NEJM CareerCenter

Career Guide

Physician jobs from the *New England Journal of Medicine* • November 2024

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Residents and Fellows Edition

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The NEW ENGLAND JOURNAL of MEDICINE

November 14, 2024

Dear Physician:

As a resident nearing completion of your training, I'm sure that finding the right employment opportunity is a top priority for you. The *New England Journal of Medicine* (NEJM) is the leading source of information about job openings, especially practice opportunities, in the United States. To assist you with this important search, a complimentary reprint of the classified advertising section of the November 14, 2024, issue is enclosed.

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

Sincerely,

Eric J. Rubin, MD, PhD

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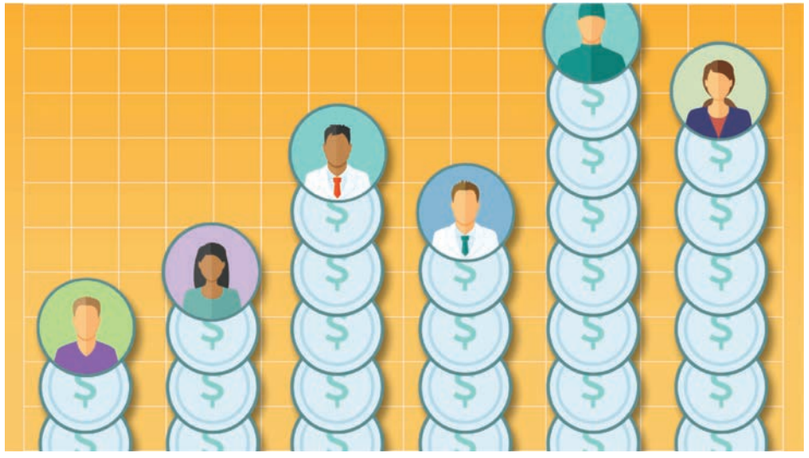

Knowing Your Worth in the Physician Job Market

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

One thing physicians seldom do in the training setting is talk about money. Between daily clinical responsibilities and call, a never-ending amount of information to learn, and doing your best to keep up with the other aspects of your life, most of us would agree we're in survival mode for most of our residency and fellowship. Learning the business and financial aspects of a life in medicine doesn't usually make it to the priority list.

Consequently, as the end of training approaches, most physicians find themselves overwhelmed with the prospect of finding a job, and under-prepared for negotiations. Many just feel grateful to have come to the conclusion of a long journey. After years of being paid a very low hourly rate and (on average) holding substantial six-figure debt, it's tempting to just be happy with the positive cash flow.

Not doing the requisite research before talking about numbers will almost always work against you. I routinely find myself encouraging physicians to know their worth — not just because I think physicians have the expertise to warrant earnings that reflect it, but because career longevity and job

satisfaction are closely intertwined with feeling valued. When I counsel early-career physicians who are dissatisfied, this is often the reason they end up seeking other opportunities within the first five years out of practice.

As salary transparency is not commonplace in medicine, trainees (and their older counterparts as well, for that matter) often don't know how to evaluate offers or know what reasonable expectations are. This is a significant disadvantage at the negotiating table, and why physicians must put the research into figuring out their market value.

Many mistakenly assume that knowing your worth means simply looking at widely cited compensation databases such as Medical Group Management Association (MGMA) and Association of American Medical Colleges (AAMC). These are available for purchase or may be available from your hospital libraries or your contract attorney. Although a great place to start, it's important to take this data into context. Compare not only the salary numbers, but the actual compensation per RVU. Know that this can range widely even within the same region of the United States depending on exact location, type of practice, stage of practice, how competitive the job market is, and a host of other factors. You should dig deeper. If the job is at an institution where compensation data is published, such as state and government organizations, look up the salaries of other physicians there. Ask your medical school classmates, mentors, training program alumni, and other physicians in your network who may have knowledge of or connections within the pertinent market.

Importantly, realize there is a lot of work that you do that may not be reflected in RVUs. This may take the form of call responsibilities, teaching or research expectations, or administrative duties. These are all things that contribute to your worth to an employer, and should be factored in when calculating your market value.

Next, it's important to do your research on the employer. Do you have a particular skill they are in need of? Some skills that may strengthen your bargaining position include fluency in a foreign language, procedural skills, the potential to attract certain patient populations, or the ability to develop a niche that the practice does not currently offer.

Finally, utilize a contract attorney, ideally one that is experienced with physician contracts. Many trainees are hesitant to spend the money, but having the objective feedback on how your deal compares to others is well worth it. Oftentimes, they will be able to point out areas where you should ask for more, give feedback on things like partnership and bonus structures, and protect you from expensive mistakes. After all that you've spent to get to this point, it's a worthwhile investment to make sure your contract is fair and in your best interest.

In every negotiation, both sides will understandably try their hardest to get the best deal for themselves. This is a business transaction, and should be approached as such. There will be give and take on both sides, but having a solid understanding of your worth will empower you to advocate for it. And remember…if you don't ask, you won't get.

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Creating a Physician CV That Shines

Simple format, brevity, and absolute accuracy — and avoiding including extraneous details — are musts.

By Bonnie Darves

Physician residents and fellows who start writing their curriculum vitae (CV) usually approach the task expecting that it will be a straightforward matter of letting the world know where they've been and what they've done, in a document that is about three pages in length. In theory, that's about right. In practice, however, many young physicians, especially those about to launch their first job search, quickly find themselves sweating the details. They wrestle with how much detail to include and how to structure their CV as the selling tool they intend it to be: a document that sets them apart from the crowd.

Fretting a bit about getting it right is not a bad thing, say recruiters and physicians who are on the receiving end and who review scores of CVs each year. Too often, young physicians don't take the time to ensure that their CV is not only polished and error-free, but also an accurate reflection of important accomplishments that prospective employers care about.

John D. "Jack" Buckley, MD, vice chair for education in the department of medicine at Indiana University School of Medicine, frequently encounters CVs that leave out the kinds of details that might be differentiators: committee work, quality-improvement initiative involvement, medical student teaching or mentoring, or even assistance on a hospital IT project.

"Ideally, everything that is on your work calendar should be on your CV, and there should be a brief description and timeline of those roles or assignments," said Dr. Buckley. In his experience, residents usually include their research work but sometimes leave out these kinds of quasi-extracurricular activities, thus missing an opportunity to demonstrate their willingness to go above and beyond what's required of them.

Sapna Kuehl, MD, director of the internal medicine residency at Saint Agnes Healthcare in Baltimore, Maryland, also urges physicians to briefly describe their roles in committee, task force, or initiative work, and associated accomplishments. "People who are hiring physicians out of training are looking for evidence of dedication and persistence," she said.

Format: keep it simple

Choosing a CV format is perhaps the easiest aspect of preparing a professional-looking CV. Examples abound online, and most training programs provide a recommended template for physicians seeking structure guidance. The basic content and suggested order of information appearance, for trainees seeking an initial practice opportunity, are as follows:

- Name and contact information
- Education, undergraduate through internships, residencies, and fellowships — including specific clinical roles and any leadership roles
- Licensure (status of applications planned or underway, if any)
- Board certification or status
- Professional experience (medicine-related only), including procedure and patient volumes, if/as applicable to the specialty, and administrative roles or duties
- Activities and committee memberships, including roles and brief descriptions of associated accomplishments
- Honors, awards, and professional affiliations
- Publications and presentations

All dated entries should be chronologically arranged on the page from present to past, in a month/year format. Physicians should be prepared to explain any gap of more than three months in a conversation or a cover letter, all sources agreed, and should never attempt to "fudge" or cover up a gap. "A gap can be a red flag to a recruiter, even if the reason is completely understandable," said Laura Schofield, a recruiter with Boston-based Atrius Health, which employs approximately 950 physicians.

Christopher Shireman, who is chief executive officer of Western Neurosurgery Ltd., in Tucson, Arizona, and has vetted scores of physician candidates over his 20 years in health care leadership, expects physicians to explain any sizable timeline gaps in an accompanying cover letter, not in the body of the CV. "I had one candidate who had a one-year gap before medical school, who spent that year working in an emergency room. In another case, the candidate took off a year during training to take care of his dying mother," Mr. Shireman said. "Most of the time, it's just a matter of letting people know why there's a gap."

Regarding date and timeline entries, physicians should doublecheck all dates before finalizing the document and ensure that the CV is up to date, according to Jeffery Johns, MD, medical director of the Vanderbilt Stallworth Rehabilitation Hospital in Nashville, Tennessee. "It's important that your CV is up to date as of the day you send it. If you have an entry that reads '2013–present,' for example, ensure that's correct," said Dr. Johns. Failing to address such an important detail reflects poorly on the physician. "When I review CVs, I am looking for meticulous attention to detail."

The CV should be rendered in a simple sans serif font in an easily readable font size — at least 11 or 12 points — and physicians should stick to a single font and size, and a very simple presentation format. "Remember that this is not an art contest," Dr. Buckley said.

Brenda Reed, who is director of physician and medical staff recruitment at Atrius Health, considers a "busy" CV — one with several fonts or font sizes, or documents that contain graphics — not only annoying but also cause for mild suspicion. It can give the impression that the physician is trying too hard. "I have seen a beautiful CV hide a candidate who had serious performance issues or other problems, so I am a bit wary when I see a fancy CV," she said.

In that same vein, Dr. Johns recommends that physicians who are preparing hard copies of their CVs to hand out at conferences or job fairs use a decent-quality paper stock — something slightly heavier than 20 lb. bond copier paper — but nothing dense, elaborate, or textured.

Keep recipient in mind

Rita Essaian, DM, MHA, executive administrator, human resources, at the Southern California Permanente Medical Group (SCPMG), which employs more than 9,000 physicians, stresses the importance of ensuring that the CV is error-free and professional in appearance. "The CV should be crisp, clean, and clearly written — no grammar or spelling errors — but also succinct," Ms. Essaian said. SCPMG hired between 500 and 900 physicians annually in the past three years, and its recruiters receive more than 4,000 CVs in a given year, she explained. A recent cardiology position posting, for example, attracted 100 CVs. Given such volume, a physician whose CV is illegible, error-ridden, or difficult to follow might not make the first cut.

"Physicians should always have their CVs reviewed and proofread before sending them," Ms. Essaian said. She added that potential candidates reaching out about a particular posted position should also ensure that the CV and cover letter clearly indicate relevance to the position of interest. The recruiters who do the initial screening, she said, will first match CVs to posted opportunities, and also screen on the basis of criteria the department chief provides before forwarding CVs to reviewing physicians.

Dr. Buckley agreed. "Residents and fellows should always have someone they trust review their CV draft," he said. Several sources recommended that trainees whose first language is not English should seek professional help crafting and polishing the document if such services are not readily available through their program.

Physicians should also pay attention to seemingly minor formatting details that, if not handled properly, could frustrate potential readers who review scores of CVs as part of their job. Page numbers and an identifying footer including the physician's name should appear on all pages. Further, ensure that the document's file name isn't cryptic, urges Ms. Reed. "One of my pet peeves is when candidates send a perfectly lovely CV, but then name the file 'myCV.' Always think about how something will be received on the other end," she said, because attachments can and do get separated from the email message. She and other sources gave their votes to file names that start with the physician's last name, followed by first name.

Finally, it's advisable to prepare the CV in PDF format. That's not a guarantee that the CV won't be altered by a recipient — unfortunately, this does happen, recruiters said. Using a PDF is a deterrent, at least, because someone who decides to alter the document for whatever reason would have to first go through the trouble of converting it to another file format.

What to include, or possibly exclude

Regarding information that should not be included in the physician CV, sources interviewed for this article had mixed opinions in some cases. Most sources advised against residents including a career statement or job objective at the top, below contact details. That information is usually more appropriate for a cover letter or accompanying email note, unless its inclusion in the CV is requested.

There might be exceptions, however, depending on the employer. The Permanente medical groups' recruiters and physician reviewers appreciate seeing a brief opening statement in a CV, especially if the physician has been in practice for several years. "In those cases, we really like to see a half-page career summary on the first page," Ms. Essaian said. Another reasonable exception, several sources acknowledged, might be for internal medicine physicians who know that they only want a hospitalist position, not an outpatient practice job.

Regarding whether cover letters or explanatory notes should be supplied with CVs, the general consensus was that doing so is usually helpful and is definitely in the category of "can't hurt." At the very least, the accompanying document provides an opportunity for the physician to state why she or he is interested in either the organization or a posted position.

Dr. Kuehl, who favors a brief personal statement or cover letter, advises that the document should be employer focused. "It shouldn't be too 'I' focused," she said. "It's an opportunity to talk about what you would bring to the organization that might distinguish you from other candidates — such as work in population management, IT expertise, patient counseling skills, or practice improvement experience," she said.

Ms. Essaian noted that her organization also likes to see evidence in the cover letter that the candidate has gone to the effort to learn something about Kaiser Permanente health plan and its medical groups, which are independent entities that care for health plan members.

Sources offered mixed opinions on whether to include test scores. The general consensus was that unless the scores are very high, such as 220 or higher on the USMLE, it's best not to include them.

Some recruiters and physicians favored a final section that lists personal interests and hobbies; others considered such detail extraneous. Ms. Essaian, for instance, said that her organization prefers not to see any personal details. Those who voted for including personal interests stressed the importance of employing brevity — two lines at most — and, of course, using good judgment in choosing what to reveal.

"I appreciate knowing a little bit about physician candidates' interests — if they like hiking or snorkeling or skiing, for example, because that often helps with icebreakers and gives me a sense of who they are," said Ms. Reed.

In the hobbies category, short-and-sweet is a must, according to Janet Jokela, MD, MPH, acting regional dean at the University of Illinois College of Medicine at Urbana. "I counsel residents that they don't need to include their interests. But if they do, it should be a simple, short list, separated by commas, with no explanatory detail," she said. "A resident who once asked me to review his CV draft had included three sentences on his basement home-brewing operation — not advisable."

Mr. Shireman, who has reviewed numerous physician specialists' CVs, appreciates knowing about candidates' personal interests for the same reason Ms. Reed cites. "Especially in an intense field like neurosurgery, I want to see that information — just a line or two — because it shows me they're human and that they have a life outside of medicine," he said.

The issue of whether to include a photo elicited varying responses, but most sources advised against including one — and definitely not embedded in the CV document — unless a photo is requested. "There is always the possibility of unconscious bias, so I think it's best to avoid including one," Dr. Buckley said. Ms. Schofield noted that some training programs encourage their international medical graduates to send photos and that some hospitals seeking candidates may require them, though she herself opposes the idea.

It should go without saying that physicians should never inflate, embellish, or mischaracterize their achievements in an attempt to give a better impression. Besides being dishonest, such tactics are likely to backfire at some point, with potentially career-damaging repercussions. "Honesty

and complete accuracy are the most important aspects of a CV. Physicians should never inflate anything," Dr. Jokela said.

Sources agreed that physicians should keep to the standard order of information appearance while attempting to position potentially distinguishing details on the first page, if possible. "Residents and fellows who have received awards or special recognition should consider moving up that information so that it appears on the first page, if it's not too awkward to do so," said Dr. Jokela. At the very least, she added, important awards shouldn't be buried at the bottom of the document.

There appears to be general agreement that the following information generally should not be included on the physician CV, under most circumstances:

Birthdates, Social Security numbers, and any other official identification number. These should be excluded for both security and bias-avoidance reasons.

Marital status. This detail falls under the category of extraneous information, all sources agreed. Besides, if a candidate proceeds to a site interview or even a formal pre-interview call, that detail will likely emerge in the context of a conversation, even though recruiters and individuals involved in hiring are prohibited by law from asking for such information.

References. Including references before they've been requested can give a recipient the wrong impression. And besides, Mr. Shireman points out, references usually won't be checked until a candidate has completed a site interview and the organization is considering setting a second site interview or drafting an offer. "Listing references before they're asked for can make it look like you're trying too hard," he said.

Extensive publication details. Ideally, the publication citations should include only the basic details — the article author(s), title, and journal name and publication date.

Conference attendance. Several sources mentioned that they have occasionally received residents' CVs that list conferences attended. This isn't an important detail, except in cases when the resident gave a presentation or talk at the conference. That information would go under the category of invited speeches/presentations, below publications.

CV length and 'version control'

The ideal length for a physician CV varies depending on the individual and the type of position being sought. In most cases, residents' CVs can and should be rendered in a few pages (three or fewer) unless the trainee happens to have an unusually extensive research or publishing history.

Most sources thought that a single CV version should suffice in most cases, but several noted that there might be situations that warrant creating a short and long version. Physicians seeking a research position, for instance, might create a short version including the basics and a longer version detailing their research interests and accomplishments, and then offer recipients the opportunity to receive the longer one. Likewise, physicians seeking an administrative position or one in which special skills in health care IT are a plus, for example, might craft an additional document or addendum that describes their related experience.

"In most cases, a longer-version CV is really more appropriate for senior faculty members than for young physicians," Dr. Jokela said.

CLINICAL PRACTICE

Patrick G. O'Malley, M.D., M.P.H., *Editor*

Prolonged Grief Disorder

Naomi M. Simon, M.D., and M. Katherine Shear, M.D.

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

A 55-year-old widow presents to her internist 18 months after her husband's sudden cardiac death. Her grief has not abated at all during this time. She is unable to stop thinking about him and is in disbelief that he is gone. The sense of isolation and longing for him has not lifted, even during the celebration of her daughter's recent college graduation. She no longer socializes with other couples because it is a too-painful reminder of her husband's absence. She cries herself to sleep every night, ruminating about how she should have seen his death coming and thinking it would be better if she died too. She has a history of diabetes and two episodes of major depression. Further evaluation is notable for a mildly elevated blood glucose level and weight gain of 4.5 kilograms (10 pounds). How should this patient's grief be evaluated and treated?

From the Department of Psychiatry, New York University Grossman School of Medicine (N.M.S.), Columbia School of Social Work (M.K.S.), and Columbia Vagelos College of Physicians and Surgeons (M.K.S.) — all in New York. Dr. Simon can be contacted at naomi.simon@nyulangone.org or at the Department of Psychiatry, NYU Grossman School of Medicine, 1 Park Ave., New York, NY 10016.

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CME

THE CLINICAL PROBLEM

Clinicians who see patients who are grieving have an opportunity to be helpful that is often not pursued. Some of these patients have prolonged grief disorder. They have pervasive, intense grief that persists past the time when most bereaved persons have begun to reengage in ongoing life and grief usually subsides. Patients with prolonged grief disorder may present with severe loss-related emotional pain and difficulty envisioning a meaningful future without the deceased person. They may have difficulty with the functions of daily life, and suicidal ideation or behavior may be present. Some believe that the death of someone close means that their own life is over as well, and that there is little or nothing they can do about it. They may be self-critical and think that they need to hide their feelings of grief. Friends and family, frustrated by the patient's continued focus on the deceased person and lack of interest in ongoing relationships and activities, may be telling the patient to "get over it" and move on.

Prolonged grief disorder is a newly classified diagnosis, and information about its symptoms and treatment is not yet widely disseminated. Clinicians may not have the training to recognize prolonged grief disorder or know how to provide efficacious treatment or evidence-guided support. The coronavirus disease 2019 pandemic[1,2] and the growing amount of literature about the diagnosis[3-7] have increased attention on ways clinicians can identify and address grief and other bereavement-related emotional problems.[8-13]

Formal diagnostic criteria relating to prolonged grief disorder were added to the *International Classification of Diseases and Related Health Problems, 11th revision* (ICD-11),[14]

KEY POINTS

PROLONGED GRIEF DISORDER

- Prolonged grief disorder is a post-loss stress syndrome in which grief after a death remains intense and preoccupying longer than is expected according to social, cultural, or religious norms (a minimum of 6 months, according to the *International Classification of Diseases and Related Health Problems, 11th revision*, or 12 months, according to the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition). Persistent, intense yearning, longing, or preoccupation with the deceased person and other grief-related symptoms cause clinically significant distress and impairment.
- An estimated 3 to 10% of persons who are bereaved owing to a death by natural causes have prolonged grief disorder, with substantially higher percentages among persons whose bereavement is caused by death of a child or partner or is the result of a sudden, unexpected death (e.g., violence or suicide).
- A simple patient-reported rating scale can be used to screen and monitor persons with prolonged grief disorder.
- Clinical evaluation of possible prolonged grief disorder should also assess other mental health conditions, including depression, anxiety, post-traumatic stress disorder, alcohol and substance use, suicide risk, and effects of symptoms on social and occupational functioning.
- Evidence-based grief-focused psychotherapies constitute first-line treatment. Antidepressant therapy has not shown efficacy for prolonged grief disorder but can be helpful for managing co-occurring depression symptoms.

by the World Health Organization in 2019 and the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5),[15] by the American Psychiatric Association in 2022. Previously used terms include complicated grief, persistent complex bereavement disorder, and traumatic, pathological, or unresolved grief. Prolonged grief disorder symptoms include pervasive intense yearning, longing, or preoccupation with the deceased person accompanied by other persistent intense and pervasive manifestations of grief.

The symptoms of prolonged grief disorder must persist for a minimum period of time (≥6 months according to ICD-11 criteria and ≥12 months according to DSM-5) and cause clinically significant distress or impaired functioning that exceeds expectations for grief in the context of the patient's cultural, religious, or social community. ICD-11 includes examples of key symptoms of emotional pain, such as sadness, guilt, anger, inability to feel positive emotions, emotional numbness, denial or difficulty in accepting the death, feeling that a part of oneself has been lost, and reduced engagement in social or other activities.[14] The DSM-5 criteria for prolonged grief disorder specifies that at least three of the following eight symptoms be present: intense emotional pain, numbness, intense loneliness, a loss of sense of self (identity disruption), disbelief, avoidance of reminders of the permanence of the loss, trouble reengaging in activities and relationships, and feeling that life is meaningless.[15]

Existing surveys suggest that an average of 3 to 10%[4-7] of persons bereaved by natural causes have prolonged grief disorder, with rates several times higher among those who lose loved ones to suicide, homicide, accidents, natural disasters, or other sudden, unexpected causes of death.[7,16,17] Percentages more than twice as high as those reported in the surveys have been reported in studies of data from medical and mental health clinics.[18,19] Risk factors for prolonged grief disorder and signs that may suggest the presence of the disorder are listed in Table 1.

The permanent loss of someone to whom one is closely attached is highly stressful and produces a wide range of disruptive psychological and social changes to which the bereaved person must adapt.[20,21] Grief is the universal response to loss, but there is no universal way to grieve or come to terms with a loss. Over time, most bereaved persons find a way to accept the new reality and move forward in their own lives. People usually oscillate between confronting emotional pain and setting it aside as they slowly accommodate to the changes in their life.[2] As they do so, the intensity of grief subsides, although grief will still escalate intermittently and sometimes intensely, especially at anniversaries and other situations in which reminders of the deceased person are prominent.

For persons with prolonged grief disorder, however, the process of adapting is derailed and grief remains intense and pervasive. Excessive avoidance of reminders of the permanence of the loss and rumination about imagined alternative scenarios are common impediments, as are self-blame and anger, difficulty in regulating emotions, and ongoing stress.[22] Prolonged grief disorder is associated with a range of increased medical and psychiatric disorders.[7,16,23-25] Prolonged grief disorder can bring a person's life to a standstill, make it difficult to form or maintain meaningful relationships, interfere with social and occupational functioning, and engender feelings of hopelessness as well as suicidal ideation and behaviors.[7,23,26-28]

Table 1. Risk Factors and Signs of Prolonged Grief Disorder.

Risk Factors	Examples
Unmodifiable	
Factors present before loss	Previous traumatic stress or traumatic loss, anxiety or overdependence in interpersonal relationships (anxious attachment style), preexisting mental or physical disorders, very close relationship to the deceased person
Circumstances of death	Death was by violent means (e.g., suicide, homicide, accident, natural disaster, or war-related), sudden unexpected medical death (e.g., cardiac arrest or rapidly deteriorating illness), death of a child or young person, death of a spouse or partner
Demographic characteristics of the patient	Female sex, low income level, low educational level
Potentially modifiable	
Factors present before loss	Intensity of anticipatory grief, excessive use of alcohol or other substances, current impairment in mental or physical health, family conflict, social isolation or inadequate or actively unsupportive social network, caregiver burnout, inadequate care or comfort received by terminally ill loved one, experiences of hurtful or insensitive communication from health care team, clergy, or other caregiving professionals
Factors associated with early bereavement	Bereavement-related depression or post-traumatic stress disorder, persistent sleep disturbance, excessive use of alcohol or other substances, current impairment in mental or physical health, serious social or financial consequences related to the death, family conflict, social isolation or inadequate or actively unsupportive social or spiritual network
Indication to screen for prolonged grief disorder or other mental health condition	Persistence of ≥6 months in high grief intensity, frequency, and duration that is interfering with functioning; lack of reengagement in activities or relationships (i.e., persistent social isolation or other functional challenges); help-seeking for persistent emotional distress since the death (e.g., sadness, loneliness, guilt or self-blame about the death, anxiety, anger, and other concerning symptoms); hopelessness or suicidal ideation or behaviors since the death; increased use of alcohol or other substances since the death; inattention to self-care; persistent sleep difficulties since the death

STRATEGIES AND EVIDENCE

DIAGNOSIS AND EVALUATION

Information about recent bereavement and its effects should be a part of clinical history taking. Tracking the death of a family member or other close relation in the medical record and inquiring how the patient is doing since the death can open a conversation about grief and its frequency, duration, intensity, pervasiveness, and effects on the patient's capacity to function. Clinical evaluation should include a review of physical and emotional symptoms since the death, current and lifetime psychiatric and medical disorders, alcohol

and substance use, suicidal thinking and behaviors, current social support and functioning, treatment history, and a mental-status examination. Prolonged grief disorder should be considered in patients whose grief is substantially affecting their daily life more than 6 months after a death.

Simple, well-validated, patient-rated tools are available for use as brief screening tests for prolonged grief disorder. The simplest is a score higher than 4 on the five-item Brief Grief Questionnaire (range, 0 to 10, with higher total scores suggesting that additional evaluation for the presence of prolonged grief disorder is indicated) (see the Supplementary Appendix, available with the full text of this article at NEJM.org).[18,29] Alternatively, a score of 30 or higher on the 13-item Prolonged Grief-13-R (range, 10 to 50, with higher scores indicating greater symptom severity) suggests that prolonged grief disorder symptoms as defined by DSM-5 are present; however, a clinical interview is still needed to establish a diagnosis.[3,12] A score greater than 25 on the 19-item Inventory of Complicated Grief (range, 0 to 76, with higher scores indicating higher levels of prolonged grief symptoms)[30] identifies possible problematic grief, and this tool is validated for monitoring change over time. The clinician-rated[27] Clinical Global Impression Scale, which focuses on grief-related symptoms, is a simple, effective way to assess changes in grief severity over time.

A clinical interview is recommended in order to make a final diagnosis of prolonged grief disorder, including differential diagnosis and treatment planning (see Table 2 for clinical guidance on loss history and the conduct of a clinical interview for symptoms of prolonged grief disorder). Differential diagnoses for prolonged grief disorder include normal continuing grief as well as other diagnosable mental disorders. Other disorders can coexist with prolonged grief disorder, especially major depression, post-traumatic stress disorder (PTSD), and anxiety disorders; coexisting disorders may also be preexisting, which may increase vulnerability for prolonged grief disorder.[16,25,31,32] Patient questionnaires can screen for co-occurring conditions, including suicidality. A recommended, widely used measure of suicidal ideation and behavior is the Columbia Suicide Severity Rating Scale (which includes the questions "Have you wished you were dead or wished you could go to sleep and not wake up?" and "Have you actually had any thoughts of killing yourself?").[33]

There has been confusion in media accounts and among some health care professionals about the difference between prolonged grief disorder and normal continuing grief. This confusion is understandable because persistence of sadness and yearning for the deceased person is usually long-lasting after the death of a loved one, and any of the symptoms of prolonged grief disorder listed in ICD-11 or DSM-5 may persist. Periods of heightened grief commonly occur in waves that are associated with anniversary dates, family holidays, or other reminders of the loss. Activation of emotions, including tearfulness, may occur when patients are asked about the person who died.

Clinicians need to be aware that not all ongoing grief is an indication for a diagnosis of prolonged grief disorder. In prolonged grief disorder, thoughts and feelings about the deceased person and grief-related emotional distress are preoccupying, persistent, intense, and pervasive in a way that interferes with engagement in meaningful relationships and activities, even with people the patient knows and loves.

TREATMENT

The fundamental goals of treatment for prolonged grief disorder are to help the patient learn to accept the permanence of the loss and to restore the capacity to have a meaningful, satisfying life without the deceased person so that yearning and preoccupation with the deceased person subside. Evidence from multiple randomized, controlled trials with active or wait-list control groups (i.e., with randomization to an active intervention or to a waiting list as a comparator) supports the efficacy of short-term, targeted psychotherapy interventions,[34-45] and treatment is strongly recommended. In one meta-analysis of 22 trials involving 2952 participants, there was a moderate-to-large effect on the reduction in grief symptoms associated with grief-focused cognitive behavioral therapy (standardized effect sizes with the use of Hedges' g were 0.65 at the end of the intervention and 0.9 at follow-up).[46]

Therapy for prolonged grief focuses on both the acceptance of the loss and restoration of the capacity to thrive. Prolonged-grief therapy is an integrated treatment that emphasizes active empathic listening and includes components of motivational interviewing, interactive psychoeducation, and a series of experiential activities administered in a planned order across 16 weekly sessions. This approach was the first treatment developed for prolonged grief disorder and currently has the strongest evidence base.[27,34,35] Several grief-focused cognitive behavioral therapies that involve a similar approach have also shown efficacy.[36-38,40-45]

The main focus of interventions for prolonged grief disorder is to facilitate acceptance

Table 2. Clinical Interviewing for Loss History and Symptoms of Prolonged Grief Disorder.

Goal	Example Approaches
Assess grief symptoms and course	
Elicit a loss history	Ask who died, when and how they died, express condolences, learn about the patient's relationship with the deceased person
Ask an open-ended question about grief	"How have things been for you since _____ died?"
Determine how much grief is still a part of everyday life	"Have you noticed any changes in your grief since _____ died?" If yes, inquire how so. If not, ask: "Does it feel as intense and persistent as the first period after the death?"
Inquire about maladaptive rumination	"Is there anything that is troubling you about _____'s death that you haven't been able to resolve?" If yes, ask: "Is it hard to stop thinking about it?"
Find out about avoidance	"Are there things you have stopped doing because it feels too painful to do them without ____?" If yes, ask: "Do you feel like this is interfering with your life?" If yes, ask: "Are you on a pathway to start doing them again?"
Gauge support from family and friends	"Do you have someone you can talk to when you want to share your feelings about _____?" and "Do you feel you are getting the support you need?"
Use questions or validated clinical interview tool to assess possibility of prolonged grief disorder	
Yearning, longing, or preoccupation with the deceased person	"How much are you yearning or longing for _____?" and "How much is _____ on your mind during the day?" and "Do you feel preoccupied by thoughts or feelings about _____?"
Emotional numbness or intense emotional pain related to the death	"Have you been feeling intense emotional pain — such as intense sadness, anger, anxiety, guilt, or shame — since _____ died?" or, if the opposite is true, "Have you been feeling emotionally numb?" If yes, ask: "Has this been interfering with your life?"
Marked sense of disbelief about the death	"Have you felt like it's really hard to believe that _____ is gone and not coming back — like you can't really wrap your mind around it or believe it's really true?"
Identity disruption (feeling like a part of oneself has died)	"Have you had the feeling that you are not the same since ____ died, like a part of yourself died with them and that it feels like you don't know who you are anymore?"
Difficulty reintegrating into relationships and activities	"Have you been less connected with friends or family, or planning or engaging in fewer activities or interests since the loss?" and "Has it been hard to feel comfortable with your friends and family, to be a part of social groups, or to feel really engaged in doing things?"
Avoidance of reminders that the person is dead	"Are there things you avoid or try to avoid because they feel too painful without ____ or because they remind you of your loss?" If so, ask: "Can you give me some examples?" and "Does this interfere with your life or your ability to do things or to be with people?"
Sense that life is meaningless	"Have you been feeling like you're not sure if you really care about things or whether you matter or belong anymore?" and "Have you been feeling like your life is empty or meaningless?"
Intense loneliness	"Have you had strong feelings of loneliness, like you are all alone in the world?" If yes, ask: "Is this because you are spending a lot more time alone since ____ died, or do you feel this way even when you are with other people?"

Table 3. Common Components of Evidence-Based Therapies for Prolonged Grief Disorder.

Key Components	Examples of Techniques	Goal
Therapeutic alliance	Active empathic listening; validation, support, and guidance	Help patient feel understood, supported, and comfortable about engaging in grief treatment
Psychoeducation and treatment rationale	Psychoeducation provided in a collaborative, interactive way; planned activities between sessions to promote experiential learning	Promote cognitive and experiential understanding of grief, prolonged grief disorder, adaptation to loss, and treatment components
Promoting patient awareness of grief and its natural oscillation	Daily grief monitoring — rating and recording daily highest and lowest levels of grief	Promote understanding of grief and associated triggers; support natural oscillation in the intensity of grief
Reactivating capacity to thrive by means of personal interests, values, and future goals	Identify intrinsic interests and values, and identify a long-term goal that connects with these; motivational interviewing; behavioral activation; scheduled pleasurable activity	Build sense of competence in the context of the loss; enhance motivation, positive emotions, and capacity for envisioning an enjoyable, meaningful life without the deceased person
Strengthening social relationships	Engage friend or family member in psychoeducation and plan for treatment; identify grief-related challenges to existing or new connections	Increase empathic support for treatment; enhance capacity for close relationships and social activity without the deceased person
Facilitating understanding of the death	Procedures to tell the story of the death repeatedly and to process it; also called "exposure"	Create a cohesive narrative and integrate permanence of death in memory; process sticking points ("derailers") related to the circumstances of the death
Addressing maladaptive thoughts	Identify maladaptive thoughts about grief and the nature of the loss; cognitive restructuring	Reduce ruminations, guilt, self-blame, and hopelessness; reduce negative interpretations of grief manifestations
Addressing excessive avoidance behavior	Establish list of avoided activities or reminders of the loss; planned exercises with regard to a return to avoided situations	Reduce excessive avoidance while supporting coping strategies and the natural healthy oscillation of grief
Connecting with the deceased person	Letter-writing or role-play conversation with the deceased person; pose questions to review memories of the deceased	Promote sense of connection to the deceased person in the context of the loss; address unresolved issues; enable access to positive and negative memories
Managing future risk	Discuss and plan for grief manifestations, triggers, or anniversary dates in the future	Relapse prevention

of the reality of the loss and address impediments. Most interventions also include a means to help patients restore their capacity for well-being (e.g., identifying a strong interest or core value and supporting engagement in an activity related to it). Table 3 describes the components and goals of these treatments.

Three randomized, controlled trials have assessed prolonged-grief therapy as compared with an efficacious treatment for depression and all showed prolonged-grief therapy to be significantly superior. After pilot results suggested that prolonged-grief therapy was superior to interpersonal therapy for depression,[39] the first randomized trial confirmed this result and showed a clinical response, defined as "much improved" or "very much improved" on a Clinical Global Impression Scale, of 51% with prolonged-grief therapy as compared with 28% with interpersonal therapy (P=0.02).[35] A second trial replicated this finding in older adults (mean age, 66 years) with responses seen in 71% with prolonged-grief therapy and 32% with interpersonal therapy (P<0.001).[34]

A third trial[27] was a four-site study evaluating the antidepressant citalopram as compared with placebo when administered with prolonged-grief therapy or with grief-informed clinical management; prolonged-grief therapy plus placebo response (83%) was superior to both citalopram

Table 4. Simple Interventions to Support Grieving Patients.

Step	Action
Build a relationship with the patient	Show interest in the patient's relationship with their deceased loved one; listen to their stories (and share your own, if you knew the person); provide validation, support, and guidance as they move forward in adapting to the loss. Schedule sessions weekly or every 2 weeks for as long as needed (e.g., 3 to 6 mo), making adjustments as the patient progresses.
Psychoeducation about grief	Explain that grief is the natural response to loss and that there is no right or wrong way to grieve. Grief subsides as a bereaved person adapts to a world changed by the loss by changing expectations, thoughts, and behaviors to learn to live without the deceased person. Adaptation is most successful when there is natural oscillation between paying attention to the painful reality and setting it aside. If relevant, explain the diagnosis of prolonged grief disorder and emphasize that it is a common condition that represents challenges to natural adaptation to loss and that it is treatable. Help the patient find ways to share this information with family members and friends.
Grief monitoring	Encourage the patient to keep a log of their daily grief levels rated on a scale of 1 (lowest) to 10 (greatest) and to note what was happening at the times of the greatest and least grief.
Simple rewarding activities	Encourage the patient to make a list of simple rewarding activities, do one every day, and to think of this exercise as a daily ritual.
Narrative of the death	Invite the patient to tell you how they learned about their loved one's death and what it was like for them.
Approach to reminders of the deceased person	Gently encourage the patient to consider trying things they are avoiding; suggest they try an activity that is challenging but doable; gently encourage them to find ways to share the experience with a supportive person.
Social connection	Inquire about social interaction and closeness; gently encourage reaching out and sharing current grief-related challenges with a previously supportive friend or family member.

(69%) (P=0.05) and placebo (54%) (P<0.01) administered with grief-informed clinical management. In addition, there was no difference between citalopram and placebo when administered with grief-informed clinical management or with prolonged-grief therapy.[27] However, citalopram plus prolonged-grief therapy, but not citalopram with grief-informed clinical management, significantly reduced co-occurring depressive symptoms.[27]

Prolonged-grief therapy integrates strategies from prolonged-exposure therapy used in patients with PTSD (an approach that encourages processing of the loss and decreasing avoidance)[47] in a model to address prolonged grief as a post-loss stress disorder. The intervention also includes procedures to strengthen relationships, work within personal values and goals, and enhance a sense of connection to the deceased person. Some data suggest that cognitive behavioral therapy for PTSD without a grief focus may be less effective,[48] and exposure-like strategies similar to PTSD probably act by means of a different mechanism in prolonged grief disorder.[49] Several grief-focused therapies that use similar cognitive behavioral therapy approaches have shown efficacy in prolonged grief disorder in both individual[36,37] and group[38,40] approaches, as well as in children.[41]

For clinicians unable to provide an evidence-based treatment, we would recommend that they seek a referral if possible and follow the patient weekly or every other week for as long as needed, using simple supportive, grief-focused interventions (Table 4). Telemedicine and patient self-guided online treatment approaches may also be effective ways to improve access, although the self-guided approach has been studied with asynchronous therapist support,[42-45] which may be necessary to optimize results. For patients who do not have a response to evidence-based psychotherapy for prolonged grief disorder, a reassessment is indicated to identify medical or psychiatric conditions that may account for the symptoms,

especially symptoms that may successfully be addressed with targeted intervention, such as PTSD, depression, anxiety, sleep disorders, and substance use disorders.

For patients with mild or subthreshold symptoms and those who are not yet able to access evidence-based treatments for prolonged grief disorder, clinicians can help by using a supportive grief-management approach. Suggestions for simple ways to use components of such treatments are listed in Table 4.

Empathic listening and normalization of grief are core basic approaches. Psychoeducation to explain prolonged grief disorder, its relationship to usual grief, and approaches that can help is often reassuring to the patient and can assist them in feeling less alone and more hopeful that help is available. Inclusion of a family member or close friend in psychoeducation about prolonged grief disorder can increase that person's capacity to provide support and empathy to the patient.

Clear communication that the goal is to facilitate the natural process of learning to live without the deceased loved one and resolution of issues interfering with this process may help engage patients in care. Clinicians can encourage patients and their families to accept grief as a natural response to loss rather than suggesting that grieving should be over. It is important not to drive a patient away from care by engendering fear that they are being asked to forget, move on, or leave their loved one behind. They can be helped to see that working toward adapting to their loss can reduce the intensity of their grief and can support a more satisfying sense of ongoing connection with the deceased person.

AREAS OF UNCERTAINTY

There is not yet sufficient neurobiologic research to elucidate pathogenic mechanisms for prolonged grief disorder and no medication or other neurophysiologic treatment has yet proved to be efficacious for prolonged grief disorder symptoms in prospective clinical trials, nor have medications been adequately tested yet. Only one prospective, randomized, placebo-controlled study of a medication was found in the literature, and as previously discussed, it did not show efficacy of citalopram for the treatment of symptoms of prolonged grief disorder, although when combined with prolonged-grief therapy, citalopram did show greater efficacy for coexisting depression symptoms. Clearly more research is needed.[27]

Adequately powered trials with appropriate controls are needed to establish efficacy for digital treatments. In addition, prevalence rates for the diagnosis of prolonged grief disorder remain uncertain because epidemiologic studies with consistent criteria have not been available and because rates vary widely depending on the circumstances of the death.

GUIDELINES

Although diagnostic criteria for prolonged grief disorder are now found in ICD-11 and DSM-5, and a substantial literature on efficacious treatments exists,[46] formal guidelines for the treatment of this disorder are not yet available.

CONCLUSIONS AND RECOMMENDATIONS

The presentation of the patient described in the vignette is typical of prolonged grief disorder in that she presented with grief of persistently high intensity, feelings of self-blame, avoidance of loss reminders, social isolation, and feelings of intense loneliness and hopelessness. The sudden death of her spouse, previous episodes of depression, and physical illness are each risk factors for prolonged grief disorder, and most of the signs listed in Table 1 are present. We would conduct a loss and grief history, including changes in sleep, eating, and level of physical activity, and a diagnostic interview for prolonged grief disorder (Table 2), major depressive disorder, and PTSD as part of a clinical assessment.

If prolonged grief disorder is confirmed by an interview, we would offer the patient (or refer her for) evidence-based psychotherapy[34-45] as the first-line treatment. We would provide psychoeducation about prolonged grief disorder and the treatment options for the disorder, providing hope that treatment can help the patient accept this reality in a way that allows her to continue to honor her spouse and her own life. The treatment components (Table 3) would help her understand and accept grief, address maladaptive self-blaming thoughts, help her narrate a coherent story of her husband's death, resume activities she has been avoiding, and restore a sense of connection to her husband through her memories. We would work with her to reconnect to her interests and values, sense of competence, and social relationships so that she can feel joy and satisfaction in her life again. If clinically significant depressive symptoms are also elicited, we would prescribe an antidepressant. We would also address unhealthy sleep and eating habits, her level of physical activity, and her weight and diabetes management, which may be affected by grief.

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

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Classified Ad Deadlines

Issue	Closing Date
January 9	December 20
January 16	December 27
January 23	January 3
January 30	January 10

Internal Medicine

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Stony Brook Medicine

Stony Brook Community Medical Group, PC

Non-Invasive Cardiologist

North Suffolk Cardiology (NSC), an affiliate of Stony Brook University Hospital, is a full-service, outpatient, cardiology physician practice, offering a wide range of expertise in cardiovascular health and wellness. North Suffolk Cardiology has four office locations that span the north Suffolk region of Long Island, and fourteen highly specialized, well-trained physicians and 11 advanced practice providers who see over 40,000 patient visits per year - making NSC the largest cardiology physician practice on the north shore.

NSC provides comprehensive cardiovascular care by using state-of-the-art technology in PET/CT, SPECT, echo/ vascular ultrasound services, as well as education in nutrition and lifestyle management to promote proper cardiovascular health. NSC offers interventional procedures to treat coronary artery disease, heart valve disorders, and other heart conditions, and also houses a device clinic that offers holter and event monitoring for patients with heart rhythm disorders. Intensive cardiac rehab services are also offered on-site for patients who are rehabilitating after a experiencing significant cardiac event and procedure.

North Suffolk Cardiology is seeking a non-invasive cardiologist to join their rapidly growing practice. The ideal candidate is BE/BC in cardiology, nuclear cardiology, and echocardiography. Excellent compensation package.

Apply at: **www.stonybrookmedicine.edu/community-medical/careers**

Enter key word: **Physician North Suffolk Cardiology**

NIH National Heart, Lung, and Blood Institute

Department of Health and Human Services
National Institutes of Health
National Heart, Lung, and Blood Institute

Non-Invasive Cardiologist – Echocardiography
Staff Clinician, Cardiovascular Branch

The Division of Intramural Research (DIR) of the National Heart, Lung, and Blood Institute (NHLBI) is seeking to recruit an outstanding **non-invasive Cardiologist** Staff Clinician, specializing in imaging to provide support for the echocardiography laboratory (adult and pediatric studies), patient care and teaching within the Cardiovascular Branch and for the NIH Clinical Center. The successful candidate will provide echocardiography and cardiology care to both inpatients and outpatients, participate in educational activities of the cardiology section, and potentially contribute to research in an area of your interest.

The Cardiovascular Branch of the NHLBI conducts research on diseases that affect the heart, blood, blood vessels and lungs with specific projects aimed to answer clinically relevant issues using methods ranging from a molecular level up to and including clinical projects in diagnostics, therapeutics and interventions; and emphasize creation of an environment where scientists and physician scientists can work together on disease specific issues using the most appropriate approaches available in the spectrum between the bench and the bedside. There are strong interactions with a wide range of independent research groups, and the position offers exceptional opportunities for interdisciplinary collaboration within and outside of the NIH.

The existing faculty in the NHLBI DIR is an outstanding group of internationally recognized biomedical researchers covering a wide range of basic and clinical research topics (please see https://www.nhlbi.nih.gov/research/intramural) complemented by the other research institutes within the DIR (please see http://www.nih.gov/science/#campus).

The successful candidate should be a board-certified/eligible or equivalent cardiologist. Additional level III echocardiography training is preferable with a strong commitment to patient care, teaching and a desire to contribute to translational clinical research.

Appointees may be US citizens, resident immigrants, or non-resident immigrants with or eligible to obtain a valid employment authorized visa. Applications from women, minorities and persons with disabilities are strongly encouraged.

TO APPLY: Applicants should send a 1-2 page descriptive letter of interest, curriculum vitae and complete bibliography, and arrange for three letters of reference to be sent via email to:

Maria G. Stoltzfus
gonzamar@nhlbi.nih.gov

The review of applications will begin on a rolling basis as complete application packages are submitted. Applications will be accepted until the position is filled.

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Salary is commensurate with education and experience and a full Civil Service package of benefits (including retirement, health, life, and long-term care insurance, and a Thrift Savings Plan) is available. There are also programs at the NIH to provide parental leave, as well as opportunities for on-site childcare.
The research is funded by the intramural research program and does not require applications for grants or external support.

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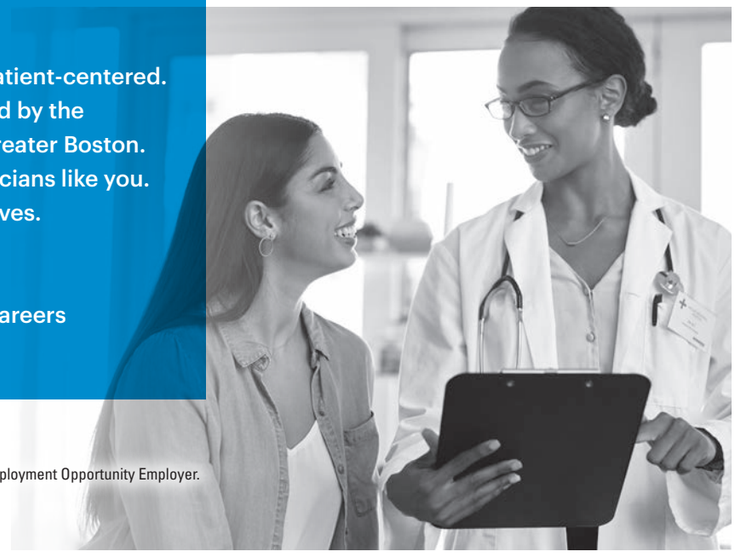

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Chief, Division of Hospital Medicine, Department of Internal Medicine, UT Southwestern Medical Center at Dallas

The University of Texas (UT) Southwestern Medical Center, Department of Internal Medicine, invites nominations and applications for the position of Division Chief of Hospital Medicine. This position represents a major leadership appointment in the Department.

Hospital Medicine will be a new Division in the department, comprised of academic hospitalists who provide inpatient care at the Clements University Hospital (750 beds), Parkland Memorial Hospital (900 beds), and VA North Texas Health Care System (279 beds).

The new Division will be home to 150 faculty and 65 APPs, making it the largest Division in the Department. Hospital Medicine faculty already play key leadership roles in the clinical operations, quality and patient safety improvement, medical education, and informatics programs of the hospitals and Department. The Division Chief will be expected to lead and grow the Division's clinical, educational, quality/safety, and research programs at all three sites. Developing the academic careers of faculty, recruiting new faculty with diverse backgrounds, and promoting health equity will be key responsibilities.

UT Southwestern is renowned for its biomedical research programs and its exceptional clinical services. It has a NIH-funded CTSA; strong research programs in health services, disparities, and clinical informatics; outstanding training programs in Internal Medicine and its subspecialties; and a new School of Public Health that opened in 2023. The two adult teaching hospitals on the UT Southwestern campus, Clements and Parkland, are state-of-the-art facilities that opened in 2014 and 2015, respectively.

Candidates must have leadership experience as an academic hospitalist and scholarly achievements in research; delivery innovation; quality, patient safety, and value; and/or medical education. Candidates are expected to contribute to the teaching and training of medical students and house staff. Applicants must be board certified in Internal Medicine and be eligible for Texas medical licensure.

***Interested applicants please apply on-line at* www.utsouthwestern.edu/careers *and* reference Job # 579526.**

Joshua M. Liao, MD, MSc *and* Gail Peterson, MD
Email: joshua.liao@utsouthwestern.edu *and* gail.peterson@utsouthwestern.edu
Department of Internal Medicine, UT Southwestern Medical Center, 5323 Harry Hines Blvd., Dallas, TX 75390

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Stony Brook Medicine
Stony Brook Community Medical Group, PC

Electrophysiologist

North Suffolk Cardiology (NSC), an affiliate of Stony Brook University Hospital, is a full-service, outpatient, cardiology physician practice, offering a wide range of expertise in cardiovascular health and wellness. North Suffolk Cardiology has four office locations that span the north Suffolk region of Long Island, and fourteen highly specialized, well-trained physicians and 11 advanced practice providers who see over 40,000 patient visits per year - making NSC the largest cardiology physician practice on the north shore.

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North Suffolk Cardiology is seeking an electrophysiologist to join their rapidly growing practice. The ideal candidate is BE/BC in cardiology, nuclear cardiology, and echocardiography. Excellent compensation package.

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***Enter key word:* Physician North Suffolk Cardiology**

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Joseph Li, MD - Chief of Hospital Medicine
JLi2@bidmc.harvard.edu
and
Rusty Phillips, MD - Director of Recruitment
wphillip@bidmc.harvard.edu

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School of Medicine

Department of Medicine
Division of Hospital Medicine

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All qualified applicants will receive consideration for employment without regard to sex, race, ethnicity, protected veteran, or disability status. Interested candidates can apply at **https://facultyopportunities.wustl.edu/Posting/Detail/1011047**

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Professor & Chief, Division of Hospital Medicine
dhmrecruitment@wustl.edu

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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
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