for getting an MBA or MMM, such as launching a new clinical service. A final subset of physicians obtains formal business education as a first step toward exiting clinical medicine and moving wholesale into a nonclinical leadership role.

For internist Pamela Sullivan, MD, MBA, the driver was twofold. She needed a better understanding of the business world to help her perform more effectively in the leadership realm in which she was already functioning as a medical director. She also wanted to make a better-informed decision about how to focus the rest of her career.

“I realized that I needed to know more, and that I needed to be able to speak the [business] language whether I was in a clinical meeting or a business meeting,” said Dr. Sullivan, who is chief clinical officer of Landmark Health, which partners with health plans and uses a “house calls” model to care for patients with multiple chronic conditions. “The MBA program gave me the confidence I needed to do that.”

Dr. Sullivan opted for the one-year physician executive MBA program at the University of Tennessee’s Haslam School of Business. In part, she chose it because it was shorter than some MBA programs, but also because she wanted a practical curriculum and the face-to-face experience of the four weeks of onsite residence. “I learn by doing, and this program was not about taking exams — we got real-life practical assignments. It was so energizing,” Dr. Sullivan said.

Andrew Furman, MD, MMM, took a more stepwise, protracted approach to getting his master’s in medical management. The emergency medicine physician started by taking courses through the American College of Healthcare Executives and the American Association for Physician Leadership (AAPL) over a few years. He then carried those credits into the MMM program at University of Southern California (USC) in Los Angeles, which he completed in 2017. Today, after stints at Geisinger Health System, and Salem Health in Oregon, he is medical director for Accolade, Inc., an innovative private care-delivery and benefits company serving self-insured employers.

The slower approach enabled Dr. Furman to initially select courses on topics that related to issues he was encountering in his work, while allowing him to accrue credits toward an eventual master’s degree. “I started piecemeal when I was three years out of residency and was doing committee work. The AAPL courses were fantastic because they set me on a path to a one-year USC program,” Dr. Furman said.

From the outset, Dr. Furman was clear about his motivation for learning about business: “I wanted to be part of the change in health care, and any change that occurs affects physicians,” he said. “If you just want the three letters after your name, you might not get much out of it. If you want to shake up the mess we’re in in health care, you will.” For Anil Singh, MD, MPH, MMM, executive medical director of clinical transformation at Highmark Health and system division director of Critical Care at Allegheny Health Network in Pittsburgh, Pennsylvania, the decision to obtain a business degree arose in part out of frustration. “I was being asked increasingly to do things that did not involve patient care, and to help fix issues,” said Dr. Singh, who obtained his MMM from Carnegie Mellon University. Business people sometimes asked him to write a pro forma or show ROI (return on investment) when he proposed a solution.

“I had no idea what they were talking about and decided I needed to understand the jargon. Being in the program opened up a different side of my brain that I’d never used before,” Dr. Singh said. “Now, when I speak to businesspeople in their own language, I’ve got immediate ‘street cred’.”

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Benefits of business education: professional and personal

Like Dr. Singh, other physicians interviewed for this article were unanimous on one key benefit of formal business education: becoming conversant in the language spoken in board rooms and management settings.

“I knew that if I was going to be communicating with CEOs and CFOs, and marketing directors, I needed to understand their language — and I needed the credentials and knowledge to participate effectively. The MBA gave me that confidence,” said anesthesiologist Talal Ghazal, MD, MBA, co-director of the Holy Cross Hospital Pain Center in Wheaton, Maryland. “I also wanted to learn about something I wasn’t trained in. I found that business is no big mystery — it’s a matter of understanding the fundamentals and concepts.”

Physicians who pursued MMM and MBA degrees that included an onsite component also cited interactions and continued networking with their cohort members as a major benefit.

“Working on an MBA, MMM, or CPE helps you develop a network of colleagues with similar goals or interests, who become an ongoing resource for advice or counsel,” according to John Jurica, MD, MPH, CPE, medical director of an Illinois urgent care network who blogs and delivers podcasts on physician leadership.

For Dr. Furman, the networking was especially gratifying. “The cohort experience was amazing. You learn so much from being in the room with people with varied backgrounds who often are experiencing similar issues,” he said. The diverse specialty and background profiles of a typical MBA cohort enrich the learning experience, notes Kate Atchley, PhD, executive director of the University of Tennessee’s Physician Executive MBA program.

“In a typical year, we’ll draw physicians who are entrepreneurial-minded, some who are in mid-career or are already in administrative positions who want business acumen, and younger physicians who know that medicine is changing and want to be part of that change,” she said. “The benefit of the physician-only environment is that the students come in with the same educational background and the same experience of clinical work — they can relate to each other.”

Dr. Singh’s cohort, for example, included hospitalists, internists, cardiologists, a pathologist, and a palliative medicine physician. “Learning from the other physicians was a phenomenal experience,” he said.

Rex Kovacevich, MBA, a professor of clinical marketing in USC’s MMM program, sees those valuable interactions firsthand. He often witnesses physicians sharing their stories and experiences, and in doing so, helping each other deal with situations in their own organizations or professional lives. “That’s one of the key benefits of the cohort model — the physicians become comfortable sharing with each other,” said Mr. Kovacevich. Monique Butler, MD, MBA, chief medical officer for Swedish Medical Center, in Englewood, Colorado, cites those networking benefits and the resulting relationships she built as an important outcome of her participation in the University of Tennessee’s Physician Executive MBA program. “The cohort experience gives you a huge support network. We’re able to just pick up the phone and call each other when we’re working through a challenge,” she said. “It’s been incredibly helpful.”

Weighing the education options

The chief decision physicians face when they decide to pursue business education is choosing which route to take. The formal physician executive MBA, MMM, and CPE programs teach similar content, but their formats differ. The traditional MBA program, offered online or in a hybrid online/on-campus format, or as an immersive on-campus experience, ranges from one to two years and focuses on business theory, concepts, and principles. There are more than two dozen traditional MBA programs that have a health care business or leadership focus. Several universities now offer physician-only executive MBA degrees structured to accommodate the schedule constraints of practicing physicians and to deliver targeted content. Programs developed as part-time offerings often impose a maximum time for completion.

The MMM, a more recent entrant in the business-degree realm, is designed specifically for physicians and typically targets those who are at least three years out of residency. Physicians who pursue an MMM often end up serving as medical directors, department chairs, chief medical officers, or president/vice president of medical affairs. The programs run 12 to 18 months, and prerequisites might be required. These programs incorporate online learning and an onsite residential component several times annually. Common courses include organizational management, health economics, health policy, health finance, health law, and operations management.

Maeleine Mira, director of the MMM program at USC’s Marshall School of Business, said that a key feature of the MMM curriculum is that it's
designed to teach students how the business cases apply in health care. “That's one of the benefits of the MMM compared to traditional MBA programs,” she said. “Every student graduates with an implementable capstone, so that they're ready to go back and institute changes.” USC also offers a pre-MMM fellowship option for final-year residents.

When considering any MBA or MMM program, prospective participants should carefully evaluate the content focus to choose a program that suits their individual needs or career objectives, several sources pointed out. Physicians should also keep in mind that some programs require that participants have three to five years of clinical experience post-residency.

The CPE that AAPL offers focuses heavily on both business content and leadership training and is pursued on a course-by-course basis in a 150-credit curriculum consisting of online learning and live events. The focus is on hands-on learning. The CPE offers flexibility for participants who might need to complete the curriculum at an uneven rate or over a longer period, and it requires a final capstone project and audiovisual presentation. A sophisticated technology platform facilitates interaction among learners, and AAPL also provides professional development resources such as career assessment and executive coaching.

Typically, physicians earn their CPE designation in two to 2 1/2 years, according to Peter Angood, MD, AAPL’s president and chief executive officer. AAPL also partners with five universities to enable students to complete prerequisites toward master's degrees and easily transition into those programs.

Other degrees that include some business content include the master in healthcare quality and safety management (MS-HQSM) and master of science in the science of healthcare delivery (MS-SHCD), as well as clinical informatics degrees. The master of health administration also includes business principles but focuses on applied health care experience.

When choosing a degree program, especially an MBA, physicians should be fairly clear about what they want to achieve. Dr. Jurica advises, in part because of the financial investment. That might range from under $10,000 for an online-only program to $100,000 for a big-name university MBA. The CPE path is generally less expensive than the traditional MBA or MMM program, he added. “It might be worth waiting to start a program, if there's a way to get your employer to help with the costs,” Dr. Jurica said. He also advised physicians who aren't ready to commit to a program to consider taking business courses through the AAPL, specialty organizations, online programs, or local education institutions.

“When it comes to deciding whether you need the name recognition — which might be the case for those who will compete for a senior management position at a large organization — or just the degree and the core business knowledge,” Dr. Jurica said. In the latter case, an economical online program might suffice.

What to expect

The prospect of continuing clinical practice while obtaining a business degree can be daunting, but it’s doable for physicians who organize their time efficiently and strategically, sources agreed. The MBA and MMM programs typically carry a workload of 12 to 25 hours weekly, in addition to the onsite periods.

Physicians who want to get a business degree should plan well in advance, all sources said, and should ensure they will have support from their families, colleagues, and organizations before they start. Ideally, they should also try to either reduce or reconfigure their clinical hours to accommodate program demands. “The most important aspects of preparing for a graduate business degree are figuring out how you’ll arrange your time when you add the program to your other responsibilities and making sure that those close to you — your spouse, your coworkers, your children — are onboard,” said Mr. Kovacevich.

That’s one reason that Dr. Ghazal, who obtained his health care MBA from George Washington University in Washington, D.C., encourages physicians who are eyeing a specific role to consider getting a degree earlier in their careers. “By the time you get to mid-career, and have a demanding practice and a family, it can be a challenge to fit it in because of the time requirements — you basically have a deadline every week.”

Deborah Vinton, MD, medical director of the emergency department at the University of Virginia in Charlottesville, found herself on a crash course path when she began the University of Tennessee Physician Executive MBA, five years after finishing residency. She started the program just six weeks after delivering her third child. Despite the logistical challenges, the timing was important: she had an opportunity to participate in planning the UVA’s new emergency department and needed business credentials to be effective.
“I wanted to be a physician leader at this academic center, and I knew I needed this education,” Dr. Vinton said. The school and her cohort were “amazingly supportive,” she said, and she was able to bring her infant daughter with her for the onsite residency portions. “I was surprised by how accommodating everyone was — I didn’t expect that,” she said.

For Jamie Eng, MD, MMM, who completed her MMM at USC as a continuation of the administrative emergency fellowship that program offers, the degree better equipped her for the administrative work she was already doing at USC-Los Angeles County Medical Center. “It was fortuitous because the fellowship actually required me to do the MMM. I looked at other administration fellowships, but this was such a good fit that I decided I might as well get the degree,” said Dr. Eng, who is associate medical director of emergency medicine at Providence Tarzana Medical Center in Tarzana, California, and director of the USC Administrative Emergency Medicine Fellowship program.

“The cohort was fantastic,” Dr. Eng said. “I feel like my administrative experience was sped up by a decade learning from the experiences of others.”

Tips for choosing a program and planning the journey

Physicians interviewed for this article offered the following additional guidance for their colleagues planning to pursue formal business education:

“When you’re evaluating programs, look at how the curriculum and the schedule can intersect with your job. If you’re not able to merge your work with the requirements, you might have to consider other options.” — Deborah Vinton, MD, MBA

“I think it’s important to get awareness of the various learning opportunities, so that you have a better sense of what you want for your professional growth.” — Peter Angood, MD, AAPL president and CEO

“When you’re looking at programs, be clear about your career and where you want to be in five years — and how a particular program or fellowship is going to get you there.” — Jamie Eng, MD, MMM

“You must be able to make the commitment before you start a program. You need a game plan, the financial resources, and the buy-in from family and colleagues. I ended up devoting two full days a week to my studies.” — Pamela Sullivan, MD, MBA

“Truly understand the time commitment. Programs might cite a certain number of hours per week but assume that that’s the minimum. It might take more time to meet your requirements.” — Talal Ghazal, MD, MBA

“Do the degree at the right time in your career. It’s important to be a good doctor first and to have that credibility. I think five years in practice is the minimum, and that seven to 10 might be the sweet spot.” — Anil Singh, MD, MPH, MMM
PREVENTION OF FALLS IN COMMUNITY-DWELLING OLDER ADULTS

• Falls are common among community-dwelling older adults and can lead to physical injury, psychological harm, or both.
• Falls often result from interacting risks that can be reduced or managed.
• Because older adults may not spontaneously mention falls, asking annually about falls in the past year is recommended to identify persons at high risk for future falls.
• Community-based and home-based exercise programs focused on balance and strength training are effective in reducing the risk of falls among older adults at average or high risk.
• For persons at high risk for falls (e.g., two or more falls in the past year), assessing a standard set of risk factors for falls and intervening to address modifiable risk factors reduces the likelihood of subsequent falls.
• Treatment of osteoporosis is important to reduce the risk of fall-related fractures.

From the Geriatric Research, Education, and Clinical Center and the Center for the Study of Healthcare Innovation, Implementation, and Policy, Veterans Affairs Greater Los Angeles Healthcare System, and the Division of Geriatrics, Department of Medicine, David Geffen School of Medicine at University of California, Los Angeles — all in Los Angeles (D.A.G.); and the Research Program in Men’s Health: Aging and Metabolism, Boston Claude D. Pepper Older Americans Independence Center for Function Promoting Therapies, Brigham and Women’s Hospital, Boston (N.K.L.). Address reprint requests to Dr. Ganz at the Veterans Affairs Greater Los Angeles Healthcare System, 11301 Wilshire Blvd., 11G, Los Angeles, CA 90073, or at dganz@mednet.ucla.edu.

An audio version of this article is available at NEJM.org

The current international classification of health (ICD) does not include a specific code for falls. Thus, the true rate of falls among older adults is unknown. However, it is estimated that 1 in 5 older adults fall each year, with the rate of falls being higher among older adults in the United States than in other countries. Falls are a major cause of physical injury, psychological harm, and both. Therefore, falls are a major cause of physical injury, psychological harm, and both.

Falls, defined as an unexpected event in which the participants come to rest on the ground, floor, or lower level, occur at least once annually in 29% of community-dwelling adults 65 years or older — a rate of 0.67 falls per person per year. Population-based studies suggest that 10% of older adults fall at least twice annually. Most falls among older adults occur in the home, with falls being more common in older adults who have had a fall in the past year. A meta-analysis of 31 randomized trials showed that exercise training is associated with fewer falls per person per year; however, the evidence suggests that exercise may reduce the risk of fall-related fractures.

Most falls result from a combination of intrinsic risks (e.g., balance impairment and extrinsic risks (e.g., trip or slip). Given the many contributors to the risk of falls, focusing on the factors that are the final common pathways to falls and are those most commonly evaluated in randomized trials leads to a core set of risk factors (Table 1). Deficits in gait and balance are the most prominent predisposing risk factors at the population level. Medications (including over-the-counter drugs), alcohol, visual deficits, impairments in cognition and mood, and environ-
Table 1. Risk Factors for Falls That Are Commonly Evaluated in Randomized Trials of Multifactorial Interventions.*

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Odds Ratio for Any Falls (95% CI)</th>
<th>Prevalence in Older Adult Cohorts (%)</th>
<th>Underlying Impairment Leading to Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance impairment</td>
<td>1.98 (1.60–2.46)</td>
<td>Sensory impairment (visual, vestibular, or somatosensory)</td>
<td>58</td>
</tr>
<tr>
<td>Gait problems</td>
<td>2.06 (1.82–2.33)</td>
<td>Difficulty in negotiating obstacles or ascending or descending stairs</td>
<td>355</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>1.35 (1.18–1.54)</td>
<td>Impairments in depth perception or in sensitivity to visual contrasts</td>
<td>10</td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
<td>1.50 (1.15–1.97)</td>
<td>Transient cerebral hypoperfusion leading to light-headedness or loss of balance or loss of consciousness</td>
<td>20</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>1.75 (1.27–2.41)</td>
<td>Sedation, confusion, orthostatic hypotension, or ataxia</td>
<td>31</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>2.30 (1.24–4.26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>1.48 (1.24–1.77)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>1.40 (1.38–1.66)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loop diuretics</td>
<td>1.36 (1.17–1.57)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td></td>
<td>Interaction between functional limitations and home environment, with hazards (e.g., trip hazards or poor lighting) acting as a precipitating cause</td>
<td></td>
</tr>
<tr>
<td>Physical disability</td>
<td>1.56 (1.22–1.99)</td>
<td>Difficulty with any ADL</td>
<td>20–27</td>
</tr>
<tr>
<td>Instrumental disability</td>
<td>1.46 (1.20–1.77)</td>
<td>Difficulty with any IADL</td>
<td>16–18</td>
</tr>
<tr>
<td>Home hazards</td>
<td>1.13 (0.97–1.36)</td>
<td>Two or more home hazards</td>
<td>91</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>1.32 (1.18–1.49)</td>
<td>Dementia</td>
<td>9</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>1.49 (1.24–1.79)</td>
<td>Depressive disorders</td>
<td>19–26</td>
</tr>
</tbody>
</table>

* Data on risk factors were obtained from meta-analyses of observational studies. The limitations of these data include considerable heterogeneity across studies in their definitions of risk factors for falls and evidence of publication bias in some cases. Also, the odds ratio is known to overestimate the relative risk when the outcome of interest is common (as in the case of falls). These data are shown to provide a general context for the increased risk of falls associated with each risk factor among older adults. ADL denotes activity of daily living (includes bathing, dressing, eating, transferring, walking, and toileting), and IADL instrumental activity of daily living (includes preparing meals, shopping, managing money, and using the telephone).

† Prevalence reflects point estimates or a range of point estimates from population-based studies involving older adults or the 95% confidence intervals of the prevalence from meta-analyses. Data are shown for cohorts of adults 60 years of age or older, 65 years of age or older, 75 years of age or older, 24 and 72 years of age or older.

‡ The prevalence estimate of 35% was derived from Table 1 of the study by Studenski et al. (results of the Third National Health and Nutrition Examination Survey).

§ Functional visual impairment was defined as difficulty in seeing the words or letters in ordinary newspaper print.

¶ Orthostatic hypotension was defined as a “sustained reduction in systolic blood pressure of at least 20 mm Hg or diastolic blood pressure of at least 10 mm Hg within 3 minutes of standing.”

‖ Examples of hazards include trip hazards (e.g., throw rugs and loose electrical cords), slippery areas, and poor lighting.

39% (95% CI, 21 to 53) lower rate. Most exercise programs lasted at least 12 weeks, and almost one third had a duration of at least 1 year.

Both home-based exercise programs (e.g., the Otago Exercise Program [see the Supplementary Appendix]) and group-based exercise programs have been shown to reduce the rate of falls. The most effective programs have been specifically designed to reduce the risk of falls and include exercises that improve leg strength and challenge balance with progressively more difficult activities. There is also some evidence of a lower rate of falls with tai chi, with programs offering classes one to three times per week for 13 to 48 weeks (7 trials showed a 10% [95% CI, 1 to 33] lower rate with tai chi than with control exercise programs).
Table 2. Common Domains of Multifactorial Assessment and Management.*

<table>
<thead>
<tr>
<th>Assessment Domain</th>
<th>Potential Interventions</th>
<th>Evidence from RCTs for Fall Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance, gait, strength</td>
<td>Group exercise in the community; home-based exercise program; outpatient physical therapy; home-based physical therapy; assistive device†</td>
<td>Systematic reviews of large numbers of RCTs strongly favor exercise (high certainty of evidence).†</td>
</tr>
<tr>
<td>Vision</td>
<td>Cataract surgery if indicated; prescription of single-lens distance glasses for outdoor use (only among people who regularly take part in outdoor activities)</td>
<td>One RCT (positive) exists for first-eye cataract surgery. An RCT of single-lens distance glasses for outdoor use among current multifocal lens wearers showed no significant reduction in the rate of falls overall but prespecified subgroup analyses showed a significantly lower rate of falls among those who regularly took part in outdoor activities (others had an increase in the rate of falls).‡</td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
<td>Pharmacologic treatment (in severe cases)</td>
<td>Data from adequately powered RCTs showing benefits of pharmacologic treatment are lacking.</td>
</tr>
<tr>
<td>Medication</td>
<td>Review medications (assess for medicines without an indication for their use, side effects, risks of central nervous system-active medications)</td>
<td>Medication dose reduction or discontinuation</td>
</tr>
<tr>
<td>Environment (e.g., home hazards or personal needs)</td>
<td>Assess basic and instrumental activities of daily living; perform a home-safety evaluation</td>
<td>RCTs have yielded inconsistent findings.‡ The evidence base for fall reduction in RCTs of home-safety assessment and modification and provision of adaptive equipment is strongest for high-intensity interventions and interventions targeted to high-risk groups.‡</td>
</tr>
<tr>
<td>Cognition and psychological health</td>
<td>Use cognitive and depression screening tools (e.g., Mini-Cog and Patient Health Questionnaire-9). If depression or dementia is identified, nonpharmacologic treatment is offered with respect to fall risk; for dementia, ensure adequate supervision of the patient during daily activities</td>
<td>A systematic review of placebo-controlled RCTs of cholinesterase inhibitors and memantine showed no decrease in the number of falls and an increased risk of syncope in the group receiving cholinesterase inhibitors. One placebo-controlled RCT of duloxetine for depression showed an increased risk of falling. One RCT of a cognitive behavioral group intervention to reduce fear of falling showed no change in the rate of falls but showed fewer people with multiple falls.‡</td>
</tr>
</tbody>
</table>

* RCT denotes randomized, controlled trial.† Group exercise in the community requires physical ability to travel outside of home and access to transportation. Also, most programs require people to stand independently and engage in at least 30 minutes of activity. A home-based exercise program can be an effective option if adequate training and progression are provided to ensure a safe and effective exercise (i.e., frequency, intensity, duration, and selection of exercise). Outpatient physical therapy is an option for persons with moderate-to-severe deficits in gait, balance, or strength or other symptoms.‡ Additional details are provided in the algorithm in the Supplementary Appendix. Home-based physical therapy must meet the definition of “home-bound” so that the patient can safely exercise (e.g., in a community-based or unsupervised home-based exercise program or under the management of a physical therapist). An algorithm to guide the selection of an exercise program is provided in the Supplementary Appendix.

**Multifactorial Assessment and Management**

Assessment of gait, balance, and strength is an essential step in fall prevention. Multifactorial assessment and management have assessed a number of factors that contribute to falls, with interventions based on the risks identified. Recommendations are provided in Table 2, and home exercises are shown in Figure 2. Links to exercises and handouts are provided in the Supplementary Appendix. Data are lacking to guide the clinician on which patients need further medical evaluation before initiating a fall-prevention exercise program. When in doubt, assessment of gait, balance, and strength can help determine whether and in what type of program patients can safely exercise (e.g., in a community-based or unsupervised home-based exercise program or under the management of a physical therapist). An algorithm to guide the selection of an exercise program is provided in the Supplementary Appendix.

Figure 2. Home-Based Exercises for Leg Strengthening and Balance.

Panel A shows a home-based leg-strengthening exercise based on the Go4Life program developed by the National Institute on Aging. Patients can use their arms to assist with standing, if needed, and progress to standing with arms outstretched as illustrated for two sets of 10 to 15 repetitions. Panel B shows a home-based exercise to improve balance based on the Go4Life program. Patients should stand on one foot behind a sturdy chair, holding on to the chair for balance, and attempt to hold the position for up to 10 seconds. The exercise is repeated 10 to 15 times for each leg. Specific instructions for patients and links to additional exercises are available in the Supplementary Appendix.

Interventions. Walking is often included in exercise programs but on its own has not been shown to prevent falls. Persons with clinically significant balance impairments should avoid exercise programs that focus exclusively on brisk walking. Long-term adherence to exercise is difficult for most people, so patients should select an exercise option that they enjoy and can easily access and incorporate into their daily lives. Various fall-prevention exercise options that clinicians can offer to patients are noted in Table 2, and home exercises are shown in Figure 2. (Links to exercises and handouts are provided in the Supplementary Appendix.) Data are lacking to guide the clinician on which patients need further medical evaluation before initiating a fall-prevention exercise program. When in doubt, assessment of gait, balance, and strength can help determine whether and in what type of program patients can safely exercise (e.g., in a community-based or unsupervised home-based exercise program or under the management of a physical therapist). An algorithm to guide the selection of an exercise program is provided in the Supplementary Appendix.

Multifactorial Assessment and Management

Assessment of a standard set of risk factors for falls, with interventions based on the risks identified, is recommended in high-risk patients. In a meta-analysis of 19 trials, the rate of falls was lower with multifactorial assessment and management than with usual care or an intervention not thought to reduce falls (1.8 vs. 2.3 falls per person per year), representing a 23% (95% CI, 13 to 33) lower rate of falls. No significant between-group differences in favor of multifactorial assessment and management were observed in the risk of falls requiring medical attention or hospitalization or in the risk of fall-related fractures, but the statistical power was limited for evaluating these outcomes; with respect to fall-related fractures (9 trials), the relative risk was 27% lower (95% CI, −1 to 47) with multifactorial assessment and management than with usual care or an intervention not thought to reduce falls. Studies of multifactorial assessment and management have assessed a number of different risk factors and provided different interventions. Here, we focus on the most commonly assessed risk factors. In Table 2, we review these risk factors and data from randomized controlled trials to provide information on the effects of various interventions. Because the performance of multifactorial assessment and management is time-intensive, a modular approach that spreads the assessment over multiple office visits can be helpful. The order of the evaluation should be informed by concerns raised by the patient or caregivers or identified through the medical history or physical examination. Some information may be available in the medical record (e.g., a recent eye examination). Resources related to the evaluations described below are provided in the Supplementary Appendix.

**Gait, Balance, and Strength**

Assessment of gait, balance, and strength is an important early step in the evaluation, because
this information can be used to match a patient with an exercise program, including physical therapy if needed. The assessment, which generally takes 5 minutes, includes watching the patient walk to assess gait speed and any obvious gait abnormalities; testing balance by asking the patient to stand with feet in side-by-side, semi-tandem, and full-tandem positions; and watching for a change in a chair of normal height without using the hands to push off. On the basis of clinical experience, a visibly slow gait speed (e.g., <0.6 m per second) or any discernible gait abnormalities, difficulties holding side-by-side or semi-tandem stances for 10 seconds, preexistence of an assistive device, or inability to rise from a chair may indicate the need for either home-based physical therapy or outpatient physical therapy. Prescriptions for physical therapy should specify any gait, balance, or strength deficits noted during this part of the examination. Patients may also benefit from physical therapy if they have substantial musculoskeletal pain, neuropathic or vestibular symptoms, or cognitive impairment that would limit participation in standard exercise programs. Patients with under way or identifiable deficits are potentially appropriate for a community-based or home-based exercise program focused on fall prevention. Patients with balance deficits who do not have an assistive device should be encouraged to use a cane, wheeled walker, or both, which can be kept in the clinic for demonstration purposes.

Medication Review
All prescribed and over-the-counter drugs should be reviewed, with a focus on tapering or discontinuing medications without a compelling indication or for which the potential harm is greater than the patient’s risk (e.g., opioid medications). This can be done without the need for medical evaluation of medications that may cause sedation, confusion, or orthostatic hypotension (e.g., anti-depressants, antipsychotics, benzodiazepine-receptor agonists, anti-epileptic drugs, opioids, and anti-hypertensive agents) and medications that may interact with alcohol use. Resources are available to support clinicians in stopping or reducing the dose of medications that increase the risk of falls and to help patients in the tapering of such drugs. For patients who are tapering their use of insomnia medications, nonpharmacologic strategies (e.g., cognitive behavioral therapy and guidance on sleep hygiene) are available.

Functional Status and Home Safety
This assessment starts with identifying patients’ limitations in basic and instrumental activities of daily living; patients with limitations can be queried about whether they have the necessary adaptive equipment (e.g., a shower chair for bathing) or someone to assist them. For patients with difficulties in basic activities of daily living, a home-safety evaluation ordered through a home-care agency is appropriate among those who are eligible. Although Medicare does not currently cover the cost of home modifications and adaptive equipment for older people with limited means through a variety of funding approaches, including health care systems, charitable organizations, and tax refunds.

Vision
Eye examinations are recommended every 1 to 2 years for adults 65 years of age or older. Regarding patients who have not had a recent eye examination or who report new visual problems, distance vision can be tested in the office, and prompt referral can be made in the case of newly identified deficits in visual acuity. Patients with balance deficits who wear multifocal lenses and regularly go outdoors may also benefit from a referral for single-lens distance glasses to use when outdoors. For patients with a corrected visual acuity worse than 20/80 in the better eye, visual field testing is recommended. A home assessment is recommended on the basis of a lower rate of falls observed among such patients who received a home-safety program than among those who did not; a lower rate of falls was observed among those who received an exercise program.

Cognition and Mood
Brief instruments, such as the Mini-Cog and the Patient Health Questionnaire-9, are helpful screening tools to assess cognitive impairments and depressive symptoms, respectively. Both of these conditions are associated with an increased risk of falls, independent of the medications prescribed for them (Table 1). Patients who meet the criteria for dementia or depression can be evaluated for reversible causes (e.g., hypothyroidism). Because anti-depressants are associated with an increased risk of falls21 and cholinesterase inhibitors with an increased risk of syncope,22 pharmacologic treatments may need to be considered first; pharmacologic treatment should be prescribed only after weighing the benefit of treatment against the potential side effects, including falls.

Orthostatic Hypotension
Orthostatic hypotension is defined as a sustained fall in systolic blood pressure of at least 20 mm Hg or diastolic blood pressure of at least 10 mm Hg within 3 minutes of standing.20 Patients who have a drop in blood pressure immediately on standing that normalizes by 3 minutes can be educated about rising slowly and not ambulating immediately after standing. In patients with confirmed orthostatic hypotension, potential causative medications (e.g., those with anticholinergic side effects) that are not necessary should be discontinued, and adequate hydration should be encouraged. Patients with refractory symptoms or profound drops in blood pressure on standing (i.e., from supine hypertension to standing hypotension) should be evaluated (or referred for evaluation) for neurogenic causes and for potential pharmacologic treatment.

Other Strategies
Features of multifactorial assessment in some randomized trials have included assessment of cardiovascular causes (e.g., carotid sinus hypersensitivity or orthostatic intolerance), hearing, musculoskeletal pain, neurologic symptoms, behavioral therapy and guidance on sleep hygiene, and then walking, and her balance should be evaluated for reversible causes (e.g., hypothyroidism). Because anti-depressants are associated with an increased risk of falls21 and cholinesterase inhibitors with an increased risk of syncope,22 pharmacologic treatments may need to be considered first; pharmacologic treatment should be prescribed only after weighing the benefit of treatment against the potential side effects, including falls.

Injury Prevention
Injury prevention should focus on assessing and managing a patient’s risk of fractures. Patients with previous vertebral or hip fracture after a minimal trauma should be offered pharmacologic treatment for osteoporosis, and women 65 years of age or older (or with other major risk factors) should be offered pharmaceutical treatment for osteoporosis without a previous vertebral or hip fracture should undergo testing of bone mineral density. Hip protectors are not recommended for community-dwelling older adults, since a meta-analysis showed no difference in the risk of hip fractures in this population.
evaluated by asking her to stand with her feet in side-by-side, semi-tandem, and full-tandem positions. If there are no major deficits, she can refer to a community-based exercise program and prescribed a cane for outdoor walking. Medications for insomnia is discouraged in favor of nonpharmacologic strategies. We would review other medications, confirm that she is independent in her basic and instrumental activities of daily living, refer her for an eye examination if she has not had one in the past 1 year, and review test results of bone mineral density (for Refer if available). Reviews of orthostatic vital signs, cognition, and mood are also warranted, either at the current visit or the next. The patient should understand that falls are not an inevitable part of aging and that the risk of falls can be markedly reduced if she addresses identified risk factors.

The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the U.S. government. No 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. We thank Shalender Bhasin, Carolyn J. Crandall, Thomas M. Gill, David B. Krishel, and Paul G. Shelker for comments on a previous version of the manuscript.

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The Department of Nephrology and Hypertension in the Glickman Urologic and Kidney Institute (GUKI) at Cleveland Clinic is seeking an experienced general Nephrologist to join our regional practice. The practice involves outpatient clinic Family Health Centers, hospital rounding at Cleveland Clinic hospitals and rounding at multiple dialysis units.

Preference given to candidate with community nephrology practice experience. The candidate should bring skills in practice development and leadership to build upon existing talent and infrastructure and to create a ‘best in class’ program. Home dialysis interest is a plus. Salary and Faculty appointment at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University will be commensurate with experience.

The Nephrology and Hypertension Department at Cleveland Clinic is committed to achieving excellence as healthcare evolves through healing, teaching, and respect for the individual. We offer unparalleled resources and opportunities for both professional satisfaction and career advancement and emphasize equity in work – life balance.

Cleveland Clinic has been delivering innovative healthcare since 1921. In over 90 years we have done some remarkable things including the world’s first coronary artery bypass in the 1950s to assisting in America’s first facial transplant. Our department staff have been innovators in patient care and research in hypertension, CKD, dialysis, and kidney transplantation for 50+ years.

About the Department of Nephrology and Hypertension:
The Department has 27 physicians, 13 Advanced Practice Providers and 8 Fellows treating patients in all subspecialties at over 30 locations in Northeast Ohio. In 2019, we are on track to complete more than 25,000 office visits and over 26,000 dialysis treatments. Patients come to us from every state in the United States and more than 82 countries.

Please apply: http://jobs.clevelandclinic.org/physicians.html

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Duke-NUS Medical School (Duke-NUS), Singapore’s only graduate-entry medical school was established as a landmark collaboration between two world-renowned institutions of higher education – Duke University and National University of Singapore. Duke-NUS provides innovative education and impactful research to enhance the practice of medicine in Singapore and beyond. Through its strategic partnership with Singapore Health Services (SingHealth) which includes Singapore General Hospital, the School is able to leverage its joint capabilities and infrastructure to develop outstanding clinical education programmes and cutting edge research collaborations that translate fundamental science into better health. Duke-NUS and its partners have created an academically-based Programme in Emerging Infectious Diseases (EID) designed to serve as a national and international resource of excellence in emerging infectious diseases. The mission of the Programme faculty is to conduct high-level basic and applied research, and to train graduate students, postdoctoral fellows and clinician-scientists in the disciplines relevant to emerging infectious diseases. Duke-NUS and its partners provide state-of-the-art research facilities, including a standalone ABSL3 unit.

We are seeking an individual with exceptional scientific credentials and leadership skills to head the EID Programme. The Programme Director will provide leadership, including engagement with the broader biomedical community in Singapore and with Duke University, strategic hiring and programme development; medical school and graduate education; faculty mentoring; budgetary and space planning. The School will provide the new Programme Director with the resources to support the highest level of research. Interested candidates should send a CV and the names of three references to Chair, Search Committee on Emerging Infectious Diseases, Duke-NUS Medical School, Singapore by email to: hr@duke-nus.edu.sg.

Applications will be accepted until the position is filled. We anticipate to begin interviewing candidates in early April 2020. More information on the Programme can be found at www.duke-nus.edu.sg.

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The University of Pittsburgh School of Medicine and the UPMC (University of Pittsburgh Medical Center) invite applications and nominations for the position of chair of the internationally renowned Department of Neurology. The chair of neurology reports to the Senior Vice Chancellor for the Health Sciences and Dean of the School of Medicine, as well as to the President of the UPMC Health Services Division and the CEO of UPMC. The incumbent will oversee the clinical, academic, and research activities of the Department of Neurology, hold the Henry B. Higman Endowed Chair, serve as clinical director of the University of Pittsburgh Brain Institute and co-director of the UPMC Neurological Institute.

The chair oversees neurology clinical services throughout the UPMC system, consisting of more than 40 hospitals, directly supervising 78 clinical faculty and 18 non-clinical faculty members. The Department’s centers of clinical and research excellence include the UPMC Stroke Institute, the UPMC Headache Center, the Alzheimer’s Disease Research Center, the Pittsburgh Institute for Neurodegenerative Diseases, the Pittsburgh Institute for Multiple Sclerosis Care and Research, the UPMC Comprehensive Epilepsy Center of Excellence, the American Parkinson’s Disease Association Advances Center for Parkinson’s Research, the Huntington’s Disease Society of America Center of Excellence, and the Commonwealth of Pennsylvania Center for Detection, Diagnosis and Intervention in Dementia. The department’s faculty research portfolio includes over 200 ongoing projects. Methods employed ranged from cell culture models, zebra fish, and transgenic mouse models of disease; human clinical studies; sophisticated neuroimaging and functional studies; to human post-mortem neuropathological studies. Productive research collaborations exist with scientists representing a variety of departments and disciplines within the University of Pittsburgh and the Veterans Affairs Pittsburgh Healthcare System. The Department of Neurology provides unparalleled educational experiences for medical students, residents, and fellows. In addition to a very competitive residency program, the Department offers clinical fellowships focused on Epilepsy, Headache, Neuro-Oncology, Women’s Neurology, Multiple Sclerosis, Stroke, Neuroendovascular, Clinical Neurophysiology, and Movement Disorders.

The University of Pittsburgh School of Medicine is one of the nation’s leading medical schools, with remarkable growth in NIH funding and renowned for a curriculum that emphasizes both the science and humanity of medicine. As an institution, the University of Pittsburgh ranks fourth in NIH funding. The University and its School of Medicine is the academic partner to UPMC. The joint mission is to train tomorrow’s health care specialists and biomedical scientists, engage in groundbreaking research that will advance understanding of the causes of and treatments for diseases, and participate in the delivery of outstanding patient care. UPMC is a global health system comprising more than 40 hospitals, 700 clinical locations as well as commercial and international ventures, 89,000 employees, a health insurance division covering more than 3.7 million members, and $21 billion in integrated global non-profit enterprises.

Candidates must have a distinguished record in academic neurology, commensurate with appointment as a tenured full professor, and significant administrative experience. International applicants are welcome. Candidates must be BC/BE and qualified for medical licensure in Pennsylvania.

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