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Career Guide

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The NEW ENGLAND JOURNAL of MEDICINE

March 23, 2023

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One such example is our popular Clinical Practice articles that offer evidence-based reviews of topics relevant to practicing physicians. This edition includes the May 5, 2022, Clinical Practice article, "Nonspecific Low Back Pain." You also might want to listen to *Intention to Treat*, a new podcast from NEJM, that draws on the world-class expertise of NEJM editors and specialists to offer patients and clinicians critical context and insights into complex research, medical interventions, and urgent health policy debates.

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Sincerely,

Eric J. Rubin, MD, PhD

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NEJM CareerCenter

Supporting Physician Wellness: Health Care Organizations Seeking — and Piloting — Programs to Help Physicians Manage Their Work-Life Stressors

By Bonnie Darves

Just when organizations were formally recognizing that many of their physicians were seriously struggling with burnout and had started to seek remedies to address the endemic problem, the pandemic hit. The timing could not have been worse, many experts on physician burnout agree, and yet, for the most part, the physician workforce navigated the added stressors of COVID-19 both admirably and competently. Physicians worked in highly functioning teams to save lives, mitigate the virus' impact on patients, and offer the highest standard of care possible under the circumstances. Many physicians also helped their organizations chart a "survival path" to navigate the operational crises the pandemic unleashed.

Organizations that employ physicians, having witnessed the steep toll that the pandemic on top of burnout took, are understandably concerned about the state of their workforce. Many organizations are actively seeking, developing, and trying out wellbeing improvement programs to help bolster physicians and other clinicians. Health care leaders are recognizing, too, that physicians are hardly exempt from "the great resignation" our country is experiencing among workers.

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Numerous approaches are being piloted or implemented, with varying degrees of success. These range from informal offerings such as hospital "wellness wagons" delivering a combination of snacks and cheering-up support and wellbeing days off for residents and fellows, to more structured programs. Examples of formal offerings include buddy systems mimicking military-type "battle buddy" practices, mental-health check-in offerings, and physician coaching resources.

The latter, when provided with anonymity guaranteed, appear to be somewhat effective for those who access them, according to Eileen Barrett, MD, MPH, a hospitalist and educator who formerly directed graduate wellness initiatives at the University of New Mexico (UNM). "Many physicians who have received coaching have benefited, and some organizations have been able to demonstrate real outcomes," said Dr. Barrett, who now practices with the Indian Health Service and has published on advocated for national clinician wellbeing improvement strategies. She said that UNM's mental health check-ins, a "renewable" offering, were also relatively well received — 78 of the 109 physicians who booked appointments when the program launched kept those appointments.

Some organizations, such as Intermountain Healthcare in Salt Lake City, Utah, are trying several approaches simultaneously — developing a physician and advanced practice provider (APP) wellbeing center and dedicated portal and scheduling wellness-focused grand rounds and separate leadership rounds to celebrate successes and learn what clinicians are struggling with in their work. Intermountain also provides a range of peer-support forums and options for connecting caregivers, aimed at offering a confidential forum for sharing emotions.

"My task is to develop resources and learn from others around the country — and at Intermountain, we're all working on this together to determine what works and what's not helpful," said Anne Pendo, MD, an internist who is senior medical director of Provider Experience and Wellbeing at Intermountain. "What we all recognize, I think, is that we as a profession weren't well before the pandemic," she said, and that the pandemic further eroded physician resiliency. "Now we have an opportunity to try to discover ways to improve wellbeing and then implement them."

Peer-support programs taking hold

At Intermountain, of the initiatives piloted to date, the peer-support offerings have been among the most successful in terms of uptake. Peer supporters have trained nearly 100 physicians to serve in the role and approximately 300 physicians and clinicians have participated. "I think it's important to position this as 'I can be a helper' if you want physicians to get involved, and to ensure you offer a safe space for sharing feelings — something physicians have historically struggled with," she said, because of fear they'll be perceived as weak.

Researchers and physicians involved in developing wellness-support programs and resources are finding that although it's challenging to figure out exactly what physicians do need in support, there's growing consensus on what physicians don't want: Tips and recommendations for improving their personal resilience. In other words, Dr. Barrett said, "Physicians don't want to hear about another yoga class or meditation practice."

Heather Farley, MD, chief wellness officer at ChristianaCare in Delaware, which rolled out the "wellbeing wagon" described earlier and created a Center for Worklife Wellbeing, concurred with Dr. Barrett. "What doesn't work is focusing too much on the personal minutiae, such as sleep hygiene. Whatever you offer has to support physicians "in their work environment," said Dr. Farley, an emergency medicine physician. Like Intermountain, ChristianaCare has seen a gradual but steady utilization uptake of peer-support offerings. "We're shifting away from the culture of 'shame and blame' to one that says, 'It's OK not to be OK,' and to reach out if you need help," she said.

At the University of Minnesota, which created the buddy system a few months into the pandemic and rolled out the program in a matter of weeks, the model was predicated on the recognition that Dr. Farley cites: everyone needs help sometimes and it's important to know that someone has your back and is willing to help. In the university's program, modeled in part on both the military-battlefield scenario and observations an anesthesiologist made in the operating room during the early weeks of the pandemic, when staff members were becoming more nervous, buddies are "paired" somewhat strategically. Ideally, they're close in age and career length and experience, so that they can both recognize and understand the stressors their buddy is experiencing — and identify when that buddy needs some extra support.

"We decided that the battle-buddy system was a brilliant idea and decided to give it a decent trial," said Cristina Sophia Albott, MD, who heads the university's division of adult mental health. "We wrote the protocol in one week, started the program in two weeks, and rolled it out across the

entire medical school." By July 2020, more than 3,000 health care personal, primarily physicians and nurses, had adopted and established the model.

Around the same time, the University of Minnesota implemented "listening groups" and established mental-health consultation services in each clinical department. The latter offering, however, despite the appointments being structured a confidential, wasn't as well received as the buddy program. "Unfortunately, few physicians availed themselves of that offers," she said.

On a positive note, even though the worst of the pandemic crises appear to have largely receded at the university, some departments have decided to continue with the buddy program, Dr. Albott reported. Although there's been considerable variation in how individual departments set up or later retooled their buddy programs, the initiative's early and ongoing success is a clear indicator of the offering's value, she added.

Desperately seeking on-the-ground support and remedies

What physicians do want in the way of support from their organizations, Dr. Barrett and others interviewed for this article agreed, is operational load-lightening, however that can be achieved and institutionalized. Offerings such as onsite childcare and schedule flexibility to address family needs rank high on the wish list for many physicians, and there's a growing consensus that the electronic health record (EHR) persists as a chief source of physician frustration and stress, despite years of organizations' attempts to ameliorate the problem.

"What does appear to work is providing physicians protected time for EHR training or having dedicated information technology (IT) support for dealing with EHR-related issues," Dr. Barrett said, or adding scribes to offload the bulk of EHR-data entry processes. In similar fashion, physicians would appreciate their institutions removing the burden of treatment prior-authorization management. And she noted that the incredibly complex and inordinately inefficient processes related to physician credentialing are ripe for fixing, as they're unnecessarily burdensome for physicians. "If credentialing were centralized, at least for Medicare, that would go a long way in reducing the burden. Most people think that the system, as it stands, doesn't really make anyone safer," Dr. Barrett said.

Health care organizations, concerned about both their physicians' wellbeing and their facilities' ability to maintain adequate staffing levels in a time when many physicians are deciding to leave jobs where they don't feel well enough supported, are taking note. They're actively trying to figure out what physicians want and need to care for patients with fewer frustrations.

Physician professional organizations are also stepping in to identify what's needed now in institutional supports to help physicians mitigate burnout and regain resiliency. The American College of Physicians' Patients Before Paperwork initiative, for example, has identified the most burdensome tasks and regulatory requirements that internists face and offered policy recommendations for reducing associated workload. The American Medical Association has also developed a multifaceted initiative to provide guidance and targeted solutions to health care organizations for many of the problems that threaten physician wellbeing.

In an article published in the Annals of Internal Medicine in September 2021, Dr. Barrett and her co-authors proposed a series of steps that organizations might take to reduce clinician burnout, keep physicians in the workforce as the health system continues to navigate COVID-19, and simply make physicians' practice lives more tolerable. In addition to the COVID-related recommendations for improving physician safety and providing practical support as needed to address system-capacity constraints, the authors urged organizations to do the following:[1]

- Help ensure more flexible scheduling for physicians who are parents or care for aging parents.
- Reduce, eradicate, or reassign administrative tasks and meetings that aren't mission critical and haven't delivered improved patient outcomes.
- Provide no-cost and truly confidential mental-health support services — and also truly encourage physicians to use their available vacation and professional development time to nurture a healthier workplace. At the same time, organizations should update credentialing and employment applications to remove unnecessary questions related to mental and physical health diagnoses, to reduce the associated stigma.

Dr. Barrett offers another recommendation to employer organizations. "If you offer resources that might support or improve physician wellbeing, make sure your physicians know about them. Physicians are so stretched and busy that they might not know what's available," she said.

Tips for structuring physician-wellness support offerings

All sources who participated in this article offered guidance for organizations trying to provide resources that might help improve physician well-being. Here are a few:

- Understand that each environment is different, which means that the problems and needs might vary widely from one health care organization to another. To develop appropriate solutions and resources, ensure that physicians are directly involved in creating them.
- Avoid focusing resources on individual-physician resilience and instead focus on system approaches that might have the added benefit of helping physicians support one another and reduce unnecessary workload. Keep in mind that some physicians have an innate distrust of "corporate-sponsored" initiatives that appear to be focused on the bottom line.
- Provide a safe forum for physicians to recommend institutional approaches that mitigate the burdens that contribute to burnout and also make their overall work lives more realistically manageable.
- If you try a wellness initiative and it doesn't produce results that are valuable to physicians, be ready and willing to abandon it. Then be prepared pilot something else — quickly.

[1]Barrett E, Hingle ST, Smith CD, Moyer DV. Getting Through COVID-19: Keeping Clinicians in the Workforce. Ann Intern Med. 2021 Nov;174(11):1614–1615. doi: 10.7326/M21-3381. Epub 2021 Sep 28. PMID: 34570597; PMCID: PMC8500335.

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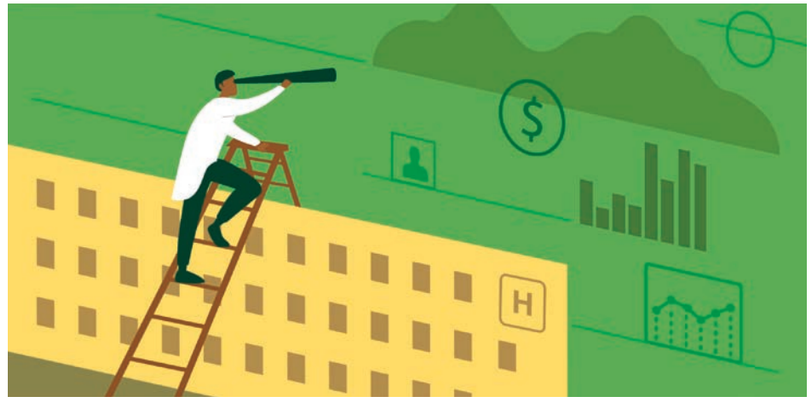

When is It Time to Change Jobs?

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

Statistically, the majority of physicians will change jobs within their first five years out of training. Additionally — even at later stages of physician careers — an increasing percentage of the physician population considering changes in their career. Physician turnover is an often talked about issue amongst hospital administrators and practice owners.

Why is this? Well, part of it has to do with the challenges associated with being a physician in the current health care landscape. My father, a cardiologist, spent four decades of his career with the same group. Many of his friends can say the same. On the other hand, I know a far lower percentage of colleagues who could say with confidence that they see themselves with the same group for the remainder of their careers. Aside from practical drivers of physician turnover, such as a desire to be closer to family or a change in the job of a significant other, many are finding their workplaces increasingly challenging. As consolidation within the health care space increases, physician demographics change, and the pressure to do more with less increases, more physicians find themselves asking if their situation is sustainable.

We all have aspects of our jobs that are pain points, and the expectation that any job will be perfect is unrealistic. How do you know you're not just trading one set of pain points for another — which in a worst case scenario, is potentially worse elsewhere?

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When considering a job change, I always recommend writing down the pain points at your current job, delineating which ones are dealbreakers, and which ones could potentially be changed if discussed openly with the employer. If you are planning on leaving anyways, it's advisable to first see if the current situation can be fixed. Although these conversations can be uncomfortable, ultimately if you're planning on leaving regardless, it may be that there's little to lose in trying. Similarly, ensuring that these same pain points are not present at the new job is prudent.

Factors such as salary, flexibility in work hours, opportunities for growth or promotion, dissatisfaction with the current job environment and the direction a company is going in, burnout, or other non-salary aspects of the compensation package are all examples of things that lead to job turnover that could potentially be negotiated with the current employer.

There are other factors which many see as writing on the wall that a change is inevitable. Sometimes these can be related to changes in ownership or management structure of a group, a confirmed trend towards cutting physician compensation or hiring patterns which suggest the physician's time at the job is limited, or administrative mandates that have been challenged and upheld which leave the physician with the conclusion that they can't practice medicine in a way that they enjoy or feel is best for the patient.

Many people stay with jobs out of comfort or fear of change. Unfortunately, this leads to burnout, and ultimately is a threat to career longevity. If you're feeling unhappy with your job, it's time to either advocate for change within your current position, or consider other options.

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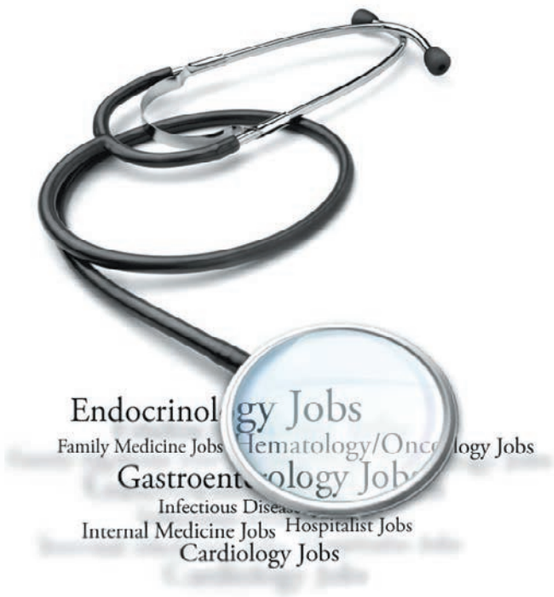

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The NEW ENGLAND JOURNAL of MEDICINE

CLINICAL PRACTICE

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

Nonspecific Low Back Pain

Alessandro Chiarotto, P.T., Ph.D., and Bart W. Koes, Ph.D.

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

A 37-year-old man reports he has had pain in his lower back for the past month. The pain is worse when he gets up in the morning, when it is associated with stiffness in the lower back. The patient has a history of episodes of low back pain that have typically occurred after vigorous sports activities. His medical history is otherwise unremarkable; he has not previously sought medical care for the pain. Physical examination shows that the patient's range of motion is limited on lumbar forward bending, and there is tenderness on palpation of the lower back. There are no neurologic deficits. How would you evaluate and treat this patient?

From the Department of General Practice, Erasmus University Medical Center, Rotterdam (A.C., B.W.K.), and the Department of Health Sciences, Faculty of Science, Vrije Universiteit Amsterdam, Amsterdam (A.C.) — both in the Netherlands; and the Department of Sports Science and Clinical Biomechanics, University of Southern Denmark, Odense (B.W.K.). Dr. Chiarotto can be contacted at a.chiarotto@erasmusmc.nl or at the Department of General Practice, Erasmus University Medical Center, Dr. Molewaterplein 40, 3015 GD Rotterdam, the Netherlands.

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THE CLINICAL PROBLEM

Low back pain, typically defined as pain below the costal margin and above the inferior gluteal folds, with or without leg pain,[1] is worldwide the most prevalent and most disabling of the conditions that are considered to benefit from rehabilitation.[2] In a systematic review that included 165 studies from 54 countries, the mean point prevalence of low back pain in the general adult population was approximately 12%, with a higher prevalence among persons 40 years of age or older and among women; the lifetime prevalence was approximately 40%.[3]

Low back pain is classified as specific (pain and other symptoms that are caused by specific pathophysiological mechanisms of nonspinal or spinal origin) or nonspecific (back pain, with or without leg pain, without a clear nociceptive-specific cause).[4] Nonspinal causes of specific low back pain include hip conditions, diseases of the pelvic organs (e.g., prostatitis and endometriosis), and vascular (e.g., aortic aneurysm) or systemic disorders; spinal causes include herniated disk, spinal stenosis, fracture, tumor, infection, and axial spondyloarthritis. Lumbar disorders with radicular pain due to nerve-root involvement have a higher prevalence (5 to 10%) than other spinal causes; the two most frequent causes of such back pain are herniated disk and spinal stenosis.[5] The overall prevalence of the other spinal disorders is low among patients with acute low back pain. For example, among 1172 patients who presented to primary care clinicians in Australia with acute low back pain, only 11 (0.9%) were found to have serious spinal conditions (mostly fractures) during 1 year of follow-up.[6] The authors of a Dutch study that involved primary care patients reported axial spondyloarthritis in almost one quarter of adults 20 to 45 years of age who presented with chronic low back pain,[7] although these findings have not been replicated.

In contrast to low back pain caused by specific identifiable causes, nonspecific low back pain probably develops from the interaction of biologic, psychological, and social factors,[4] and it accounts for approximately 80 to 90% of all cases of low back pain.[1] Low back pain is usually classified according to pain duration as acute (<6 weeks), subacute (6 to 12 weeks), or chronic (>12 weeks).[8]

KEY CLINICAL POINTS

NONSPECIFIC LOW BACK PAIN

- Nonspecific low back pain is diagnosed on the basis of the exclusion of specific causes, usually by means of history taking and physical examination.
- Imaging is not routinely indicated in patients with nonspecific low back pain.
- Most patients with an acute episode of nonspecific low back pain will recover in a short period of time.
- Education and advice to remain active are recommended for patients with acute or chronic low back pain.
- For chronic low back pain, exercise therapy and behavioral therapy represent first-line options, with medications considered to be second-line options.

RISK FACTORS

Risk factors for an episode of nonspecific low back pain include physical risk factors (e.g., prolonged standing or walking and lifting heavy weights), an unhealthy lifestyle (e.g., obesity), psychological factors (e.g., depression and job dissatisfaction), and previous episodes of low back pain.[9] In a case–crossover study that included 999 patients with sudden-onset acute low back pain, performance of manual tasks (e.g., those involving heavy loads or awkward postures) and distraction during an activity or task were identified as triggers of a new episode of pain.[10]

NATURAL HISTORY AND PROGNOSIS

Low back pain is increasingly understood to be a long-lasting condition with a variable course rather than isolated, unrelated episodes. According to a systematic review of prospective inception cohort studies (33 cohorts and 11,166 patients) that were conducted mainly in primary care and involved a variety of approaches to treatment,[11] new-onset episodes of low back pain generally abated substantially within 6 weeks, and by 12 months the average reported pain levels were low (6 [95% confidence interval {CI}, 3 to 10] on a scale of 0 to 100, with lower scores indicating less pain). Research on the course of nonspecific low back pain has identified three main pain-trajectory subgroups that emerge in the year after presentation and apply to both acute and chronic low back pain: a recovery trajectory in which the patient's condition improves rapidly or gradually toward a state of no or little pain, an ongoing trajectory in which the patient has moderate or fluctuating pain, and a persistent trajectory in which the patient perceives constant and severe pain (Fig. 1).[12] The majority of patients with acute low back pain (approximately 70%) have a pain trajectory that is prognostic for recovery, whereas this trajectory is less frequent in patients with chronic low back pain (approximately 30%), a population in which many patients (40 to 50%) have an ongoing pain trajectory.

According to a review of observational studies, factors that are consistently associated with poor outcomes (i.e., ongoing pain, disability, or both) in patients with low back pain included the presence of widespread pain, poor physical functioning, somatization, high pain intensity, long pain duration, high levels of depression or anxiety (or both), previous episodes of low back pain, and poor coping strategies.[13] An observational study with 5 years of follow-up that involved 281 patients with nonspecific low back pain showed higher risks of a persistent pain trajectory among patients with high pain intensity (relative risk ratio per unit increase, 1.87; 95% CI, 1.33 to 2.64), low socioeconomic status (relative risk ratio, 5.39; 95% CI, 1.80 to 16.2), negative illness perceptions (negative cognitive and emotional responses to low back pain) (range of relative risk ratio per unit increase, 0.83 [95% CI, 0.71 to 0.97] to 1.19 [95% CI, 1.06 to 1.34]), and passive coping behaviors (helplessness and reliance on others with regard to coping with low back pain) (relative risk ratio per unit increase, 1.90; 95% CI, 1.17 to 3.08).[14]

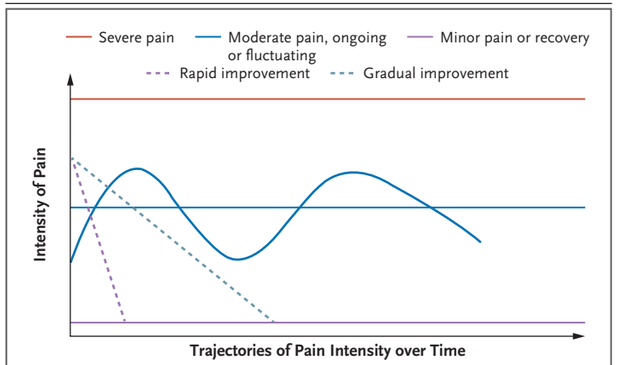

Figure 1. Simplified Principal Trajectories of Pain Intensity among Patients with Low Back Pain.

Adapted from Kongsted et al.[12]

STRATEGIES AND EVIDENCE

DIAGNOSIS AND EVALUATION

Diagnosis of nonspecific low back pain is made after specific disorders of spinal and nonspinal origin are ruled out. A detailed history taking and physical examination can point to spinal conditions or nonspinal conditions that may lead to specific intervention. The history should include attention to red flags (e.g., history of cancer or trauma, parenteral drug use, long-term glucocorticoid use, immunocompromise, fever, and unexplained weight loss), since their presence warrants consideration of an occult serious diagnosis (e.g., cancer, infection, or inflammatory disease) and close follow-up, although only some of these historical features have been shown to be useful predictors of such serious diagnoses. For example, in systematic reviews, a strong clinical suspicion for cancer[15] or a history of cancer[15,16] has been associated with an increased likelihood of a malignant condition, whereas other classic red flags (e.g., unexplained weight loss or fever) did not substantially affect the post-test probability of cancer.[15] Older age (>70 years), trauma, and the prolonged use of glucocorticoids have been associated with a high specificity for and considerable increased probability of spinal fracture, with the highest probability of fracture seen when multiple features are present.[16] History taking should also elicit whether pain is limited to the lower back or is more widespread; the latter may point to other conditions, such as fibromyalgia.

If a herniated disk is suspected, a positive ipsilateral straight-leg-raising test (in which pain results when the leg on the side of the back or leg pain is raised) is highly sensitive (in 92% of patients), and a positive contralateral straight-leg-raising test (in which pain is produced when the leg opposite the side of the back or leg pain is raised) is highly specific (in 90% of patients).[5] In the case of radiculopathy, a neurologic evaluation can rule out weakness, loss of sensation, or decreased reflexes; if any of these features are present, referral to a specialist may be indicated. Other maneuvers on physical examination have generally low diagnostic accuracy for the identification of other sources of low back pain (i.e., facet joints, sacroiliac joints, and disks).[17,18]

Screening tools can be used to estimate the risk that acute nonspecific low back pain will become chronic. The Predicting the Inception of Chronic Pain (PICKUP) tool is a validated prediction model that estimates the risk of chronic low back pain on the basis of five measures (i.e., disability compensation, presence of leg pain, pain intensity, depressive symptoms, and perceived risk of persistent pain) among patients who have an initial episode of low back pain.[19] A meta-analysis of studies that assessed other screening questionnaires showed that the Subgroups for Targeted Treatment (STarT) Back screening tool and the Örebro Musculoskeletal Pain Questionnaire, although not informative predictors of chronic pain, are predictive of subsequent disability; the latter was also highly predictive of work absenteeism.[20] The use of these screening tools in practice allows for the early identification of patients who are at risk for persistent low back pain–related disorders and may guide treatment.[21]

IMAGING

Routine imaging is not recommended in patients with nonspecific low back pain. Systematic reviews of observational studies have shown inconsistent findings with regard to the association between abnormal imaging findings and low back pain (Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org).[22,23] In a study that included patients 65 years of age or older who presented with acute low back pain without radiculopathy, the use of early imaging (e.g., radiography, magnetic resonance imaging, or computed tomography) was not associated with improved patient outcomes at 1 year.[24] Nevertheless, imaging may be performed when informative red flags are present, when there is a neurologic deficit, or when persistent low back pain with or without nerve-root involvement does not abate with conservative care.

TREATMENT

Numerous randomized, controlled trials and systematic reviews have assessed the effectiveness of interventions for nonspecific low back pain. Tables 1 and 2 summarize the pooled effects on acute and chronic low back pain, respectively, and the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach to the certainty of evidence obtained from systematic reviews of randomized trials that assessed the interventions that have most frequently been evaluated by practice guidelines.[27-45] Overall, first-line treatments are currently represented by nonpharmacologic interventions, which should be prioritized before pharmacologic treatment is prescribed.[46]

Acute Low Back Pain

Patient education and advice to remain active should represent routine care for patients with acute low back pain.[46] Education may address the benign, nonspecific nature and favorable course of low back pain, and patients should be encouraged to continue with regular activities. A meta-analysis of randomized trials showed (with moderate-certainty evidence) that individual patient education, as compared with usual care or other control, although not effective for pain, was effective in reassuring patients and reduced primary care visits due to low back pain at 1 year.[47] Meta-analyses of randomized trials support the use of a few sessions of spinal manipulative therapy or acupuncture for the reduction of pain, although the certainty of evidence for spinal manipulative therapy is moderate and that for acupuncture is low.[30,33] Heat and massage therapy are without risks and are reasonable to try, although the benefit of these therapies is supported only by limited data.[31,32] Exercise therapy that is prescribed or planned by a health professional has not been shown to be effective in patients with acute low back pain (Table 1),[29] but may be considered in patients at risk for poor recovery, given evidence from randomized trials of the effectiveness of exercise therapy in alleviating chronic low back pain[46] (Table 2) and in reducing the risk of episodes of low back pain.[48]

Among pharmacologic interventions, acetaminophen was not shown to be effective in a large clinical trial (Table 1),[34] whereas nonsteroidal antiinflammatory drugs (NSAIDs) have shown benefit.[35] However, caution is advised in the use of NSAIDs in older adults and in patients with coexisting conditions such as renal disease. Topical NSAIDs (e.g., topical diclofenac) have been shown to have fewer adverse events than oral NSAIDs, but their efficacy has not been rigorously studied in patients with low back pain. Results of a meta-analysis of the effects of muscle relaxants suggested that the use of nonbenzodiazepine antispasmodics begun within the first 2 weeks of the onset of pain had positive effects, but the analysis was based on very-low-certainty evidence.[36] These and other muscle relaxant agents had no significant effect on pain or disability during longer follow-up and were associated with a higher risk of adverse events.[36] Given the lack of data and the associated risk of addiction, the use of opioids should be minimized; weak opioids (e.g., tramadol) may be considered for use in carefully selected patients.[46]

Chronic Low Back Pain

In patients with chronic low back pain, education should play a key role, with supervised exercise and behavioral therapy as other first-line therapeutic options. Head-to-head randomized, controlled trials that compared these approaches have shown similar beneficial effects on pain in the short term (with low-to-moderate-certainty evidence),[39] although the effects of exercise and behavioral interventions over longer follow-up are unclear as compared with the effects of usual care or other conservative interventions.[38,39] A recent systematic review with network meta-analysis that included more than 200 randomized trials of 11 different types of exercise showed that most types of exercise had beneficial effects on alleviating pain and improving functioning, as compared with minimal treat-

Table 1. Effectiveness of Interventions on Pain Intensity and Physical Functioning Outcomes at Immediate-Term Follow-up (0–4 Weeks) in Patients with Acute Nonspecific Low Back Pain.*

Intervention vs. Control	Pain Intensity			Physical Functioning		
	No. of Studies	Pooled Effect (95% CI)†	Evidence Certainty	No. of Studies	Pooled Effect (95% CI)†	Evidence Certainty
Conservative intervention						
Advice to stay active vs. bed rest[27]	3	−0.4 (−4.0 to 3.2)	Low	2	−3.5 (−1.1 to −5.9)	Moderate
Individual patient education vs. no intervention[28]	3	NS	Moderate‡	3	NS	Very low‡
Individual patient education vs. non-educational interventions[28]	6	NS	Low‡	6	NS	Very low‡
Exercise therapy vs. no intervention or sham[29]	3	0.6 (−11.5 to 12.7)	Low‡	3	−2.8 (−15.3 to 9.7)	Low‡
Exercise therapy vs. other conservative interventions[29]	7	−0.3 (−0.7 to 0.1)	Low‡	6	−1.3 (−5.5 to 2.8)	Low‡
Spinal manipulative therapy vs. sham or other interventions[30]	NK	−9.8 (−17.0 to −2.5)	Moderate	NK	−2.9 (−6.6 to 1.0)	Moderate
Superficial heat vs. sham or non-heated wrap[31]	1	−32.2 (−38.7 to −25.7)	Very low‡	2	−8.8 (−12.8 to −1.2)	Very low‡
Massage therapy vs. inactive interventions[32]	1	−24.8 (−37.0 to −12.8)	Very low	1	−6.0 (−12.7 to 0.7)	Very low
Acupuncture vs. sham[33]	2	−9.4 (−17.0 to −1.8)	Low‡	3	NS	Moderate‡
Pharmacologic intervention						
Acetaminophen vs. placebo[34]	1	1.5 (−1.3 to 4.3)	High	1	−1.9 (−4.8 to 1.0)	High
NSAID vs. placebo[35]	4	−7.3 (−11.0 to −3.6)	Moderate	2	−8.4 (−12.1 to −4.8)	High
Muscle relaxant vs. placebo						
Nonbenzodiazepine antispasmodic agent[36]	16	−7.7 (−12.1 to −3.3)	Very low	7	−3.3 (−7.3 to 0.7)	Very low
Antispastic agent[36]	1	−1.6 (−15.3 to 12.1)	Low	1	2.0 (−15.6 to 19.6)	Low
Benzodiazepine[36]	1	2.0 (−9.8 to 13.8)	Moderate	1	0 (−13.2 to 13.2)	Low
Opioid vs. placebo[37]§	0	—	Very low‡	0	—	Very low‡

* If data for more than one follow-up between 0 and 4 weeks were present, the follow-up closer to 1 week was used. NK denotes number of studies not known, NS no significant between-group differences reported in the individual trials and no pooled effect, and NSAID nonsteroidal antiinflammatory drug.
† A negative value indicates a pooled effect in favor of the intervention. When the pooled effect was calculated as a standardized mean difference, it was converted to a scale of 0 to 100 by multiplying the standardized mean difference by 20 for pain intensity and by 12 for physical functioning. These values approximately represent the standard deviations of the most-used instruments (i.e., numerical rating scale for pain intensity and Oswestry Disability Index[25] for physical functioning) for these constructs. When the pooled effect was calculated on a scale of 0 to 24 (Roland–Morris Disability Questionnaire[26]), it was converted to a scale of 0 to 100 by multiplying the effect by 4.17.
‡ Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) scores were calculated by the authors, not reported by pooled-study investigators.
§ No trials of opioids for the treatment of acute nonspecific low back pain are available.

ment.[49] As compared with other exercises, Pilates therapy (which is focused on isometric contractions of the core muscles, attention to body movement, and improved posture) and McKenzie therapy (which involves repeated movement directional exercises, postural training, and education about patients' self-management of pain) resulted in reduced pain and improved functioning.

Behavioral therapies include respondent therapy (which involves relaxation techniques to reduce the physiologic response to pain), operant therapy (which is aimed at ceasing positive reinforcement of pain behaviors and promoting

Table 2. Effectiveness of Interventions on Pain Intensity and Physical Functioning Outcomes at Short-Term Follow-up (1–4 Months) in Patients with Chronic Nonspecific Low Back Pain.*

Intervention vs. Control	Pain Intensity			Physical Functioning		
	No. of Studies	Pooled Effect (95% CI)†	Evidence Certainty	No. of Studies	Pooled Effect (95% CI)†	Evidence Certainty
Conservative intervention						
Individual patient education vs. non-educational interventions[28]	1	NS	Moderate‡	2	NS	Moderate‡
Exercise therapy vs. no intervention or usual care[38]	26	−16.4 (−20.3 to −12.4)	Moderate	30	−7.4 (−9.2 to −5.6)	Moderate
Exercise therapy vs. other conservative interventions[38]	47	−8.6 (−13.1 to −4.1)	Moderate	44	−4.0 (−6.0 to −1.9)	Moderate
Behavioral therapy vs. waiting list[39]	5	−12.0 (−19.4 to −4.4)	Low	4	−4.4 (−10.4 to 1.6)	Low
Behavioral therapy vs. usual care[39]	2	−5.2 (−9.8 to −0.6)	Moderate	2	−2.4 (−4.9 to 0.2)	Moderate
Spinal manipulative therapy vs. sham[40]	8	−7.5 (−19.9 to 4.8)	Low	6	−8.8 (−16.2 to −1.3)	Low
Spinal manipulative therapy vs. guideline-recommended interventions[40]	17	−3.2 (−7.8 to 1.5)	Moderate	16	−3.0 (−4.9 to −1.1)	Moderate
Massage therapy vs. inactive interventions[32]	7	−15.0 (−18.0 to −12.0)	Low	6	−8.6 (−12.6 to −4.7)	Low
Massage therapy vs. active interventions[32]	12	−7.4 (−12.4 to −2.6)	Very low	6	−2.9 (−7.4 to 1.6)	Very low
Acupuncture vs. sham[41]	5	−10.0 (−17.2 to −2.8)	Low	3	−4.6 (−8.3 to −0.8)	Moderate
Acupuncture vs. no intervention[41]	3	−10.1 (−16.8 to −3.4)	Moderate	3	−4.7 (−8.6 to −0.7)	Moderate
Yoga vs. nonexercise intervention[42]	5	−4.5 (−7.0 to −2.1)	Moderate	7	−9.1 (−15.0 to −3.2)	Low
Yoga vs. exercise intervention[42]	1	−15.0 (−19.9 to −10.1)	Very low	2	−4.1 (−12.0 to 3.8)	Very low
Multidisciplinary rehabilitation vs. usual care[43]	9	−11.0 (−16.6 to −5.6)	Low	9	−4.9 (−7.4 to −3.8)	Moderate
Multidisciplinary rehabilitation vs. physical intervention[43]	12	−6.0 (−10.8 to −1.2)	Low	13	−4.7 (−8.2 to −1.2)	Low
Pharmacologic intervention						
Acetaminophen vs. placebo[34]§	0	—	Very low‡	0	—	Very low‡
NSAID vs. placebo[44]	6	−7.0 (−10.7 to −3.2)	Low	4	−3.5 (−5.4 to −1.7)	Low
Muscle relaxant vs. placebo						
Antispastic agent[36]	1	−5.4 (−13.7 to 2.9)	Very low	1	−3.2 (−8.3 to 1.8)	Very low
Other[36]	1	−19.9 (−31.5 to −8.3)	Moderate	1	−5.6 (−20.6 to 9.4)	Low
Antidepressant vs. placebo						
Serotonin–noradrenaline reuptake inhibitor[45]	4	−5.3 (−7.3 to −3.3)	Moderate	4	−3.5 (−5.2 to −1.9)	Moderate
Selective serotonin-reuptake inhibitor[45]	3	1.5 (−5.4 to 8.4)	Low	1	−2.2 (−8.1 to 3.7)	Low
Tricyclic antidepressant[45]	7	−10.0 (−21.5 to 1.6)	Very low	4	−12.9 (−26.5 to 0.6)	Very low
Opioid vs. placebo[37]¶	13	−9.0 (−11.7 to −6.2)	Very low	0	NA	NA

* If data for more than one follow-up between 1 and 4 months were present, the follow-up closer to 3 months was used.
† A negative value indicates a pooled effect in favor of the intervention. When the pooled effect was calculated as standardized mean difference, it was converted to a scale of 0 to 100 by multiplying the standardized mean difference by 20 for pain intensity and by 12 for physical functioning. These values represent approximately the standard deviations of the most-used instruments (i.e., numerical rating scale for pain intensity and Oswestry Disability Index[25] for physical functioning) for these constructs. When the pooled effect was calculated on a scale of 0 to 24 (Roland–Morris Disability Questionnaire[26]), it was converted to a scale of 0 to 100 by multiplying the effect by 4.17.
‡ GRADE scores were calculated by the authors, not reported by pooled-study investigators.
§ No trials of acetaminophen for the treatment of chronic nonspecific low back pain are available.
¶ In this study cited for opioid versus placebo, physical functioning was not a specified outcome, so pooled effect and evidence certainty for that outcome are not applicable (NA).

healthy behaviors, including exercise), and cognitive therapy (which focuses on identifying and modifying negative thoughts with regard to pain and disability); randomized, controlled trials comparing these therapies have shown they have similar effects on pain and functioning.[39] The choice of therapy from among conservative interventions should take into consideration the patient's preferences and other factors, such as out-of-pocket costs.

Other therapies for chronic low back pain include spinal manipulative therapy, massage therapy, yoga, and multidisciplinary rehabilitation.[32,42,43] A systematic review with moderate-certainty evidence showed no clinically relevant differences in effects on pain and functioning with spinal manipulative therapy as compared with recommended first-line options (Table 2).[40] Multidisciplinary interventions that combine physical and psychological components may be especially suited for patients with low levels of functioning and with psychosocial risk factors for poor outcomes, although data showing superior effectiveness for this patient group are lacking.[43]

There is at best moderate-certainty evidence to support various pharmacologic options for the management of chronic low back pain (Table 2). NSAIDs can be considered in patients at low risk, although the effects appear to be modest and are supported by low-certainty evidence.[44] Muscle relaxants and antidepressants (e.g., serotonin and norepinephrine reuptake inhibitors) may be used as adjuvant therapy in some patients, although they have had limited effectiveness (with evidence of moderate to very low certainty) (Table 2) and have potential risks.[36,45] The use of opioids should be limited to very carefully selected patients and only for short periods of time with appropriate monitoring.[46] Invasive therapies, such as epidural glucocorticoid injections and surgery, are rarely indicated for nonspecific low back pain.[46]

AREAS OF UNCERTAINTY

There is some controversy regarding the term "nonspecific" low back pain, since structures such as muscles, joints, or disks (or a combination of these) may be causing the pain but are not readily identified by means of history taking and physical examination. Some patients with nonspecific low back pain may have symptomatic spinal osteoarthritis; in contrast to osteoarthritis of the peripheral joints, there are no diagnostic criteria for spinal osteoarthritis, and data are needed to guide its diagnosis and management.

High-quality randomized trials are needed to assess the effects on pain and function of several interventions, including heat, massage therapy, NSAIDs (oral and topical), muscle relaxants, and opioids for acute low back pain and NSAIDs, muscle relaxants, and antidepressants for chronic low back pain. Also, data are needed to inform whether the effects of these or other interventions vary according to patient characteristics. A meta-analysis of individual patient data from 27 trials did not show clinically relevant modifiers of the effect of exercise on chronic low back pain.[50] In a trial involving patients with low back pain that compared usual care with care stratified according to prognosis (estimated with the use of the STarT Back tool; patients at low risk received minimal intervention, those at medium risk received physical therapy, and those at high risk received "psychologically informed" physical therapy), patients in the stratified-care groups had greater reduction of disability and low back pain–related health care costs than those who received usual care.[21] However, these positive findings were not confirmed by subsequent trials conducted in primary care settings in the United States.[51,52]

GUIDELINES

A previously published overview summarized the recommendations of 15 clinical practice guidelines for the management of nonspecific low back pain in primary care.[53] More recent guidelines (e.g., those of the American College of Physicians) have moved away from pharmacotherapy (owing to limited efficacy and risk of adverse effects) in favor of initial nonpharmacologic care for both acute and chronic low back pain.[54] The recommendations presented here are generally consistent with those guidelines.

CONCLUSIONS AND RECOMMENDATIONS

The patient described in the vignette is experiencing an acute episode of recurrent low back pain. In the absence of worrisome findings on the history and physical examination, imaging would not be recommended. The PICK-UP tool or the Örebro Musculoskeletal Pain Questionnaire may be used to evaluate the patient for risk of the episode becoming chronic. The patient should be reassured of the very high likelihood that there is no serious condition causing his low back pain and of the anticipated favorable prognosis of the current episode. He should be encouraged to continue his regular activities, even if he has some pain when engaging in them. We would suggest considering the use of a heating pad (although this recommendation is based on limited data[31]); short-term use of NSAIDs may be helpful in the absence of contraindications. If the low back pain does not abate within 2 months after the first visit, we would recommend referral to a specialist for supervised exercise or behavioral therapy. We would consider referral for exercise therapy earlier if there is concern about a risk of the condition becoming chronic, given the evidence of the benefit of exercise in alleviating chronic low back pain and minimizing the risk of recurrent low back pain. We would engage in shared decision making with the patient, with treatment decisions guided by his preferences and priorities.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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We charge $10.55 per word per insertion. A 2- to 4-time frequency discount rate of $7.85 per word per insertion is available. A 5-time frequency discount rate of $7.55 per word per insertion is also available. In order to earn the 2- to 4-time or 5-time discounted word rate, the request for an ad to run in multiple issues must be made upon initial placement. The issues do not need to be consecutive. **Web fee:** Classified line advertisers may choose to have their ads placed on NEJM CareerCenter for a fee of $130.00 per issue per advertisement. The web fee must be purchased for all dates of the print schedule. The choice to place your ad online must be made at the same time the print ad is scheduled. **Note:** The minimum charge for all types of line advertising is equivalent to 30 words per ad. Purchase orders will be accepted subject to credit approval. For orders requiring prepayment, we accept payment via Visa, MasterCard, and American Express for your convenience, or a check. All classified line ads are subject to the consistency guidelines of NEJM.

How to Advertise

All orders, cancellations, and changes must be received in writing. E-mail your advertisement to us at ads@nejmcareercenter.org, or fax it to 1-781-895-1045 or 1-781-893-5003. We will contact you to confirm your order. Our closing date is typically the Friday 20 days prior to publication date; however, please consult the rate card online at **nejmcareercenter.org** or contact the Classified Advertising Department at 1-800-635-6991. Be sure to tell us the classification heading you would like your ad to appear under (see listings above). If no classification is offered, we will determine the most appropriate classification. Cancellations must be made 20 days prior to publication date. Send all advertisements to the address listed below.

Contact Information

Classified Advertising
The New England Journal of Medicine
860 Winter Street, Waltham, MA 02451-1412

E-mail: ads@nejmcareercenter.org
Fax: 1-781-895-1045
Fax: 1-781-893-5003
Phone: 1-800-635-6991
Phone: 1-781-893-3800
Website: **nejmcareercenter.org**

How to Calculate the Cost of Your Ad

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

Bradley S. Smith III, MD..... = 5 words
Send CV ..... = 2 words
December 10, 2007 ..... = 3 words
617-555-1234 ..... = 1 word
Obstetrician/Gynecologist ... = 1 word
A ..... = 1 word
Dalton, MD 01622 ..... = 3 words

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

MEDICAL DIRECTOR — A dynamic, growth-oriented home health care company is looking for a full-time Medical Director in greater New York. Ideal candidate should be board certified in internal medicine with subspecialties in oncology or gastroenterology. Willing to visit patients at home. Good verbal and written skills required. Attractive salary and benefits. Send CV to: E-mail address.

This advertisement is 56 words. At $10.55 per word, it equals $590.80. This ad would be placed under the Chiefs/Directors/ Department Heads classification.

Classified Ads Online

Advertisers may choose to have their classified line and display advertisements placed on NEJM CareerCenter for a fee. The web fee for line ads is $130.00 per issue per advertisement and $220.00 per issue per advertisement for display ads. The ads will run online two weeks prior to their appearance in print and one week after. For online-only recruitment advertising, please visit nejmcareercenter.org for more information, or call 1-800-635-6991.

Policy on Recruitment Ads

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

Classified Ad Deadlines

Issue	Closing Date
April 27	April 7
May 4	April 13
May 11	April 21
May 18	April 28

Cardiology

NONINVASIVE CARDIOLOGIST NEEDED — Noninvasive cardiologist to join a large group of 20 cardiologists in northern New Jersey. Excellent salary and benefit package. Please e-mail CV to: terri.urgo@heartandvascularnj.com. We are a well-established multispecialty medical group that is rapidly expanding. www.hvamedicalgroup.com

SEEKING A BC/BE INTERVENTIONAL OR NON-INVASIVE CARDIOLOGIST AROUND NEWPORT BEACH, CALIFORNIA — Proficiency in structural heart and vascular interventions a plus. Competitive salary, benefits, partnership track. E-mail CV to: drocheartandvascular@gmail.com

Find your next *locum tenens* hire at NEJM CareerCenter.
(800) 635-6991
NEJMCareerCenter.org

Hospitalist

HVA MEDICAL GROUP — Is seeking a board-eligible or board certified internal medicine physician to join our hospitalist team in north New Jersey. We welcome the opportunity to share more information with you and learn about what you seek in a position. Location: Northern New Jersey. Job Benefits: Schedule is 7x7, base salary with wRVU; Closed ICU; Flexible schedule; Codes and procedures NOT required; Comprehensive benefits include: fully paid professional liability insurance with tail coverage, health, dental, vision, 401(k), CME; Opportunity to increase salary as desired. Please e-mail resume to: vibuvarghese@gmail.com

Medical Genetics

EXPERIENCED GENE THERAPY SCIENTIST/FACILITY — With access to US/overseas lab or start new lab, to prepare AAV mediated Calpainopathy gene product for trial (Methodology published) by private investor. md6099@gmail.com

PHYSICIAN RECRUITER
The physician you're seeking is one of our readers. Advertise in the next issue of the *New England Journal of Medicine* and reach physicians in all specialties nationwide. For more information, contact Classified Advertising Sales at (800) 635-6991.

Rheumatology

RHEUMATOLOGIST PHYSICIAN — To join a large multispecialty group in northern New Jersey. Excellent salary and benefits package. Please e-mail CV to: annu.bikkani@hvamedicalgroup.com

Advertise in the next *Career Guide*.
For more information, contact:
(800) 635-6991
ads@nejmcareercenter.org

Jobs for you, right to your inbox.
*Sign up for **FREE** physician job alerts today!*
It's quick and easy to set up and can give you a valuable edge in finding your next job. Simply set your specialty and location and we'll automatically send you new jobs that match your criteria.
***Get started now at:** nejmcareercenter.org/newalert*
NEJM CareerCenter

EMERSON HOSPITAL OPPORTUNITIES

Location, Location, Location

WORLD-RENOWNED AFFILIATIONS | 30 MINUTES FROM BOSTON | QUALITY OF LIFE

Find out why so many top physicians are practicing at Emerson Hospital. At Emerson, you will find desirable practice locations, strong relationships with academic medical centers, superb quality of life, competitive financial packages, and more...

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

Emerson Hospital Opportunities

- Gastroenterology
- Hospitalist, Inpatient – Psychiatry, Orthopedics, OB/GYN
- Primary Care
- Urgent Care

If you would like more information please contact:

Diane Forte Willis
dfortewillis@emersonhosp.org
phone: 978-287-3002
fax: 978-287-3600

About Concord, MA and Emerson Hospital

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

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

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

Emerson Health
emersonhospital.org

0722

NEJMCareerCenter.org

YOU BELONG AT BAYSTATE

DIVERSE PROVIDERS. DIVERSE PATIENTS. DIVERSE PRACTICE LOCATIONS.

Primary Care Opportunities

ASK ABOUT OUR $50,000 SIGN-ON BONUS!

Full- and Part-time

Western Massachusetts

Baystate Health (BH) is Western Massachusetts's premier healthcare provider and home to the University of Massachusetts Chan Medical School – Baystate.

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

ChooseBaystateHealth.org

Baystate Health offers:

- **Supportive Work Environment**
  - Nurse Triage- Daytime, Nighttime, first call after hours & weekends
  - Scribes
  - 1:1 Medical Assistant
  - Direct access to a large multispecialty group including Behavioral Health network integration
  - Lab and practice specialty scheduler onsite
  - State-of-the-art EMR system with technology support
- **Work Life Balance**
  - Flexible work schedules
  - Full-time 4 day work week
  - Full- and Part-time
  - Built in administration time and ramp up time for new physicians
  - Very reasonable patient volume expectations
- **Academic & Nonacademic Positions**
  - Faculty appointment UMASS school of medicine (dependent on practice setting)
- **Outstanding Benefits Package**
  - Up to $50K sign on bonus (paid within first 30 days of EMPLOYMENT, specific dollar amount will be dependent on experience & site of employment)
  - Generous compensation package
  - CME Allowance and time, high quality, low cost medical/dental, robust paid time off

All correspondence can be directed to:

Paige Livingston, *Provider Recruiter* • Paige.Livingston@baystatehealth.org
Phone: 413-794-7874 • Fax: 413-794-5059

Baystate Health | UMass Chan MEDICAL SCHOOL

baystatecareers @baystatecareers

Baystate Health is an Equal Opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, marital status, national origin, ancestry, age, genetic information, disability, or protected veteran status.

NEJMCareerCenter.org

Be seen as a person, not just a CV.

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

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

www.comphealth.com/n-mostpersonalized

NEJMCareerCenter.org

North Shore Physicians Group (NSPG), the largest multi-specialty physicians group north of Boston, is looking for BC/BE Internal Medicine, Family Medicine and Internal Medicine/Pediatrics physicians to join our rapidly expanding primary care team.

We have opportunities in the following communities near Boston, Massachusetts, including:

• Beverly • Danvers • Lynn • Marblehead • Peabody • Rowley • Salem • Saugus • Swampscott

Join a team of 450+ clinicians and medical professionals who are rethinking the way we deliver integrated Primary Care services. As a physician at NSPG, you'll have the opportunity to be part of an exciting physician-led culture that is focused on making the practice of medicine smarter, more efficient and more rewarding for patients and providers alike.

Discover the advantages of practicing medicine with NSPG, including:

- Being a member of the Mass General Brigham health care system and being affiliated with Mass General Brigham Salem Hospital.
- A team-based care model that helps to balance workloads and alleviate physician burnout.
- Practice innovations that help to streamline workflows and enhance the ways physicians interact with patients.
- Integrated EMR to more efficiently provide patient care and communications across our practices and affiliate locations.
- Opportunities to teach and train residents.
- After-hours NP-staffed call.
- Excellent salary and comprehensive fringe benefits.
- Exceptional quality of life in the North Shore area, including great schools, coastal communities, recreation, culture and close proximity to Boston.

WE'RE A BEACON OF NEW THINKING IN INTEGRATED MEDICINE. **JOIN US.**

Submit your CV and letter of interest to **Michele Gorham, Senior Physician Recruiter** at **mgorham@partners.org**.

Applicants with relevant experience will be considered. Mass General Brigham is an affirmative action/equal opportunity employer. Minorities and women are strongly encouraged to apply. Pre-employment drug screening is required.

www.joinnspg.org

NEJMCareerCenter.org

A-Cross Medicine Reviews

ABIM-Focused Internal Medicine Board Review for Initial Certification and MOC

Live, In-Person
33+ hours of CME/MOC Available!

July 13-16, 2023 at the Sheraton Suites O'Hare Airport Hotel, Chicago, IL

This live activity has been approved for AMA PRA Category 1 Credit™ and is jointly-provided with Tulane University Health Sciences Center.

Besides Board Review, we also have fun CME course locations including Hawaii, Disney, Universal, Sonoma, Vegas.

For Details Visit:
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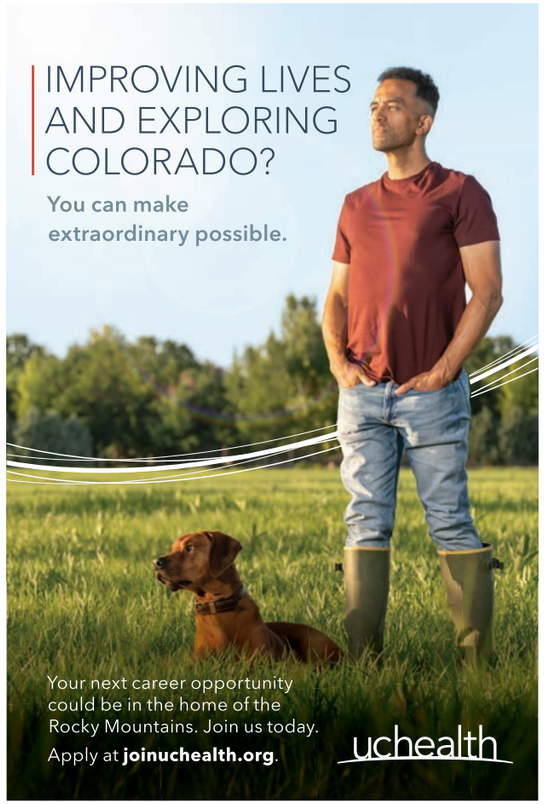
1-855-722-7677



Atrius Health

Dedham Medical Associates | Granite Medical Group
Harvard Vanguard Medical Associates | PMG Physician Associates

Atrius Health, an innovative healthcare leader, delivers an effective system of connected care for adult and pediatric patients at more than 30 medical practice locations in eastern Massachusetts.

At Atrius Health we work together to develop and share best practices to coordinate and improve the care delivered in our communities. Our long-term relationships with prestigious medical and nursing schools, hospitals and universities, allows us to sponsor teaching programs across the health care profession.

Our physicians enjoy close clinical relationships, superior staffing resources, minimal call, a fully integrated electronic medical record, excellent salaries, and an exceptional benefits package.

We have openings in the following specialties:

• Allergy • Dermatology • Family Medicine • Hematology/Oncology
Internal Medicine • Nephrology • Neurology • Non-invasive Cardiology
OB/GYN • Optometry • Pediatrics • Pulmonology • Psychiatry
• Physiatry • Reproductive Endocrinology • Rheumatology • Urgent Care • Urology
• Weight and Lifestyle Management

Apply at **atriushealthproviders.org**, send confidential CV to:
Brenda Reed, 275 Grove Street, Suite 2-300, Newton, MA 02466
or email: **Physician_Recruitment@atriushealth.org**

DHA
Defense Health Agency

WE OFFER CIVILIAN PHYSICIANS WHAT MATTERS MOST.

THE WORK-LIFE BALANCE YOU NEED, THE BENEFITS YOU DESERVE.

- Competitive Salary
- Generous Paid Time Off
- Recruitment Bonuses
- Flexible Schedules
- Job Security
- Supportive Work Environment
- Worldwide Locations

DHA employees are NOT subject to military requirements such as "boot camp," enlistments, or deployments.
Department of Defense is an equal opportunity employer.

FIND JOBS | POST YOUR CV | LEARN MORE
CIVILIANMEDICALJOBS.COM

Primary Care Physicians

Houston, Texas

Kelsey-Seybold Clinic is Houston's premier multispecialty group practice where more than 700 physicians and allied health professionals practice at 40+ locations. Kelsey-Seybold offers quality medical care in 65 medical specialties.

Due to tremendous growth, Kelsey-Seybold Clinic is currently seeking Internal and Family Medicine physicians for multiple clinic locations throughout Greater Houston.

When you join Kelsey-Seybold, you become part of an established, physician-owned, and led multispecialty group practice with a 70-year legacy of caring for patients.

- **72 physicians hold leadership positions**
- **56% of our physicians are shareholders**
- **The average physician tenure is 11 years**
- **Physician-led board of managers**
- **A defined path to partnership**

Our compensation package is productivity-based and includes salary, pathway to shareholder status, paid time off, CME, matching 401K, regular weekday hours full nursing and clerical support, and paid malpractice and tail coverage.

To learn more and apply, please visit:
Kelsey-SeyboldProviders.com

Kelsey-Seybold Clinic
Changing the way health cares.

Equal opportunity employer.

NAMED ONE OF THE NATION'S
TOP 1% HOSPITALS
FOR THE SECOND YEAR IN A ROW (2022-2023)

Tower Health is a regional integrated healthcare system that offers compassionate, high quality, leading edge healthcare and wellness services to communities in Berks, Chester, Montgomery, and Philadelphia Counties. With approximately 11,500 employees, Tower Health consists of Reading Hospital in West Reading; Phoenixville Hospital in Phoenixville; Pottstown Hospital in Pottstown; and St. Christopher's Hospital for Children in Philadelphia, in partnership with Drexel University. Tower Health is strongly committed to academic medicine and training, including multiple residency and fellowship programs, the Drexel University College of Medicine at Tower Health, and the Reading Hospital School of Health Sciences in West Reading. For more information, visit *towerhealth.org*.

The Tower Health system includes 66 primary care ambulatory physicians (47 family medicine, 19 internal medicine) and 27 APPs.

Explore family medicine primary care vacancies across our service area. *Scan the QR Code, go to Careers.TowerHealth.org to explore opportunities throughout the system, or email your CV to medicalstaffrecruitment@towerhealth.org.*

TOWER HEALTH
Advancing Health. Transforming Lives.

Tower Health is an Equal Opportunity Employer committed to creating a diverse and inclusive environment reflective of the communities we serve.

View our LinkedIn® Profile

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NEJMCareerCenter.org

PHYSICIAN CAREERS AT
The US Oncology Network

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

To learn more about physician jobs, email physicianrecruiting@usoncology.com

The US Oncology Network

The US Oncology Network is supported by McKesson Specialty Health.
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CHA Cambridge Health Alliance | HARVARD MEDICAL SCHOOL TEACHING HOSPITAL | Tufts University School of Medicine

Medical Director, Primary Care
Cambridge Health Alliance • Cambridge, MA

Cambridge Health Alliance (CHA), is a **Harvard Medical School** and **Tufts University School of Medicine** teaching affiliate and award winning, academic public healthcare system. CHA is recruiting a full-time primary care physician leader for the Medical Director opportunity.

- Medical Director will practice clinically and have dedicated time devoted to leadership and management of the provider team
- Our site provides care to the local community including primary care for all ages, women's health and pregnancy care, mental health services, onsite pharmacy, lab services and more
- The site is NCQA certified, level 3 Patient Centered Medical Home and delivers team based care
- Engage and participate in ambulatory strategy, primary care and specialty care integration, and site initiatives to assess and improve financial and operational performance
- Lead and encourage innovation, community involvement, and primary care growth
- Participate in ACO related initiatives including population health
- The position carries a Harvard Medical School (HMS) and/or Tufts University School of Medicine appointment of Instructor, Assistant or Associate Professor, available commensurate with appointment criteria, candidate qualifications, and commitment to teaching responsibilities.

CHA is inclusive of three hospital campuses, an established network of 15 primary care clinics and integrated outpatient medical specialty services. We are located throughout Cambridge, Somerville and Boston's metro-north area. CHA is clinically affiliated with Beth Israel Deaconess Medical Center

Qualified candidates will be Board Eligible/Certified in Family Medicine, Internal Medicine or Internal Medicine/Pediatrics and have demonstrated experience in leading physicians and care teams. Candidates should possess a strong desire to provide the highest quality care to our diverse patient population.

Interested candidates please visit www.CHAproviders.org to apply through our secure and confidential portal. Alternately, candidates may apply via email to CHA Provider Recruitment at providerrecruitment@challiance.org and by phone at (617) 665-3555.

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, sexual orientation, relationship identity or relationship structure, gender identity or expression, veteran status, disability or any other characteristic protected by law. We are committed to establishing and maintaining a workplace free of discrimination. We are fully committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment or career development. Furthermore, we will not tolerate the use of discriminatory slurs, or other remarks, jokes or conduct, that in the judgment of CHA, encourage or permit an offensive or hostile work environment.

ChenMed | **Join us. Learn more at chenmed.com/physicians-nejm or contact us at mdcareers@chenmed.com.**

NEJM CareerCenter

SEARCH AND APPLY FOR JOBS FROM YOUR iPHONE.

- Search or browse quality physician jobs by specialty and/or location
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- Apply for jobs directly from your phone!

Download or update the FREE iPhone app and start your search today!

NEJMCareerCenter.org

Yale

ASSISTANT PROFESSOR
INFECTIOUS DISEASES,
YALE UNIVERSITY SCHOOL OF MEDICINE

A full-time faculty position is available at the level of **Assistant Professor in the Section of Infectious Disease** in the Department of Internal Medicine at the Yale University School of Medicine. Applicants should have an M.D., completed fellowship training in infectious diseases, have interest and experience in addiction medicine and have exceptional potential for a career in academic medicine. Candidates are expected to (a) participate in extramurally funded research program with plans to develop own independent extramurally funded research program and (b) participate in the clinical and educational activities of the section including providing care on a mobile health unit in rural Connecticut providing infectious disease with specific emphasis on HIV prevention and treatment plus addiction medicine care. Review of applications will begin immediately and will continue until the position is filled.

Yale University is an affirmative action, equal opportunity employer. Applications from women, persons with disabilities, protected veterans, and members of minority groups are encouraged.

Review of applications will begin immediately and will continue until the position is filled.

Please apply at: apply.interfolio.com/121821

SIVIMED

Sivimed Internal Medicine and Primary Care is a fast-growing practice in the city of Frederick, MD that prides itself on top-quality patient care. Dr. Sivakumar, our CMO, has over three decades of experience, in hospitals, as part of physician groups, and running her own practice.

Sivimed currently has a large new patient backlog, and we are urgently looking for qualified physicians. We are searching for an IM/FM resident or established physician looking for an innovative and thriving practice, excelling in Public Health goals through such federal/state and private programs as MD-PCP and Patient Centered Medical Home. This is an excellent opportunity to settle down in the great city of Frederick, considered the affordable bedroom community of DC and located in the exciting tech corridor of DMV. With a suburban feel, amazing schools, and short drives to cultural centers like the free Smithsonian Museums of DC or the Inner Harbor of Baltimore, it's the best of both worlds.

Please take a look at our website (**www.sivimedassociates.com**) and our reviews on the Internet to find out what patients are saying about Sivimed.

Please reach out to our HR Manager, Scott Sacks, with any questions or interest at 240-696-3927 and/or email scott.sacks@sivimedassociates.com

UNIVERSITY of MARYLAND SCHOOL OF MEDICINE

The **Department of Medicine at the University of Maryland School of Medicine** is recruiting faculty to join our expanding programs in endocrinology, gastroenterology, general medicine, geriatrics, and pulmonary and critical care. Opportunities with descriptions and application instructions are at the following link: **https://www.medschool.umaryland.edu/medicine/Open-Faculty-Positions**. Expected faculty rank for all positions will be Assistant Professor or higher. Final rank, tenure status and salary will be commensurate with candidates' qualifications and experience.

The Department of Medicine provides state-of-the-art patient care, and advances treatment by means of cutting-edge clinical research. We have trained high caliber physicians since 1807, including more than half the physicians practicing in Maryland. With more than 400 full and part-time faculty members, Medicine, the largest department in the School of Medicine, trains approximately 300 residents and fellows annually. Current active research funding exceeds $180 million, over half from NIH and other federal agencies. With nearly 150 funded investigators, the department has an extensive research base in both the basic and clinical sciences, and our extensive research training programs include basic, clinical, and translational research training awards. Our faculty also conduct international research, with robust infrastructure in South America and Africa.

We are pleased to offer a competitive salary, medical/dental benefits, disability plans, retirement plans, and more!

The University of Maryland School of Medicine is part of the University of Maryland Baltimore campus ranked 13th in '*Forbes*' 2021 America's Best Large Employers Survey and 6th by *Forbes* among educational institutions for Best Employers for Diversity in 2022.

UMB is an equal opportunity/affirmative action employer. All qualified applicants will receive consideration for employment without regard to sex, gender identity, sexual orientation, race, color, religion, national origin, disability, protected Veteran status, age, or any other characteristic protected by law or policy. We value diversity and how it enriches our academic and scientific community and strive toward cultivating an inclusive environment that supports all employees.

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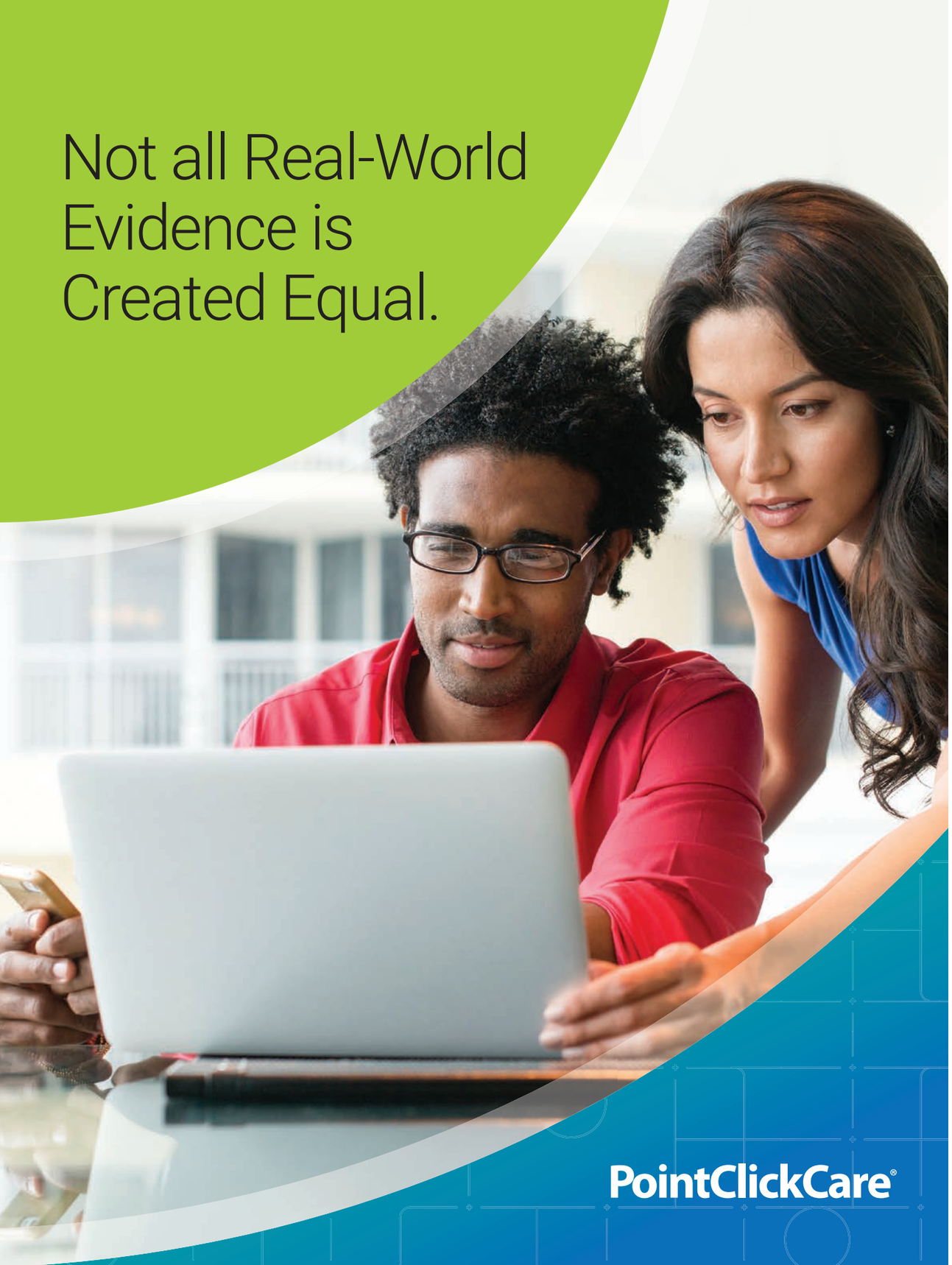
Not all Real-World Evidence is Created Equal.



PointClickCare®

Physician Opportunities in a Variety of Specialties

Northern and Central California

The Permanente Medical Group, Inc. (TPMG) is one of the largest medical groups in the nation with over 9,000 physicians, 22 medical centers, numerous clinics throughout Northern and Central California, and an over 75-year tradition of providing quality medical care.

EXTRAORDINARY BENEFITS:

- Competitive compensation and benefits package, including comprehensive vision, medical, and dental
- Interest Free Home Loan Program up to $250,000 (approval required)
- Relocation Assistance up to $10,000 (approval required)
- Malpractice and Tail Insurance
- Life Insurance
- Optional Long-Term Care Insurance
- Paid holidays, sick leave, and education leave
- Shareholder track
- Three retirement plans, including a pension plan and 401(k)

A FEW REASONS TO CONSIDER A PRACTICE WITH TPMG:

- **Work-life balance** focused practice, including flexible schedules and unmatched practice support.
- We can focus on providing excellent patient care **without managing overhead and billing.** No RVUs!
- We demonstrate our commitment to a culture of **equity, inclusion, and diversity** by hiring physicians that reflect and celebrate the diversity of people and cultures. We practice in an environment with patients at the center and deliver culturally responsive and compassionate care to our member populations.
- Multi-specialty **collaboration** with a mission-driven integrated health care delivery model.
- An **outstanding electronic medical record system** that allows flexibility in patient management.
- We have a very rich and comprehensive **Physician Health & Wellness Program**.
- We are **Physician-led** and develop our own leaders.
- **Professional development** opportunities in teaching, research, mentorship, physician leadership, and community service.
- Ask us about our **Forgivable Loan Program**!

To learn more about these career opportunities and our wage ranges, please visit our website at northerncalifornia.permanente.org; forward your CV to: MDRecruitment.tpmg@kp.org; or call: 800-777-4912.

We are an EOE/AA/M/F/D/V Employer. VEVRAA Federal Contractor

CONNECT WITH US:

NEJMCareerCenter.org

NEJMCareerCenter.org

Family Medicine Opening

Opportunities at our main campus as well as rural locations

PACKAGE DETAILS:

COMPETITIVE COMPENSATION
at or above the MGMA median with productivity incentive bonus

EDUCATIONAL FORGIVENESS LOAN
up to $150,000 - renewable

$50,000 SIGN-ON BONUS

240 HOURS PAID TIME OFF

BLESSING Health System

Blessing Health System is made up of two multi-specialty provider groups with over 200 employed providers. Blessing is the largest medical provider serving a 300,000 population region composed of West Central Illinois, Northeast Missouri, and Southeast Iowa.

TAYLOR.JANUS@BLESSINGHEALTH.ORG

The Department of Medicine at the VA Northeast Ohio Healthcare System is seeking one full-time staff physician interested in a Nocturnist/SNF Hospitalist position. Principal clinical responsibilities will include 50% allocation to overnight patient care duties on the inpatient medical wards and Nursing Home Care Unit and participation in solo overnight coverage schedule for the Emergency Department, as well as 50% allocation to daytime rounding in our Community Living Center.

Qualified candidates will have prior clinical experience in Emergency Department settings and will have prior experience caring for the geriatric population with cognitive impairments. Candidates will be able to demonstrate strong interpersonal skills and be able to work in an interdisciplinary care model. Board Certification is preferred. Candidates will be eligible for faculty appointment at Case Western Reserve University School of Medicine commensurate with experience.

Competitive salary and comprehensive benefits package; *EOE.*

Applicants should submit their curriculum vitae via the VA Northeast Ohio Healthcare System Resources Management Service, ATTN: Jason Petrakos
email: jason.petrakos@va.gov

Are you a physician who believes healthcare means treating patients with Compassionate Care?

At The Brooklyn Hospital Center, you'll be part of a supportive and receptive healthcare system that shares your commitment to caring for the whole person. We're a well-established hospital serving a diverse community that's taking a fresh look at improving and delivering cutting-edge technology and advanced evidence-based care to our community.

Some of our opportunities involve educating and training fellows in our robust Fellowship programs and community service. There are many possibilities for a physician to either take a direct practicing and/or leadership role that will inspire, and stretch one's imagination, experience, and opportunities.

We are actively seeking forward-thinking BE/BC physicians to join our dynamic, diverse team in various specialty areas, including:

- **Adult & Child Psychiatry**
- **Endocrinology**
- **Family Medicine**
- **Gastroenterology**
- **Hematology/Oncology**
- **Internal Medicine**
- **Neurology**
- **OB/GYN**
- **Orthopedic**
- **Pain Management**
- **Physical Medicine & Rehabilitation**
- **Pulmonary/ICU**
- **Radiology – Interventional & Neuroradiologist**
- **Rheumatology**

If you have earned a medical degree from an accredited university, have or are eligible to obtain a New York State medical license, and are BE/BC in your field, **please email cover letter and CV to: recruiter@tbh.org.**

We support our employees with a work/life balance, salaries commensurate with experience and a complete benefits package. TBHC is proud to be an equal opportunity employer.

The Brooklyn Hospital Center
Keeping Brooklyn Healthy
www.tbh.org

Join Our Team!

Visa Sponsorship Available!

We're hiring **Physicians, Surgeons, NPs, PAs, CRNAs** for Hospital Medicine, Outpatient Primary Care, Anesthesiology, Oncology, Orthopedics, Gastroenterology, Vascular, Cardiology, Palliative Care, Pulmonology, and Neurology

Primary Care Physicians for Rumford start at $300,000 with a $50,000 Sign on Bonus

Learn more

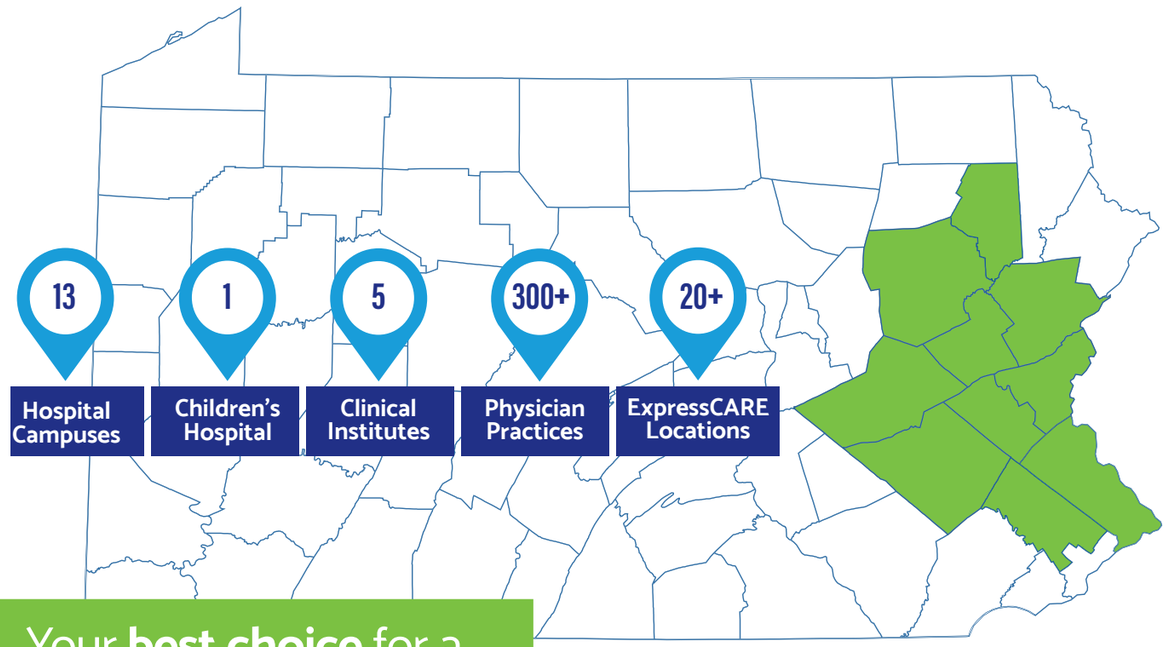
Visit www.cmhc.org/careers using the **QR code** at left or **text NEJM** to **857-400-0656** to reach our Provider Recruiting team directly.

Significant sign on bonus
Tuition reimbursement
Student loan repayment

- Competitive wages
- Comprehensive benefits
- Income protection
- Ongoing certification support
- Flexible schedules for work life balance
- Great leadership
- Supportive teams

Central Maine Healthcare

Bridgton Hospital | Central Maine Medical Center
Central Maine Medical Group Specialty and Primary Practices | Rumford Hospital



Your **best choice** for a career in primary care.

Here is your extraordinary opportunity to join one of the nation's most advanced health networks. Lehigh Valley Physician Group (LVPG) is a physician-led organization caring for the communities served by LVHN.

BEST REGIONAL HOSPITALS U.S.News & WORLD REPORT ALLENTOWN METRO RECOGNIZED IN 19 TYPES OF CARE 2022-23

Start or continue your career in primary care
- Patient-centered, progressive leadership
- Variety of rural, suburban and urban practice settings
- Opportunities for teaching, research and leadership
- Academic appointment available

Attractive benefits and support
- Flexible Monday-Friday schedule
- Highly competitive compensation, superb benefits package, generous bonus package
- Loan forgiveness assistance program, educational stipend
- Monthly educational stipend for residents and fellows

Explore opportunities

Interested applicants should send their CV to Karen Fay at Karen_R.Fay@lvhn.org. Karen can be reached at 484-294-5651. See all opportunities at **LVHN.org/careers.**

Lehigh Valley Health Network

Explore your opportunities at:

northwest.permanente.org

Please contact:
Bridgitte Ngo
Bridgitte.A.Ngo@kp.org

PERMANENTE MEDICINE®
Northwest Permanente

Primary Care Physicians, Urgent Care Physicians & Nocturnists

Opportunities available in Portland and Salem, Oregon, and Southwest Washington, including Longview

Join our medical group
When you join Northwest Permanente, you are joining a practice with a purpose that provides unparalleled opportunities for a meaningful and rewarding career in medicine. Northwest Permanente is a physician-led, multi-specialty group of 1,500 physicians, surgeons, clinicians, and administrative staff caring for 630,000 Kaiser Permanente members in Oregon and Southwest Washington. Kaiser Permanente is one of the nation's pre-eminent health care systems, a benchmark for comprehensive, integrated, value-based, and high-quality care.

Why Northwest Permanente Physicians Work Here
Practicing in an integrated health care model like ours means that our clinicians have instant access to dozens of specialties, which allows for a level of collaboration and comprehensive treatment not found just anywhere.

If health equity is a priority in your career, Kaiser Permanente Northwest has an amazing Primary Care opportunity in our new Center for Black Health and Wellness. **Learn more about this opportunity - bit.ly/NWP_blackcenterofexcellence**

We are an EOE/AA/M/F/D/V Employer

Working for Northwest Permanente, you'll enjoy:
- 21% employer contribution to retirement programs, including pension *(this is not a match - NWP contributes 21% of clinician earnings to retirement programs regardless of employee contribution)*
- 90%+ employer paid health plan
- Student loan assistance programs*
- Relocation allowance
- Generous sign-on bonus*
- Leadership opportunities
- Paid annual education leave + allowance
- Shareholder opportunities
- Paid sabbatical after attaining shareholder status

• for qualifying departments

KAISER PERMANENTE®

NEJMCareerCenter.org

NEJMCareerCenter.org

Vital Roles in a Vibrant Community
Physician Opportunities

BERKSHIRE HEALTH SYSTEMS IS SEEKING COMPASSIONATE, COMMUNITY-FOCUSED PHYSICIANS IN THE FOLLOWING DISCIPLINES:

ANESTHESIOLOGY • CARDIOLOGY • DERMATOLOGY • ENDOCRINOLOGY • ENT • FAMILY MEDICINE • GASTROENTEROLOGY • HEMATOLOGY/ONCOLOGY • NEUROLOGY • NEPHROLOGY • OB-GYN • PSYCHIATRY • PRIMARY CARE • RHEUMATOLOGY • UROLOGY

Berkshire Health Systems (BHS) is the leading provider of comprehensive healthcare services for residents and visitors to Berkshire County, in western Massachusetts. From inpatient surgery and cancer care to provider visits and imaging, BHS offers a continuum of programs and services that help patients to connect to the care they need, no matter where they are located in the rural Berkshire community. As the largest employer in Berkshire County, BHS supports more than 4,000 jobs in the region, and, as a 501(c)(3) nonprofit organization, BHS is committed to partnering with local municipalities and community organizations to help the county thrive. Working at BHS offers a unique opportunity to both practice and teach in a state-of-the art clinical environment at Berkshire Medical Center, the system's 298-bed community teaching hospital in Pittsfield, which is a major teaching affiliate of the University of Massachusetts Chan Medical School and the University of New England College of Osteopathic Medicine in Maine.

At BHS, we also understand the importance of balancing work with quality of life. The Berkshires, a 4-season resort community, offers world renowned music, art, theater, and museums, as well as year round recreational activities from skiing to kayaking. Excellent public and private schools make this an ideal family location. We are also only a 2½ hours drive from both Boston and New York City.

Contact us to learn more about these exciting opportunities to practice in a beautiful and culturally rich region, as part of a sophisticated, award-winning, patient-centered healthcare team.

Interested candidates are invited to contact:

Michelle Maston or Cody Emond
Provider Recruitment, Berkshire Health Systems
(413) 447-2784 | mmaston@bhs1.org
cemond@bhs1.org
Apply online at: berkshirehealthsystems.org

Berkshire Health Systems

Seeking Rheumatologist

- *Seeking BC/BE rheumatologist committed to clinical excellence*
- *Full-time opportunity (4-day work week, no weekends)*
- *Inpatient care provided by hospitalists*
- *1:3 call schedule*
- *Hospital infusion within walking distance*
- *Clinical research opportunity*
- *Competitive compensation package*
- *Year-round recreational location*

Situated at the edge of Glacier National Park, Logan Health offers an opportunity like none other against the backdrop of one of the most beautiful places in the world. Enjoy world-class amenities alongside pristine nature, all while delivering much needed care to the people of Montana.

We are dedicated to investing in our staff and committed to providing you with the tools you need to care for our communities. Logan Health has a collection of services and specialists who are committed to excellence in education, treatment, and care of our patients.

Advancing Medicine. Enhancing Care.

logan.org/joinourteam

To learn more please contact:
Jared Wilson, Physician Recruiter
(406) 751-5318 · jwilson@logan.org

One team

One mission

Many locations where you can do **your life's best work**℠

As a physician at Optum, you'll be part of the largest network of medical groups in the nation. Our progressive physician-led organization is transforming health care across the country by empowering physicians to lead care locally. Join our team of over 64,000 aligned physicians and advanced practitioners who are redefining how medicine should be practiced – focused on managing risk, higher-quality outcomes and driving change through collaboration and innovation.

Find an Optum practice where you can do **your life's best work.**℠
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Optum

Purposeful Presence

Reconnect with what matters most in your medical career.

Being clinically driven inspires our physicians to pursue medical excellence. But it's our purpose that truly allows us to change lives.

When you practice medicine at SSM Health, a leading Catholic, not-for-profit integrated health system serving Illinois, Missouri, Oklahoma, and Wisconsin, you can practice medicine that is restoring health, invigorating hope, and transforming care when and where it's most needed. That's the kind of profound health care that comes from being purposefully present.

Our healing ministry offers opportunities in a variety of specialties with a diverse selection of settings that range from community practices to academic medical centers.

Discover the career benefits of practicing at SSM Health:

- Develop a practice that can make a true difference.
- Work in a collaborative and inclusive practice culture with a network of providers who are clinically driven and guided by purpose.
- Receive generous compensation, substantial benefits, and family friendly PTO to allow you to achieve work/life balance.

Reconnect with your purpose at SSM Health.

JoinSSMHealth.com

SSMHealth