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The latest physician jobs brought to you by the NEJM CareerCenter

Primary Care Edition
How to Prepare for Your Physician Job Interview

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

Finally! You’ve done countless interviews at this point, but for many of you, this is the first one where you are interviewing for a “real job.” Some of the same rules apply, but others are very different.

To start, the dynamic in this interview is much different than others. You are likely interviewing with people who will be your colleagues, and your impression of them counts just as much as their impression of you. Depending on the job market in your field, there’s a distinct possibility that they may even need you more than you need them.

Additionally, in an ideal scenario, you are picking a job that will last longer than a set time period of training. You are designing what potentially decades of life could look like for you and your family. Since this isn’t just a stepping stone to the next thing, your approach will need to be more all-inclusive. Also, unlike residencies and fellowships, where a similar core set of responsibilities and expectations are already outlined, there is a lot of variability between jobs, even within the same city and specialty. It’s important you are able to leave the interview with a 360-degree view of the position and the life you will build around it.
Keeping all of that in mind, here are some of my core tips for preparing for an interview:

1. Do your research about a job ahead of time. Not doing this is one of the biggest mistakes I see applicants making. Showing up to a job and asking basic questions whose answers can easily be found online will cause interviewers to question why you're at the interview and how serious you are about the job. You want to come in knowing how the group is structured from a management perspective, what its patient population looks like, who the referral base may be, and what areas within your field the group specializes in, as well as some areas or topics where you may be able to add value. Look at the group's website and the members and see if there are any connections that you might have where you might be able to find common ground. Call the people you know who may be familiar with the group and ask them for insights. Find out if people have left the group recently, as it may raise some red flags. This will all lead to more sophisticated questions that you can ask and more valuable information to consider when you are making your decision. It will also tell group members you are serious about the opportunity, which will help your chances as they decide whether to extend a job offer. Time and resources are precious in this process, and many won't want to waste their time if they feel they are 1 of 100 possibilities.

2. Try and allot time to get to know the city you are interviewing in. For those of you who are trying to return to a known place, this may be less of an issue, but nonetheless, training somewhere or growing up somewhere is different from living there as an adult and potentially raising a family in that location. Make sure the place offers outlets to foster your interests outside of work, as it will play into your happiness and burnout. Tour neighborhoods you may want to live in, and if you have educational preferences for your children, take some time to explore your options. If applicable, bring your significant other with you so that you're on the same page about pros and cons of living there.

3. When interviewing with potential future colleagues, don't be afraid to be yourself. It's important that the fit feels natural and that there is a mutual desire to work together. As the saying goes, you can't choose your family, but you can choose your friends. Similarly, you can choose colleagues that you are confident will contribute to your happiness at the job, whether it be via friendships, accommodating emergencies when they arise, splitting work in a way that feels equitable, or being respected.

You should see yourself fitting into the culture of the group's members and in line with the standards, ethics, and practice patterns that they embrace.

4. In a similar vein, take note of how colleagues are interacting with each other. As the landscape of health care delivery gets more challenging and complicated, it's important that you feel that the group is cohesive and supports each other. If there are obvious tensions within the group, it may be a sign that there is more beneath the surface that's resulting in conflict, whether it's RVU (relative value unit) structures, partnership issues, different beliefs about the direction the company is taking, etc.

5. Talk about money and opportunities for growth. After all, this is a job. Put some effort into figuring out how revenue is generated, when you get to share in those profits, and what the plans of the group are in terms of expansion. If the compensation structure is complicated, ask for details. You don't have to take up your entire interview time talking about it, but get a basic sense and then ask the interviewer to send you a summary with details later. Understand the benefits. If the group's members do something a lot different from other groups you've interviewed with or your colleagues are interviewing with, ask them why they chose to structure things in that way.

6. If possible, spend some time shadowing someone whose job is similar to the one you're interviewing for. Make sure you can see yourself happy in his or her shoes, and if there are obvious pain points or dealbreakers, take note of them. You may not be able to do this on the day of the interview, but if you have doubts about whether you'd enjoy the particular setting ahead of time, see if an interviewer can incorporate this on a later date. Again, it's in everybody's best interest to ensure a job is a good fit for you.

I could go on, but your goal on your interview day is to confirm the job is one you can see yourself enjoying for years to come. You're really picking more than a job — you're picking a lifestyle and a vision for your future, and you want to make sure you are keeping a keen eye out for pros, cons, and red flags.

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For example, hospitalists may work with colleagues in the ER and critical care, cardiology, neurology, orthopedics, and, in limited cases, trauma specialists, Dr. Rohal said. In a newer role, serve as physician advisers assessing the status of and optimal care setting for an even broader range of patients.

Increasingly, Dr. Rohal said, hospitalists are also integrally involved in managing transitions of care and the systems issues that challenge hospitals. Hospitalists are moving into informatics, quality improvement (QI), care management, telehealth, and services utilization. “The possibilities, in terms of career paths for hospitalists, are robust — and growing. Hospitalists were already being viewed as leaders in the hospital before the pandemic hit. Their impressive performance during COVID-19 cemented that,” said Dr. Rohal, whose company employs approximately 3,000 hospitalists at 200 U.S. sites.

Jerome C. Siy, MD, a past president of the Society of Hospital Medicine and division medical director of hospital-based specialties for HealthPartners in Minneapolis, Minnesota, agrees that hospitalists’ role in helping hospitals navigate the pandemic has revealed even more ways, particularly in telehealth, that hospital medicine physicians’ expertise might bring value.

Today, Dr. Siy said, hospitalists are being tapped for key roles in operations — improving electronic health records (EHRs) and consulting on informatics innovations. “We’re even seeing hospitalists getting involved in emerging areas such as predictive analytics, patient risk scoring, population health, and nascent hospital-at-home programs,” he said.

Per Danielsson, MD, a hospitalist who has helped hospitals pilot hospital-at-home (HAH) programs, which seek to provide hospital-level care for older patients who may be at risk for functional decline or other problems associated with long inpatient stays if they remain in the hospital. He views the model as a win-win for hospitals and the hospitalists who clinically

“As an early-career hospitalist, you have to invest in growing your knowledge base and carving out time to do committee work if you want to pursue a leadership role. There are new skill sets to learn, and that takes time.”

— Jerome C. Siy, MD, HealthPartners

For young physicians contemplating where they’ll hang their stethoscopes, that broad swath of practice possibilities is a large part of the specialty’s appeal, according to Rohit Uppal, MD, MBA, chief clinical officer for TeamHealth Hospitalist Services in Orlando, Florida. “The lure of hospitalist practice is that physicians are exposed to aspects of medicine that they might not encounter elsewhere and also have the opportunity to learn leadership skills on the job,” Dr. Rohal said. “There’s really no other specialty that exposes you to the breadth of medicine.”

Hospital medicine has made a lot of headway for a relatively new physician specialty. In just over 25 years, hospitalists have integrated themselves into virtually every aspect of care delivery in hospitals and health systems. From their beginnings as in-hospital internists and family medicine physicians managing the inpatient care of community primary care physicians’ patients, a vital role that persists today, hospitalists are now serving in top leadership positions, commandeering quality improvement initiatives, and developing facility-wide protocols. They’re also co-managing specialists’ patients and delving deep into hospital operations and IT infrastructures to help facilitate systems improvements.

Hospitalist Update: For Hospital Medicine Physicians, Emerging Opportunities Plentiful in Clinical and Operational Realms

By Bonnie Darves
Young physicians are looking for ways to serve the community at large. They’re increasingly articulating that desire when they interview for positions, observed Dr. Nwelue, now a veteran of the field. “That’s something we’ve been seeing a lot in recent years — young physicians wanting dedicated time for community outreach, for opportunities to care for or teach patients outside of the hospital setting,” she said. “It’s a common request of this new generation.”

Hospitalists want to teach, too

Also high on the wish list for many young hospitalists are formal or informal teaching opportunities. Although hospitalists in academic medicine have such opportunities as a matter of course, many of those practicing in other settings such as community hospitals also want to spend some time teaching students, residents, or even other colleagues, several sources mentioned. Fortunately, some of the hybrid community hospital/academic institution partnerships that have emerged in the past decade are giving hospitalists a chance to do some teaching and research work in addition to their clinical duties.

In the academic realm, some programs are seeking more expedient pathways for early-career hospitalists move into medical education more quickly — with the objective of providing that career satisfier sooner that it might occur traditionally in competitive academic environments. The University of Chicago, for instance, has pioneered an innovative Passport to Clinical Teaching program, which offers early-career hospitalists access to medical education opportunities that they can pursue on their own time and can coordinate with their clinical responsibilities.

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In recent years, another brand of hospitalist has emerged — transitionalists. These hospitalists focus on the intersection of inpatient care and so-called step-down units. Transitionalists practice either part-time or full-time in post-acute settings such as inpatient rehabilitation facilities, long-term acute-care hospitals, or skilled nursing facilities. In such roles, hospitalists often serve as medical directors.

In another recent development, hospitalists are being tapped as in-house consultants. They’re helping hospitals reduce unnecessary services utilization, assess medical-necessity issues, and streamline post-discharge care continuity. Because hospitalists develop in-depth familiarity with specialists’ practice patterns, test ordering, and patient lengths of stay, hospitals are discovering that hospitalist input pays dividends in both reducing costs and improving care.

Inside hospitals and health systems, organizations are realizing that young tech-savvy hospitalists can also be instrumental in helping them vexing issues. Hospitalists are being tapped to help resolve workflow, IT, and EHR issues that cause inefficiencies — or clinician frustration. “This is an ideal role for early-career hospitalists who have an interest and some expertise in healthcare technology,” said Dr. Siy. “There’s a real demand for such skills.”

One of the big draws in the early years of hospital medicine was that hospitalists working “7/7” schedules could use some of the off-week time to moonlight at local hospitals, perhaps to pay off education debt more rapidly. Although moonlighting isn’t as common as it once was in the field, some hospitalists recognize that they can use their off time to learn new clinical or business skills or even start new ventures.

Mitchell Durante, DO, and Anthony King, DO, hospitalists at BJC Healthcare Christian Hospital in St. Louis, Missouri, recently decided to take advantage of their “7/7” schedule flexibility to start a manipulative medicine clinic that’s open during their off weeks. “It took us a few years to get this up and running, but we’re excited about starting our own business,” Dr. Durante said. “That’s one of the good things about hospital medicine — it gives you the flexibility to do something like this.”

Some hospitalists are also utilizing their newly developed telemedicine skills with their flexibility to carve out opportunities to provide remote care and consultations from home. Others are developing new products or apps, launching podcasts, or serving an independent medical reviewers.
For Jessica Porter, MD, a TeamHealth hospitalist medical director at Memorial Hospital Miramar in Hollywood, Florida, the opportunity to lead came early — soon after she completed residency in 2016. She jumped at the chance. “I’d always been interested in leadership, and in contributing, because, well, someone did the same for me. It was a steep learning curve, but I managed it and found I really enjoyed the administrative work,” said Dr. Porter.

Today, although Dr. Porter maintains a full clinical schedule, she manages to fit in most of her administrative duties during her “on” weeks, and receives a stipend for her leadership work. Those duties include managing operations and coaching physicians, representing hospitalists’ interests at hospital management meetings and, as needed, boosting morale. “It’s very gratifying work, and I think it’s important to have a seat at the table when organizational decisions are being made,” she said.

Dr. Porter advises young hospitalists who are interested in leadership to look for committee and task force openings, engage in quality improvement initiatives and, above all, express their interest in leadership roles. “If you don’t ask, you don’t get it — whether it’s a raise or a leadership opportunity,” she said.

The other ‘ists’ — growth of specialty hospitalists is slow, but steady

In the past 15 years, several specialties have made strides in developing inpatient-only services based on the hospitalist model as specialists wrestle with the growing challenges of simultaneously managing a combined outpatient/inpatient practice.

The mainstays of the specialty hospitalist movement remain orthopedics, trauma, anesthesiology, OB/GYN, general surgery, and gastroenterology. But psychiatry and neurology are both increasingly embracing the hospitalist model. In a pioneering venture, the University of California, San Francisco has started a Neurohospitalist Division that utilizes a structure similar to the traditional medicine hospitalist model.

Leadership roles

Although it’s not uncommon now to see hospitalists as medical directors, chief medical officers, and health-system committee chairs, young hospitalists should understand that both a learning curve and a willingness to devote extra time to small-scale initiatives are prerequisites for obtaining leadership roles, Dr. Siy noted. “As an early-career hospitalist, you have to invest in growing your knowledge base and carving out time to do committee work if you want to pursue a leadership role. There are new skill sets to learn, and that takes time,” he said.

Organizations are trying to accommodate hospitalists’ desires to move into leadership roles without waiting a decade or longer. TeamHealth, for example, operates a designated leadership track for interested hospitalists. And it’s a popular option, according to Dr. Uppal. In addition, the Society of Hospital Medicine’s Leadership Academy offers a wide range of courses that enable hospitalists to obtain leadership and management skills.

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— Rohit Uppal, MD, TeamHealth Hospital Medicine
A 71-year-old man had previously received a diagnosis of stage IV non–small-cell lung cancer that was positive for epidermal growth factor receptor (EGFR) and metastatic to the spine. The cancer responded to treatment with an EGFR tyrosine kinase inhibitor, providing the patient with an excellent quality of life for 3 years. During that time, his main priority was caring for his wife, who has dementia. The patient now has leptomeningeal disease and worsening back pain. His oncologist reports the news of the disease progression and discloses the prognosis that the patient’s remaining life may be as short as a few months. Despite multiple conversations with his clinician, the patient continues to state that he hopes to live several more years and that he feels his oncologist is giving up on him. In addition to starting chemotherapy and radiation therapy and referring the patient to outpatient palliative care, how can his clinicians support him in integrating information regarding his prognosis and help him with end-of-life planning?

Many clinicians have not had the opportunity to master the communication skills necessary to help seriously ill patients cope with their illnesses. These skills include recognizing that a patient’s continued extreme hopefulness is a normal part of coming to terms with an uncertain or poor prognosis. To help patients with serious illness develop their capacity to cope with the enormity of their illness, clinicians need skills that go beyond selecting the most appropriate forms for communicating bad news. These skills should include recognition of the patient’s current understanding of their illness and their capacity to adaptively cope with prognostic information, and clinicians should be able to help cultivate prognostic awareness and existential maturation.

Prognostic awareness is a patient’s ability to integrate the likely illness trajectory both cognitively and emotionally.1,2 It is not uncommon that patients who have a serious illness, such as cancer or heart failure, continue to express seemingly unrealistic hopefulness despite conversations in which accurate prognostic information has been well communicated and tailored to the patient’s preferences. This reaction is something clinicians want to understand for important reasons. The patient and are rightly concerned that a patient may not be prepared for the end of life.2 Such concerns that lack of preparation can lead to poor-quality end-of-life care are supported by evidence of late referrals to hospice and unwanted in-hospital deaths.2 Several factors contribute to the difficulty of conversations about prognosis. Consideration of matters related to death is difficult for patients and clinicians across most cultures, and therefore, patients may have a poor understanding of their illnesses and clinicians may not know how to help patients cope. The task of the clinician is to assess and guide the patient’s awareness and adaptive coping process, including discerning the patient’s priorities for this last part of life. Such considerations include the patient’s relationships; their feelings regarding disability, pain, and treatment invasiveness; and the evolving nature of all these issues. As the prognosis translates into medical decisions, the process must be coordinated across medical teams. These tasks are as yet imperfectly practiced.2

THE CLINICAL PROBLEM

CONVERSATIONS ABOUT PROGNOSIS CAN BE DIFFICULT AND CONFUSING FOR BOTH PATIENTS AND PHYSICIANS. THIS IS ESPECIALLY TRUE FOR PATIENTS WITH A SHORT EXPECTED SURVIVAL.

Navigating and Communicating about Serious Illness and End of Life

Vicki A. Jackson, M.D., M.P.H., and Linda Emanuel, M.D., 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.
Best practices suggest that a clinician tailor population-level data to the individual patient, acknowledging uncertainty (including uncertainty resulting from a lack of data), providing times in ranges, and respecting the patient's information preferences.18

However, even when effective communication methods are used, patients often have misconceptions about their illness that affect treatment decision making. One study showed that 69% of patients with metastatic lung cancer and 83% of patients with colorectal cancer did not understand that chemotherapy was unlikely to cure their cancer,31 and data have confirmed misperceptions across numerous populations, including patients with hematologic cancer, congestive heart failure, and end-stage liver disease.32-34 Patients who overestimate the likelihood of survival are more likely to choose intensive care measures at the end of life and are less likely to discuss their end-of-life care preferences with their clinicians.35-37 These data show that there is an opportunity for clinicians to help patients develop a more accurate understanding of the likely course of their illness. Rather than insisting that a patient immediately accept a harsh new reality, the clinician can offer support as the patient builds the capacity to come to terms with the likelihood of dying.38

EMOTIONAL INTEGRATION OF PROGNOSTIC INFORMATION

The process of emotional integration of difficult prognostic information necessitates that the patient grieve losses, reimagine hopes, and manage fears and worries in order to tolerate and effectively cope with the distress related to their prognosis. It is often a bumpy, oscillating developmental process that involves conflicting, intense emotions. Patients oscillate between expressions of extreme hopefulness (“I know I will beat this. I don’t believe the oncologist.”) and realism (“I don’t know what the future holds. I hope I feel well enough to take a trip with my family this summer.”) Oscillation between conflicting states of mind is a fundamental part of normal emotional processing and development and is well-established in psychological theories that have been applied to processing the realities of serious illness.39 With the benefit of time comes the opportunity to explore hopes and worries in a trusted environment, patients tend to progress toward prognostic awareness and existential muturation.40,41

EVOLUTION OF INTEGRATED AWARENESS

Studies have shown that deeper prognostic awareness happens over time, often across a continuum of conversations.42-44 Patients and clinicians often “cycle” through short portions of this ongoing conversation over periods of weeks, months, or years, depending on the patient and the cadence of the illness. Clinicians can align with patients in these oscillations, not only accepting patients’ hopes but exploring them in order to better understand what is most important to the patient. Additional factors that may facilitate this interaction include showing empathy, normalizing patient reactions; slowly exploring the sadness, grief, and loss; and maintaining a reliable and accessible partnership to help the patient cope and live as fully as possible in this final phase of life, however long it may be.45

The cycling of these discussions over time and in different settings (e.g., palliative care, oncology, and primary care) and with different disciplines (e.g., social work, psychology, and chaplaincy) allows the patient to develop a language for discussions about the possibility of dying and the adaptive coping skills to participate in those discussions. Crucial conversations about these matters also involve families and loved ones. Some conversations with family and loved ones entail divergent hopes and worries that affect the patient’s process of understanding the prognostic information and may need to be discussed with the clinician. Throughout the course of all these conversations, patients increasingly link a cognitive and emotionally integrated understanding of the illness to their expression of what is most important, and they are able to make more fully informed decisions (Fig. 1). Despite effective communication and partnership with their clinicians, some patients may continue to struggle to cognitively and emotionally integrate prognostic information. This lack of fully informed decision making may result in patients feeling more technical than clinical and finding themselves in a situation in which a patient is requesting a treatment that is unlikely to be of benefit. The competing precepts of autonomy and nonmaleficence can be difficult to balance. Continued attuned conversations and, perhaps, a time-limited trial of treatment may be helpful.46
Clinicians and researchers need to be able to measure the degree to which patients have cognitive and emotionally integrated key prognostic information and how well they are adaptively coping.6,10 We need a better understanding of which domains of patient concern are germane to medical decisions — such as relationships and thresholds regarding disability, physical suffering, and invasiveness of treatment — and how patients relate to the oscillation of the hopes and worries.45,46 More research is needed to better understand the ideal timing, content, and structure of these conversations and how these elements might vary with factors such as a patient’s baseline coping strategies, cultural preferences, lack of trust in the medical system (including concerns about systemic racism), physical or spiritual suffering, and the patient’s ability to develop trusting relationships.4,5,11,12 We also know very little about how factors that affect clinicians, such as self-awareness, burnout, existential maturity, and coping to uncertainty, influence their abilities in this area.

In addition, research needs to produce a better understanding of the ways in which well-cultivated psychosocial interventions could be helpful to patients with serious illness, not only in mitigating psychological symptoms such as anxiety and depression but also in cultivating prognostic awareness, coping, and the quality of decisions.4,5,9,10 Reconsideration of how best to conduct the research and the clinical process of advance care planning in the early weeks of life, including the patient’s understanding of the nature of being mortal. New York: Columbia University Press, 2021.


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At the end of your training, where do you want to be?

WE GET WHAT MATTERS TO YOU MOST.

DHA CIVILIAN PHYSICIANS GET THE WORK-LIFE BALANCE THEY NEED & THE BENEFITS THEY DESERVE.

- Competitive Salary
- Generous Paid Time Off
- Job Security
- Supportive Work Environment
- Flexible Schedules
- 350+ 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.

JOIN INDUSTRY-LEADING BANNER HEALTH IN ARIZONA!
We’re expanding our GI footprint in Phoenix & Tucson.

DHA CIVILIAN PHYSICIANS GET THE WORK-LIFE BALANCE THEY NEED & THE BENEFITS THEY DESERVE.

We offer a generous salary, sign-on and recruitment incentives, along with an industry leading benefits package that provides security for you and your family!

Banner Health is one of the largest non-profit healthcare systems in the nation with 30 hospitals (15 in Arizona), including University of Arizona academic campuses in Phoenix and Phoenix, six long term care centers and and hundreds of primary care and multi-specialist clinics in six Western states. Banner Health promotes collaborative team-oriented workplaces and clinical settings that focus on providing excellent patient care. We are physician-led, and value the voice of our providers. We take pride in being integrated and innovative, developing ways to make Health Care Made Easier, Life Made Better.

- Comprehensive medical, dental, vision & pharmacy plans | eligible for benefits within 30 days
- ATO & CME days, with reimbursement
- Paid malpractice, licensure & DEA registration fees
- 401K 4% match after one year of service
- Financial savings resources & mortgage assistance
- Leadership & career advancement with optimal work/life balance

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

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
Together, we can all be better.

At Optum, we’re making health care human again by giving clinicians the freedom and flexibility to be better. Better at caring for your patients. Better at caring for yourself. Better at creating a career path without limits. Better at making health care better for everyone. Join Optum, where we’re Caring. Connecting. Growing together.

Build your career your way.

Finding your way back to loving medicine starts with a career built around your life, your preferences, and your passions. Our specialty-specific recruiters are ready to go to the mat to find you the job with all the little details that matter to you.
Purposefully Present
Reconnect with what matters most in your medical career.

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.

We invite dedicated, committed, and compassionate physicians to join us and immerse themselves in a practice culture infused with greater purpose, enhanced support, and increased presence.

At SSM Health, you can expect:
• A competitive salary linked to value and quality metrics.
• Excellent benefits, including malpractice and tail coverage.
• Tuition reimbursement and relocation assistance.
• Opportunities to take part in teaching, research, and transformational health care initiatives.

Explore our available opportunities in Missouri today at JoinSSMHealth.com.