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The latest physician jobs brought to you by the 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.
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:

- Help ensure more flexible scheduling for physicians who are parents or 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.

- 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.

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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?
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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Non-specific Low Back Pain
Alessandro Chiarotto, P.T., Ph.D., and Bart W. Koes, Ph.D.

This clinical 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?

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, is worldwide the most prevalent and most disabling of the conditions that are considered to benefit from rehabilitation. 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%. Low back pain is classified as specific (pain and other symptoms that are caused by specific pathophysiologic mechanisms of nonspecific or spinal origin) or non-specific (back pain, with or without leg pain, without a clear nociceptive-specific cause). Nonspecific causes of 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 spondyloarthritides. 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. 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. The authors of a Dutch study that involved primary care patients reported axial spondyloarthritides in almost one quarter of adults 20 to 45 years of age who presented with chronic low back pain, although these findings have not been replicated. In contrast to low back pain caused by specific identifiable causes, non-specific low back pain probably develops from the interaction of biologic, psychological, and social factors, and it accounts for approximately 80 to 90% of all cases of low back pain. Low back pain is usually classified according to pain duration as acute (<6 weeks), subacute (6 to 12 weeks), or chronic (>12 weeks).

Risk Factors
Risk factors for an episode of non-specific 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. 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.

Natural History and Prognosis
Low back pain is increasingly understood to be a long-lasting condition with a variable course and 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. An observational study with 5 years of follow-up that included 281 patients with non-specific 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, 1.30 to 21.9), negative illness perceptions (negative cognitive and emotional responses to low back pain) (range of relative risk ratio per unit increase, 1.19 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).
Adapted from Kongsted et al. 12

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 or nonspinal conditions or nonspecific conditions that may lead to specific intervention. The history should include attention to red flags (e.g., history of malignancy, fever, weight loss, and prolonged low back pain), red flags for spine-related conditions (e.g., radiculopathy, inflammatory disease) and close follow-up, although only some of these historical features have been shown to be useful predictors of serious disease or malignancy. A strong clinical suspicion for cancer or a history of cancer15,16 has been associated with an increased likelihood of a malignant condition, whereas other classic red flags (e.g., unexplained weight loss or fever) do 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 likelihood of a nonspinal disorder. A positive history of asthma may signal obstructive airway disease, 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.64 However, 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 of 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.27–40 Overall, first-line treatments are currently represented by nonpharmacologic interventions, which should be prioritized before pharmacologic treatment is prescribed.48

#### Acute Low Back Pain

Patient education and advice to remain active should represent routine care for patients with acute low back pain.42 Education may address the benign, nonspecific nature and favorable prognosis of patients with acute low back pain without radiculopathy, the use of exercise therapy in alleviating chronic low back pain (Table 1) and in reducing the risk of episodes of low back pain.42

Among pharmacologic interventions, acetaminophen was not shown to be effective in a large clinical trial (Table 1), whereas nonsteroidal antiinflammatory drugs (NSAIDs) have shown benefit.46 However, caution is advised in the use of NSAIDs in older adults and patients with coexisting conditions such as renal disease. Topical NSAIDs (e.g., 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 began within the first 2 weeks of the onset of pain had positive effects, but the analysis was based on very-low-certainty evidence.49 These and other muscle relaxant agents had no significant effect on pain reduction or disability during longer periods of time and were associated with a higher risk of adverse events.50 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.48

#### 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. Heat and massage therapies are without risks and are reasonable to try, although the benefit of these therapies is supported only by limited data.54 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), 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 (Table 2) and in reducing the risk of episodes of low back pain.46

### 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).16,18 In a study that included patients 65 years of age or older who presented with 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.64 However, 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.
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.*

<table>
<thead>
<tr>
<th>Intervention vs. Control</th>
<th>Pain Intensity</th>
<th>Physical Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of Studies</td>
<td>Pooled Effect (95% CI)</td>
</tr>
<tr>
<td>Conservative intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice to stay active vs. bed rest†</td>
<td>3</td>
<td>-0.4 (-4.0 to 3.2)</td>
</tr>
<tr>
<td>Individual patient education vs. no intervention‡</td>
<td>3</td>
<td>NS</td>
</tr>
<tr>
<td>Individual patient education vs. non-educational interventions§</td>
<td>6</td>
<td>NS</td>
</tr>
<tr>
<td>Exercise therapy vs. no intervention or sham¶</td>
<td>3</td>
<td>0.6 (-1.1 to 12.7)</td>
</tr>
<tr>
<td>Exercise therapy vs. other conservative interventions¶</td>
<td>7</td>
<td>-0.3 (-0.7 to 0.1)</td>
</tr>
<tr>
<td>Spinal manipulation therapy vs. sham or other interventions‖</td>
<td>NK</td>
<td>-2.9 (-17.0 to 5.2)</td>
</tr>
<tr>
<td>Superficial heat vs. sham or non-heated wrap‖</td>
<td>1</td>
<td>-32.2 (-38.7 to -25.7)</td>
</tr>
<tr>
<td>Massage therapy vs. inactive interventions‖</td>
<td>1</td>
<td>-24.8 (-37.0 to -12.8)</td>
</tr>
<tr>
<td>Acupuncture vs. sham‖</td>
<td>2</td>
<td>-9.4 (-17.5 to -1.3)</td>
</tr>
<tr>
<td>Pharmacologic intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen vs. placebo¶</td>
<td>1</td>
<td>1.5 (-1.3 to 4.3)</td>
</tr>
<tr>
<td>NSAID vs. placebo¶</td>
<td>4</td>
<td>-7.3 (-11.3 to -3.6)</td>
</tr>
<tr>
<td>Muscle relaxant vs. placebo</td>
<td></td>
<td></td>
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<tr>
<td>Nonbenzodiazepine antispasmodic agent¶</td>
<td>16</td>
<td>-2.3 (-12.1 to 3.3)</td>
</tr>
<tr>
<td>Antispastic agent¶</td>
<td>1</td>
<td>-1.6 (-13.5 to 12.1)</td>
</tr>
<tr>
<td>Benzodiazepine¶</td>
<td>1</td>
<td>2.0 (-9.9 to 13.6)</td>
</tr>
<tr>
<td>Opioid vs. placebo¶</td>
<td>0</td>
<td>---</td>
</tr>
</tbody>
</table>

*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 signifies 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 for physical functioning), for these constructs. When the pooled effect was calculated on a scale of 0 to 24 (Roland-Morris Disability Questionnaire), 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.

¶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 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 for physical functioning), for these constructs. When the pooled effect was calculated on a scale of 0 to 24 (Roland-Morris Disability Questionnaire), it was converted to a scale of 0 to 100 by multiplying the effect by 4.17.

*GRAGE scores were calculated by the authors, not reported by pooled-study investigators.

**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).
Diagnosis and treatment of low back pain.

A meta-analysis of individual patient data from 27 trials did not show clinically relevant modifications of the effect of exercise on chronic low back pain. 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 medium risk received physical therapy and opioids for acute low back pain and NSAIDs, muscle relaxants, and antidepressants for chronic low back pain. Data are needed to inform whether the effects of these or other interventions vary according to patient characteristics. The recommendations presented here are generally consistent with those guidelines.

A previous published overview summarized the recommendations of 15 clinical practice guidelines for the management of non-specific low back pain in primary care. 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 nonpharmacologic therapy (owing to limited efficacy and risk of adverse effects) in favor of nonpharmacologic therapy.

The patient described in the vignette is experiencing an acute episode of recurrent low back pain. The presence of worrisome findings on the history and physical examination, imaging would not be recommended. The PICK-UP tool or the Orebro 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 lacking).

G U I D E L I N E S

There is some controversy regarding the term “non-specific” 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 thus no need to guide its diagnosis and management.

A systematic review with moderate-certainty evidence showed no clinically relevant differences in effects on pain with functional manual therapy as compared with recommended first-line options (Table 2). Multidisciplinary interventions that combine physical and psychological components may be especially suited for patients with low levels of functioning and with perceived risk factors for poor outcomes, although data showing superior effectiveness for this patient group are lacking. 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. Muscle relaxants and antidepressants (e.g., serotonin and noradrenergic reuptake inhibitors) may be considered for patients, although they have had limited effectiveness (with evidence of moderate to very low certainty) (Table 2) and have potential risks. The use of opioids should be limited to very serious (with evidence of moderate to very low certainty) (Table 2) and have potential risks.

The recommendations presented here are generally consistent with those guidelines.

R E F E R E N C E S


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Internal Medicine/Pediatrics  
Medical Genetics  
Medical Genetics  
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Nuclear Medicine  
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Ophthalmology  
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Pediatrics, General  
Pediatric Gastroenterology  
Pediatric Intensivist/Critical Care  
Pediatric Neurology  
Pediatric Orthopedic Surgery  
Pediatric Surgery  
Pediatric Urology  
Physicians' Assistant  
Physician Services  
Positions Sought  
Practices for Sale

Classified Advertising Section

Sequence of Classifications

Classified Advertising Rates

We charge $10.55 per word per insertion. A 2- to 4-minute frequency discount rate of $7.95 per word per insertion is available. A 5-minute frequency discount rate of $7.55 per word per insertion is also available. In order to earn the 2- to 4-minute or 5-minute 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. The request for an ad to run in multiple issues must be made upon initial placement. The choice to place your ad online must be made at the same time the print ad is scheduled.

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
December 10, 2007 ....................... = 3 words
December 10, 2007 ....................... = 3 words
December 10, 2007 ....................... = 3 words
December 10, 2007 ....................... = 3 words
December 10, 2007 ....................... = 3 words

How to Advertise

All orders, cancellations, and changes must be received in writing. Email 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 consider 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.

How to Calculate the Cost of Your Ad

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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 or 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/Departments/Department Heads classification.

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.

Contact Information

Classified Advertising
The New England Journal of Medicine
860 Winter Street, Waltham, MA 02451-1412
Email: ads@nejmcareercenter.org
Phone: 1-800-635-6991
Fax: 1-781-893-5003
Website: nejmcareercenter.org

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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.
Classified Ad Deadlines

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**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 call RVU; 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: vbstrand@gmail.com

**Rheumatology**

RHEUMATOLOGIST PHYSICIAN — To join a large multispecialty group in northern New Jersey. Excellent salary and benefits package. Please e-mail CV to: anna.bバック@hvacaregroup.com

**Medical Genetics**

EXPERIENCED GENE THERAPY SCIENTIST/ FACULTY — With access to US/overseas lab or start new lab, to prepare AAV-mediated C57bl6/J-knockout mice for viral and host cell adaptations. Methodology published. 2 years or more experience. Please e-mail resume to: vincentw@nmunh.edu

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This 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

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**Advertise in the next Career Guide.**

For more information, contact:
(800) 635-6991
ads@nejmcareercenter.org

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**Location, Location, Location**

**Concord**  - - - - :30  - - - - **Boston**

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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@emersonhospital.org
phone: 978-287-3002
fax: 978-287-3600

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Primary Care Opportunities

Full- and Part-time
Western Massachusetts

Baystate Health offers:
> Supportive Work Environment
  - Multi-Stage: Dupont, Nighttime, First call after hours & weekends
  - Scribes
  - Medical Assistant
  - Direct access to a large multi-specialty group including Behavioral Health
  - Lab and procedure specialists scheduled onsite
  - State-of-the-art EHR system with technology support
> Work Life Balance
  - Flexible work schedules
  - Full-time 4-day work week
  - Full-time 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

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, national origin, ancestry, age, genetic information, disability, or protected veteran status.

All correspondence can be directed to:
Paige Livingston, Provider Recruiter • Paige.Livingston@baystatehealth.org
Phone: 413-794-7874 • Fax: 413-794-5059

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As a trusted physician recruitment partner to thousands of healthcare organizations for over 36 years, Cejka Search has an opportunity for every physician.

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Find your next dream job at jobs.jacksonphysiciansearch.com

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See how knowing about locums can open doors.

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A PROVEN PATH TO EXCELLENCE.
JOIN THE LARGEST PHYSICIANS GROUP NORTH OF BOSTON.

North Shore Physicians Group

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 existing 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.

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.

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

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.
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**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.

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**Endocrinology/General Medicine**

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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.
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

Significant sign on bonus Tuition reimbursement Student loan repayment

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• Flexible schedules for work life balance
• Great leadership
• Supportive teams

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.

The Department of Medicine at the VA Northeast Ohio Healthcare System is seeking one full-time staff physician interested in a Nocturnist/ERF 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
e-mail: jason.petrakos@va.gov

Family Medicine Opening

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 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

Blessing Health System

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 competitive benefits package. TBHC is proud to be an equal opportunity employer.

The Brooklyn Hospital Center
www.tbh.org

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Significant sign on bonus Tuition reimbursement Student loan repayment

• Competitive wages
• Comprehensive benefits
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• Flexible schedules for work life balance
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- 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 competitive benefits package. TBHC is proud to be an equal opportunity employer.

The Brooklyn Hospital Center
www.tbh.org

CFMA CareerCenter.org
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

Explore your opportunities at:
northwest.permanente.org

PERMANENTE MEDICINE®
Northwest Permanente

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

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

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.

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.

Explore opportunities

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

Kaiser Permanente

See all opportunities at LVHN.org/careers
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.

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- 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

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

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

Vital Roles in a Vibrant Community
Physician Opportunities

One team
One mission
Many locations where you can do your life’s best work℠
Reconnect with your purpose at SSM Health.
JoinSSMHealth.com

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