INSIDE

Career: Eyeing Physician Career Boost Via Formal Business Education. Pg. 1

Career: Defining Success in the Workplace. Pg. 9

Clinical: Pulmonary Embolism, as published in the New England Journal of Medicine. Pg. 11

The latest physician jobs brought to you by the NEJM CareerCenter

Residents and Fellows Edition

Featured Employer Profile

Geisinger
Dear Physician:

As you near completion of your training, I’m sure that finding the right employment opportunity is a top priority for you. The New England Journal of Medicine (NEJM) is the leading source of information about job openings, especially practice opportunities, in the country. Because we want to assist you in this important search, a complimentary copy of the 2022 Career Guide: Residents and Fellows edition booklet is enclosed. This special booklet contains current physician job openings across the country. To further aid in your career advancement, we’ve also included a couple of recent selections from our Career Resources section of the NEJM CareerCenter website (NEJMCareerCenter.org).

NEJMCareerCenter.org continues to receive positive feedback from physician users. Because the site was designed specifically based on advice from your colleagues, many physicians are comfortable using it for their job searches and welcome the confidentiality safeguards that keep personal information and job searches private. Physicians have the flexibility of looking for both permanent and locum tenens positions in their chosen specialties and desired geographic locations.

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A career in medicine is challenging, and current practice leaves little time for keeping up with changes. With this in mind, we have developed these new features to bring you the best, most relevant information in a practical and clinically useful format each week.

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

Sincerely,

Eric J. Rubin, MD, PhD

October 6, 2022

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, a Seattle-based freelance health care writer

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 them 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 implementation for 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...
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 meetings.

“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 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 Acelerate, 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 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.’”
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 2½ 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
“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 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
Defining Success in the Workplace
By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

We all have different definitions of success in the workplace, and it’s important to be honest with ourselves about what those are. They will be the gauge by which we derive career satisfaction, so they are of utmost importance when considering a job.

Importantly, there is no right approach, as much as we may all know the stereotypically correct answers to give at interviews. The things that drive us and give us purpose are inherently intertwined with who we are as individuals, and after years of being told what the “right” answers are, it may require some real introspection to realize what things we are truly aiming for.

Therefore, prior to embarking on the job search, take a few hours and write down the things that you value and you think will ultimately lead to job satisfaction. If applicable, discuss these goals with your family, and even ask your friends if they agree with your personal assessment. Sometimes they know you better than you know yourself, and they will be able to get to the heart of what you really want. Taking this time to challenge what you’ve been groomed to think you want is well worth it, as over time, these things will reveal themselves in the form of job turnover.

Once this is done, you should look at each job to determine if the job is compatible with the priorities you have outlined.

If you view leadership as one of your goals and indicators of success, you are going to want to pick a job where there is a pathway to promotion or ownership. A private practice that does not offer partnership options or a position in a company where the senior leadership is not composed of physicians would likely not be a good fit for you.

If you think having more vacation or more flexibility in work hours will help you achieve work-life balance and career satisfaction, you may want to look at a large practice where there are more coverage options or start a solo practice if your specialty is amenable to flexibility in this setting. In these scenarios, you will likely sacrifice some element of compensation or willingly take on inefficiencies in practice overhead in order to have the options you want.

“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

Did you find this article helpful? Sign up for our Career Resources Update e-newsletter to get more physician career articles delivered right to your inbox! www.nejmcareercenter.org/register.
A 41-year-old man presents to the emergency department with a 3-week history of breathlessness. He recently completed a course of antibiotic medication for presumed pneumonia. On the day of presentation, he awoke with dull pain on the right side of the back. His medical history is otherwise unremarkable. His heart rate is 88 beats per minute, blood pressure 149/86 mm Hg, respiratory rate 18 breaths per minute, temperature 37°C, and oxygen saturation 95% while he is breathing ambient air. Auscultation of his chest reveals normal breath sounds and normal heart sounds. An examination of the legs is normal. His creatinine and troponin levels are within normal limits, and a radiograph of the chest is normal. The physician’s implicit assessment is that the likelihood of pulmonary embolism is greater than 15%. The patient’s Wells score is 0 (on a scale of 0 to 12.5, with higher scores indicating a higher probability of pulmonary embolism), and the D-dimer level is 2560 ng per milliliter. How would you evaluate this patient for pulmonary embolism, and how would you manage this case?
PULMONARY EMBOLISM

- Pulmonary embolism is a common diagnosis and can be associated with recurrent venous thromboembolism, bleeding due to anticoagulant therapy, chronic thromboembolic pulmonary hypertension, and long-term psychological distress.
- A minority of patients who are evaluated for possible pulmonary embolism benefit from chest imaging (e.g., computed tomography).
- Initial treatment is guided by classification of the pulmonary embolism as high-risk, intermediate-risk, or low-risk. Most patients have low-risk pulmonary embolism, and their care can be managed at home with a direct oral anticoagulant.
- Patients with acute pulmonary embolism should receive anticoagulant therapy for at least 3 months. The decision to continue treatment indefinitely depends on whether the associated reduction in the risk of recurrent venous thromboembolism outweighs the increased risk of bleeding and should take into account patient preferences.
- Patients should be followed longitudinally after an acute pulmonary embolism to assess for dyspnea or functional limitation, which may indicate the development of post-pulmonary-embolism syndrome or chronic thromboembolic pulmonary hypertension.

STRATEGIES AND EVIDENCE

DIAGNOSTIC TESTING FOR PULMONARY EMBOLISM

Perhaps the most challenging aspect of testing for pulmonary embolism is knowing when to test. Common symptoms of pulmonary embolism are fatigue, breathlessness, chest pain, dizziness, cough, diaphoresis, fever, and hemoptysis. A meta-analysis of cohort studies showed that a history of dyspnea, immobilization, recent surgery, active cancer, hemoptysis, previous venous thromboembolism, or syncope was associated with an increased likelihood of pulmonary embolism. Testing for pulmonary embolism should also be considered if a patient appears not to have had a response to treatment for another diagnosed respiratory condition, because initial misdiagnosis is common. In North America, pulmonary embolism is diagnostically optimized for every patient for whom suspicious symptoms make a deep venous thrombosis or pulmonary embolism highly likely. In cases in which physicians have an implicit sense that their patient is very unlikely to have pulmonary embolism (estimated likelihood, <15%), large cohort studies have shown that the Pulmonary Embolism Rule-out Criteria (PERC) rule can safely rule out pulmonary embolism without further diagnostic imaging. In practice, however, implicit estimation typically overestimates the probability of pulmonary embolism, which can limit the use of the PERC rule. Physicians should be familiar with a validated decision rule to guide the use of D-dimer testing. Among patients with a low structured clinical probability score - a Wells score of 4.0 or less (found in 80% of patients tested in North America), a revised Geneva score of 10 or less (on a scale ranging from 0 to 22, with higher scores indicating a greater probability of pulmonary embolism), and a simplified Geneva score of 4 or less (on a scale ranging from 0 to 9, with higher scores indicating greater probability of pulmonary embolism), Pulmonary embolism can be safely ruled out on the basis of D-dimer levels when manufacturer-recommended cutoffs were used (sensitivity, 98 to 99%; specificity, 37 to 40%). Additional details of the scoring systems and their use are provided in Figure 1. Older data from a different D-dimer assay suggested that a D-dimer level of less than 500 ng per milliliter could be used to rule out pulmonary embolism without consideration of clinical risk factors, but more data are needed to confirm the usefulness of this approach with current assays and relative to currently recommended strategies. The diagnostic accuracy of D-dimer testing in patients with coronavirus disease 2019 (Covid-19) remains unchanged.

Newer approaches have adjusted the D-dimer threshold for ruling out pulmonary embolism and are validated for D-dimer assays for which the manufacturer-recommended cutoff is equivalent to 500 ng per milliliter. These strategies include D-dimer levels that are adjusted for age, (reported sensitivity for the age-adjusted approach ranges from 97 to 99%, and specificity ranges from 42 to 47%) or that are adjusted to the YEARS algorithm for ruling out pulmonary embolism (sensitivity, 98 to 99%; specificity, 54 to 63%) or the Wells score (sensitivity, 91 to 97%; specificity, 61 to 67%). Randomized trials that compare various D-dimer strategies in patients with pulmonary embolism are lacking.

Diagnostic imaging is reserved for patients in whom pulmonary embolism cannot be ruled out on the basis of a decision rule, given the potential harms of radiation exposure. CT pulmonary angiography is usually the most timely and accessible imaging technique; however, to minimize lung and breast-tissue irradiation in younger patients, ventilation-perfusion single-photon-emission CT (SPECT) is a low-radiation option. The incidence of false positive results from CT screening varies among providers and may be as high as 5%. Within 3 months after having normal results on CT that had been performed because of a history of dyspnea, immobilization, recent surgery, or both are considered to have intermediate-risk pulmonary embolism. Among patients with low body weight. Alternative reperfusion approaches include surgical thrombectomy and catheter-directed thrombolysis (with or without thrombectomy). Additional supportive measures include the administration of inotropes and the use of extracorporeal life support.

Intermediate Risk

Patients with echocardiographic or CT evidence of right heart strain, elevated biomarkers (such as troponin or brain natriuretic peptide), or both are considered to have intermediate-risk pulmonary embolism. Systemic thrombolysis is not typically recommended for these patients; in cases of intermediate-risk pulmonary embolism, systemic thrombolysis is the most readily available option for reperfusion, and protocols include a weight-based dose of tenecteplase, alteplase at a dose of 0.6 mg per kilogram of body weight, or alteplase at a dose of 100 mg administered over a period of 1 to 2 hours. Rather, patients with intermediate-risk pulmonary embolism should receive anticoagulant therapy and be closely monitored.
Physicians may use Pulmonary Embolism Rule-out Criteria (PERC) to rule out pulmonary embolism if their implicit sense suggests there is less than 15% probability that the patient has pulmonary embolism. Otherwise, physicians should use a d-dimer assay to rule out pulmonary embolism in patients who have a low structured clinical probability score (a Wells score of ≤4.0 on a scale of 0 to 12.5) and a revised Geneva score of ≤10 on a scale ranging from 0 to 22, or a simplified Geneva score of ≤4 on a scale of 0 to 9; on all three scales, higher scores indicate a greater probability of pulmonary embolism) or should use the YEARS algorithm. Each circled number refers to a different clinical decision rule, and each circled letter to a distinct d-dimer strategy. Imaging can be avoided in patients with clinical probability scores at or below the given cutoff and d-dimer level below the given cutoff. Computed tomography (CT) and ventilation–perfusion single-photon-emission computed tomography (SPECT) are reserved for patients with a clinical probability score above the preset cutoff for the chosen score or a d-dimer at or above the preset cutoff for the chosen d-dimer option. The adjusted d-dimer thresholds have been validated for assays with a manufacturer-recommended cutoff of 500 ng per milliliter. DVT denotes deep-vein thrombosis.

Key

<table>
<thead>
<tr>
<th>Wells score</th>
<th>Points</th>
<th>Revised points</th>
<th>Simplified points</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE is the most likely diagnosis</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Signs and symptoms of DVT</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Heat rate ≥100 beats/min</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>In previous 48 h, immobilization for &gt;3 days or surgery</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Previous DVT or PE</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Age ≥50 yr</td>
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<td>1</td>
</tr>
<tr>
<td>Active cancer</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Heart rate 75–94 beats/min</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Heart rate ≤74 beats/min</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pain in lower limb</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hemoptysis</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>NEW ITEMS</td>
<td>Points</td>
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<td>PE is the most likely diagnosis</td>
<td>5</td>
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<tr>
<td>Hemoptysis</td>
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<td></td>
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<tr>
<td>Clinical signs of DVT</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


d-dimer < manufacturer-recommended cutoff

CT angiogram or ventilation-perfusion SPECT

Positive

Negative

PE ruled out

PE diagnosed

Figure 1 (facing page). Overview of Testing for Pulmonary Embolism in Outpatients or Patients in the Emergency Department.

Patients with pulmonary embolism whose conditions are hemodynamically stable and who have no right ventricular strain and normal cardiac biomarkers are considered to have low-risk pul monary embolism. Most of these patients can be treated with a direct oral anticoagulant (on the basis of high-quality trial data) and assessed for outpatient treatment. The decision for a patient to be treated at home can be guided by the score on the simplified Pulmonary Embolism Severity Index (PESI) or the Hestia score (Fig. 2). In contrast to the Hestia score (a checklist of criteria that preclude treatment at home), the score on the simplified PESI predicts the risk of death rather than nonfatal complications and does not account for important variables such as the availability of support for the patient at home. Results of a randomized, controlled trial showed a low risk of adverse events among patients with no Hestia criteria or with a score of 0 on the simplified PESI who received treatment as outpatients.

Subsequent Management

Direct oral anticoagulants are the first-line treatment for most patients. Randomized trials have shown that direct oral anticoagulants, which do not necessitate monitoring, are as effective as the risk of recurrent venous thromboembolism as vitamin K antagonists and result in a lower risk of major bleeding. Because comparisons of direct oral anticoagulants are lacking, the choice of agent is guided by pharmacologic properties and patient characteristics and preferences (e.g., concomitant interacting medications and patient preference for once-daily or twice-daily medication). In contrast to patients with intermediate-risk pulmonary embolism, the therapeutic effects of immediate treatment with direct oral anticoagulants rivaroxaban and apixaban as compared with low-molecular-weight heparin have not been studied in patients at intermediate risk for pulmonary embolism, and unfractionated heparin causes excess bleeding. When available, catheter-directed thrombolysis remains an option for patients at intermediate risk who have proximal, central pulmonary embolism; however, there is insufficient evidence to support catheter-directed thrombolysis over low-molecular-weight heparin in these patients.
Pulmonary embolism (PE) has been diagnosed

High-Risk PE
- Shock, end-organ hypoperfusion, hypotension, or cardiac arrest

Immediate reperfusion therapy

Intermediate-Risk PE
- Signs of right heart strain on imaging, elevated troponin or BNP, or both

Admit, monitor vital signs, and administer LMWH

Low-Risk PE
- All other patients

Choose and know one decision tool for determining disposition:

No Hestia criteria
OR
Simplified PESI score = 0
OR
Implicit assessment that patient’s condition is stable without IV medication or oxygen and that the patient has sufficient home support and is not at risk for imminent bleeding

AND
Rapid, expert outpatient follow-up is available

Patient suitable for discharge:
- Discharge from hospital while taking DOAC (LMWH or VKA if indicated)

Patient not suitable for discharge:
- Admit, DOAC (LMWH or VKA if indicated)

Hestia score
- Condition is hemodynamically unstable
- Patient considered for reperfusion strategy
- High risk of bleeding
- Oxygen supplementation indicated
- IV angiose indicated
- PE was diagnosed while patient was taking an anticoagulant
- Other medical reason for admission
- Inadequate social support to discharge
- Creatinine clearance <30 mL/min
- Severe hepatic impairment
- Pregnancy
- History of heparin-induced thrombocytopenia

Simplified PESI score

<table>
<thead>
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<th>Points</th>
<th>Simplified PESI score</th>
</tr>
</thead>
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<td>≥2</td>
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<td>≥3</td>
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<tr>
<td>≥4</td>
<td>2</td>
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<tr>
<td>≥5</td>
<td>3</td>
</tr>
<tr>
<td>≥6</td>
<td>4</td>
</tr>
</tbody>
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Table 1. Anticoagulant Treatment Regimens for Pulmonary Embolism.*

<table>
<thead>
<tr>
<th>Initial Phase of Anticoagulation</th>
<th>Short-Term Phase of Anticoagulation (3–6 mo)</th>
<th>Indefinite Phase of Anticoagulation (after 3–6 mo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dabigatran, administered orally, 150 mg twice a day</td>
<td>Dabigatran, administered orally, 150 mg twice a day†</td>
<td>Dabigatran, administered orally, 150 mg twice a day‡</td>
</tr>
<tr>
<td>Rivaroxaban, administered orally, 20 mg once a day</td>
<td>Rivaroxaban, administered orally, 20 mg once a day</td>
<td>Rivaroxaban, administered orally, 20 mg once a day or 10 mg once a day§</td>
</tr>
</tbody>
</table>

* Direct oral anticoagulants and low-molecular-weight heparin are contraindicated in patients with severe renal impairment. Dosing of these medications in patients with renal impairment differs with the specific agent and among jurisdictions. With regard to use of direct oral anticoagulants in patients with obesity, post hoc analyses of phase 3 trials, observational data, and pharmacokinetic and pharmacodynamic data suggest that direct oral anticoagulants and vitamin K antagonists have similar effectiveness and safety in patients with body weight up to 120 kg or a body-mass index (BMI; the weight in kilograms divided by the square of the height in meters) of up to 40. For patients who weigh more than 120 kg or have a BMI higher than 40, standard doses of rivaroxaban or apixaban are among appropriate anticoagulant options. Fewer supportive data exist for apixaban than for rivaroxaban. Other options include vitamin K antagonists, weight-based low-molecular-weight heparin (administered according to manufacturer recommendations), and fondaparinux. 52 INR denotes international normalized ratio.

† A reduction in dose may be considered after 3 to 6 months of therapy.
‡ Low-molecular-weight heparin may be administered subcutaneously throughout initial, short-term, and indefinite phases of treatment, with dosing according to body weight.
§ Low-molecular-weight heparin should be administered for 3 to 10 days before the initiation of dabigatran or edoxaban and concurrent to initiating vitamin K antagonists.

Figure 2. Overview of Pulmonary Embolism Management in the Context of Risk Stratification.

At the time of diagnosis, pulmonary embolism should be stratified as low risk, intermediate risk, or high risk. Patients with high-risk pulmonary embolism should be assessed for immediate reperfusion interventions such as systemic thrombolysis. Patients with intermediate- or low-risk pulmonary embolism should be carefully monitored and assessed for initiation of treatment with low-molecular-weight heparin (LMWH). Most patients have low-risk pulmonary embolism and can be assessed for outpatient anticoagulant therapy according to their Hestia score, score on the simplified Pulmonary Embolism Severity Index (PESI), or the physician’s implicit judgment. All patients discharged home would benefit from rapid, reliable outpatient follow-up. BNP denotes brain natriuretic peptide, DOAC direct oral anticoagulant, IV intravenous, and VKA vitamin K antagonist.

with pulmonary embolism, since vitamin K antagonists and direct oral anticoagulants cross the placenta and are associated with adverse pregnancy outcomes. 25,27

Duration of Therapy

Patients with acute pulmonary embolism should receive anticoagulant therapy for at least 3 months to reduce the risks of further embolization, thrombus extension, early recurrence of venous thromboembolism, and death (Table 1). 38 Whether treatment is stopped at 3 months or continued indefinitely depends on whether the reduced risk of recurrent venous thromboembolism with continued anticoagulation therapy outweighs the increased risk of bleeding, and the decision should take patient preferences into account. 28,29

Among patients who have pulmonary embolism that was provoked by a major transient (i.e., reversible) risk factor (e.g., surgery with general anesthesia lasting ≥30 minutes, confinement to bed in the hospital for ≥3 days due to an acute illness, or major trauma or fracture), the long-term risk of venous thromboembolism recurrence is low and anticoagulation therapy can be stopped after 3 months. If the pulmonary embolism was very large or was associated with moderate dysfunction of the right ventricle or if the patient has persistent residual symptoms, some experts recommend that treatment extend to 6 months. 39 In patients with persistent procoagulant factors such as active cancer or antiphospholipid syndrome or who have had previous episodes of unprovoked venous thromboembolism, the long-term risk of recurrence is higher and anticoagulation therapy should be continued indefinitely. 39,40
Use of inferior vena cava filter
Recommended against inferior vena cava filter in patients who can receive anticoagulation
Consider extended anticoagulation instead of stopping anticoagulation at 3 mo
Duration of anticoagulation, including cancer-associated PE
Recommended 3 mo anticoagulation for primary treatment
7 In PE provoked by major transient risk factor, recommended stopping anticoagulation at 3 mo; if patient has active cancer without high bleeding risk, recommended extended anticoagulation instead of stopping anticoagulation at 3 mo, if high bleeding risk, suggested extended anticoagulation instead of stopping anticoagulation at 3 mo; if high bleeding risk, suggested extended anticoagulation instead of stopping anticoagulation at 3 mo

* These guidelines do not include management of pulmonary embolism (PE) and venous thromboembolism (VTE) risk during pregnancy planning, pregnancy, and postpartum; these topics are addressed in other guidelines. 19 19 The new england journal of medicine
lism, the long-term risk of recurrence is high and indefinite anticoagulation therapy is recommended.35,36,40 Decision making is more nuanced in patients with a first pulmonary embolism that was unprovoked or weakly provoked (i.e., associated with a minor transient risk factor, such as estrogen therapy, pregnancy, minor surgery, or minor leg injury). Among these patients, the risks of recurrent venous thromboembolism and fatal pulmonary embolism after stopping anticoagulation therapy are 10% and 0.4%, respectively, at 1 year, and 36% and 1.5% at 10 years; the risks are higher among men than among women.42 Trials have shown that extended anticoagulation therapy, as compared with shorter durations of anticoagulation, is highly effective for the prevention of recurrent venous thromboembolism. However, in a meta-analysis (involving 14 randomized, controlled trials and 13 cohort studies), extended anticoagulation with direct oral anticoagulants was associated with a risk of 1.12 major bleeding events per 100 person-years (case fatality, 9.7%), and extended anticoagulation with vitamin K antagonists was associated with a risk of 1.10 bleeding events per 100 person-years (case fatality, 8.3%).43 The risk of bleeding was higher among older patients and among patients who had a creatinine clearance of less than 50 ml per minute, a history of bleeding, had received antplatelet therapy, or had a hemoglobin level of less than 10 g per deciliter.44

Although indefinite treatment with anticoagulation therapy is typically recommended for unprovoked or weakly provoked venous thromboembolism event, particularly in patients who are not at high risk for bleeding, time-limited treatment may be appropriate in some patients, including those among whom the estimated risk of recurrent venous thromboembolism is less than 5% within the first year after anticoagulation therapy is stopped.45 Decision making with respect to the treatment of venous thromboembolism in women may be guided by the HERDOO2 rule, a prospectively validated prediction score that identifies some women with a first unprovoked or weakly provoked venous thromboembolism event who can safely discontinue anticoagulation therapy (Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org).46 No validated score is currently available for use in men who have had a first un-

### Current guidelines for pulmonary embolism management include those issued by the American College of Chest Physicians (ACCP),47 the American Society of Hematology (ASH),48,49 and the European Society of Cardiology (ESC).50 A summary of the key recommendations in these guidelines is provided in Table 2. Our recommendations align with these guidelines, which are largely concordant but differ in the strength of their recommendations for some topics. ACCP and ASH guidelines recommend anticoagulation be stopped at 3 months in the case of a first pulmonary embolism provoked by a weak transient risk factor, a recommendation supported by ESC guidelines, which suggest that indefinite anticoagulation be considered in such patients. Our approach to this situation generally aligns with the ACCP and ASH guidelines while taking into account factors that influence the risk of recurrence (e.g., male sex or older age) and patient preference.

### Areas of Uncertainty

Appropriate management of subsegmental pulmonary embolism (a single isolated subsegmental pulmonary embolus or multiple emboli, without the presence of pulmonary embolism in a segmental or more proximal pulmonary vessels and without deep-vein thrombosis in the legs) is uncertain. Although some guidelines suggest clinical surveillance instead of anticoagulation in patients with low-risk subsegmental pulmonary embolism, a recent prospective cohort study involving such patients who were treated without anticoagulation therapy showed a higher-than-expected incidence of recurrent venous thromboembolism during 90-day follow-up.49 A randomized, placebo-controlled trial of clinical surveillance as compared with anticoagulation in this patient population is ongoing (ClinicalTrials.gov number, NCT04263038).

Whether a particular direct oral anticoagulant administered at a treatment-level dose, in the absence of an increased bleeding risk and considering our preferences, we would recommend switching to a low-dose direct oral anticoagulant on a long-term basis for secondary prevention. Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

### Conclusions and Recommendations

The patient with breathlessness described in the vignette was estimated to have greater than a 15% likelihood of pulmonary embolism. In the context of the patient’s low Wells score for pulmonary embolism, d-dimer testing was warranted to guide the need for imaging. CT is indicated, given the d-dimer level of more than 1000 ng per milliliter. Under the presumption that the patient’s CT scan confirms pulmonary embolism and shows normal right-ventricle dimensions, he would be classified as having low-risk pulmonary embolism, given his normal anatomy and lack of injuries. Treatment with a direct oral anticoagulant should be started promptly, and the patient should be given information about the pulmonary embolism diagnosis. In the absence of contraindications to treatment on an outpatient basis (no Hestia criteria present), the patient can be discharged directly from the emergency department with prompt clinical follow-up.

We would recommend that he undergo cancer screening appropriate for his age and personal risk. After the patient receives 3 to 6 months of therapy with a direct oral anticoagulant administered at a treatment-level dose, in the absence of an increased bleeding risk and considering our preferences, we would recommend switching to a low-dose direct oral anticoagulant on a long-term basis for secondary prevention.

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5. Kempny A, McCabe D, Dimopoulos K, C. Current guidelines for pulmonary embolism management include those issued by the American College of Chest Physicians (ACCP), the American Society of Hematology (ASH), and the European Society of Cardiology (ESC). A summary of the key recommendations in these guidelines is provided in Table 2. Our recommendations align with these guidelines, which are largely concordant but differ in the strength of their recommendations for some topics. ACCP and ASH guidelines recommend anticoagulation be stopped at 3 months in the case of a first pulmonary embolism provoked by a weak transient risk factor, a recommendation supported by ESC guidelines, which suggest that indefinite anticoagulation be considered in such patients. Our approach to this situation generally aligns with the ACCP and ASH guidelines while taking into account factors that influence the risk of recurrence (e.g., male sex or older age) and patient preference.

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Physician Investigator

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Cardio-Oncology Research and Clinical Fellowship
Program Director: Dipti Gupta, MD, MPH
Chief, Cardiology Service: Richard M. Steinart, MD
The Cardiology Service at Memorial Sloan Kettering Cancer Center is offering one to two-year fellowship training in Cardio-Oncology for board eligible/certified cardiologists. It is a clinically rigorous and supportive program with unparalleled inpatient and outpatient clinical experiences. Fellows also work side by side with accomplished clinical and translational researchers in the production of multiple peer-reviewed publications. Exposure to advanced imaging in cardio-oncology including echocardiography, cardiac PET, coronary CTA and cardiac MRI is an important aspect of the program.

Recruitment:
Positions available for July 2023 start date. Please complete an application and submit three letters of recommendation; curriculum vitae, personal statement, and medical school diploma.

For more information, please contact:
Xavier Aristy
Fellowship Coordinator
Phone: (212) 639-5154
Fax: (212) 717-3624
Email: medcardfellow@mskcc.org

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Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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Mount Sinai Hematologist/Oncologist

The Department of Hematology/Oncology at the Icahn School of Medicine at Mount Sinai affiliated with NYU School of Medicine is seeking a full time Hematologist/Oncologist for our teaching hospital based Cancer Center. We are seeking an energetic, highly motivated, and talented individual to join our team.

Responsibilities entail:
- 4 half day oncology clinic, 1 half day hematology clinic, and On Call duties shared among the 5 Hematologists/Oncologists. Oncologists (call and home) with rare emergency in-house consults.
- Clinical Service on in-patients in shared equally.
- Each Oncologist has a full-time Oncology APNP working with them.

Successful candidates must be board certified/eligible in Internal Medicine or Hematology and Medical Oncology and must have training in clinical and research aspects of Hematology and Oncology.

The Icahn School of Medicine at Mount Sinai is a national leader in clinical care, medical education, research, and community service.

Please submit a detailed resume highlighting your professional accomplishments. Compensation is competitive and proportionate with qualifications and excellent fringe benefits.

To apply please visit www.CHAProviders.org

Candidates must submit CV/confidentiality via email to ProviderRecruitment@challiance.org

CHA Provider Recruitment –

Tel: 617-665-3555

San Juan Regional Medical Center

San Juan Regional Medical Center is a non-profit hospital located in the heart of historic and cultural sites. As a nationally recognized, award-winning public healthcare system, we provide comprehensive primary care, specialty and emergency care to our diverse patient population through an established network of outpatient clinics, a dedicated psychiatry inpatient facility, and full service hospital. As a Harvard Medical School and Tufts University School of Medicine affiliate, we offer unique learning opportunities with medical students and residents.

We utilize a fully integrated EMR system (Epic) throughout both ambulatory and inpatient locations.

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- Non-Invasive Cardiology
- Dermatology
- Genetics
- Psychiatry
- Neurology
- Sleep Medicine
- Otolaryngology
- Endocrinology

Primary Care
- Family Medicine
- Internal Medicine
- Med/Peds

Adult Psychiatry
- Child/Adolescent Psychiatry
- Psychology
- Neuropsychology
- Division Chief, Psychiatry
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- Family Medicine
- Gastroenterology
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Contact Terri Smith at 888.282.6591 or 505.609.6011

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CHA is passionate about helping children and their families, join our expanding team and make a difference!

Psychiatry Opportunities:
- Inpatient Child/Adolescent Psychiatrists
- Inpatient Child/Adolescent Psychology
- Inpatient Neuropsychologists
- Child/Adolescent Psychiatry

CHA is a teaching affiliate of Harvard Medical School (HMS) and academic appointments are available commensurate with medical school criteria.

Psychology Opportunities:
- Inpatient Child/Adolescent Psychologists
- Inpatient Neuropsychologists
- Pediatric Neuropsychologists

Please visit www.CHAproviders.org to learn more and apply through our secure candidate portal. CVs may be sent directly to Melissa Kelley, CHA Provider Recruiter via email at providerrecruitment@challiance.org. CHA’s Department of Provider Recruitment may be reached by phone at (617) 665-3553 or by fax at (617) 669-2932.

In keeping with federal, state, and local laws, Cambridge Health Alliance (CHA) policy forbids employees and associates to discriminate against anyone based on race, religion, color, gender, age, marital status, national origin, ancestry, sexual orientation, marital status, disability, or any other characteristic protected by law.

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To learn more about our opportunities at Cambridge Health Alliance, please visit

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Tower Health is comprised of five hospitals that span three counties and serve almost 2.5 million people in Southeastern PA, just 90 minutes from Philadelphia.

Among offering more than 20 residency and fellowship programs approved by the Accreditation Council for Graduate Medical Education and the American Osteopathic Association, in addition to other graduate and undergraduate training, Tower Health has partnered with Drexel University College of Medicine to expand opportunities for medical training in the region. This collaboration brings graduate and undergraduate clinical education and research less than one-mile walking distance from Reading Hospital, a regional medical campus for Drexel University College of Medicine at Tower Health.

Throughout Tower Health, outstanding academic and clinical experiences focused on patient outcomes combined with the area’s cultural events, historic treasures, outdoor activities, and visual arts create an environment for showcasing your professional attributes and enjoying quality leisure time. Go to Careers.TowerHealth.org to explore opportunities throughout the system or email your CV to Cynthia Forintos@towerhealth.org for consideration.

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UNIVERSITY OF WASHINGTON
Harborview Medical Center Echo Lab Director

The Division of Cardiology, Department of Medicine at the University of Washington is recruiting a full-time Assistant Professor without tenure by source of funding (with clinical, research, and teaching responsibilities) to support the department’s commitment to patient care, scholarship and medical education. This position offers opportunities to make a significant contribution to the outstanding opportunity for collaboration at the University of Washington. The successful candidate will work within the leadership team at the Harborview Medical Center (HMC) Echocardiography Lab, bringing one of the nation’s premier echocardiography laboratories to the forefront of clinical care through leadership in disease-specific specialty training and investigation. The anticipated start date will be January 1, 2023 or earlier.

All University of Washington faculty engage in teaching, research and service.

Applicants must hold an MD degree (or foreign equivalent) and be board certified in cardiovascular disease and echocardiography (or foreign equivalent) and must have demonstrated excellence in echocardiography. Preference will be given to candidates with experience in advanced training in echocardiography and practice in echocardiography laboratories focused on the specialized training and investigations necessary for effective training on echocardiographic interpretation.

Preference will be given to candidates with experience in advanced training in echocardiography and practice in echocardiography laboratories focused on the specialized training and investigations necessary for effective training on echocardiographic interpretation.

Applicants are strongly encouraged to apply immediately, with all applications received after October 15, 2022, considered. Submit CV and cover letter to: Kelly Phan, kelly.phan@uwmc.edu

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