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A career in medicine is challenging, and current practice leaves little time for keeping up with new information. While our commitment to delivering the highest quality research and clinical content remains unchanged, NEJM continually develops new features and enhancements to bring you the best, most relevant information each week in practical and clinically useful formats.

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Eric J. Rubin, MD, PhD

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Preparing Physician CVs and Resumes for Consumption in the Digital Age

Customization and confidentiality are key considerations in the current recruiting marketplace

By Bonnie Darves

A physician's curriculum vitae (CV) has long functioned as a passport of sorts into the realm of potential practice opportunities, which is why physicians must make sure that the all-important document does well what it's intended to do: provide a comprehensive but succinct and completely accurate overview of your medical training, work, and accomplishments, in a format that's easy to read and digest. Today, however, when everything moves at, well, cyberspeed, physicians should be prepared to respond in near real time when a desirable opportunity comes up — by not only submitting a polished document but by also ensuring that the CV is tailored to the position, according to Peter Angood, MD, chief executive officer of the American Association for Physician Leadership.

"It's important for physicians to customize their CV each time they submit it, to ensure they're including the appropriate keywords," Dr. Angood said, to match qualifications the organization is seeking in a candidate. "Remember that you're trying to get through the initial screening, so the CV keywords should ideally match those in the job position."

That screening, these days, often includes computer technology that ingests, "scrapes," and dissects the document via machine learning, artificial intelligence, and other mechanisms to identify specific experience or specialization. Because this process typically occurs before the document is routed for human review, the CV should include keywords included in the job description, Dr. Angood said. The idea is to make sure that the physician's qualifications "pop out" readily during both electronic and human screening. "Even in that human screening, keep in mind that the HR professional or a recruiter might only spend 30 seconds to a minute initially reviewing the CV — that's why it should be customized," he added.

Getting the CV through the first electronic screening hurdle is, to some extent, a numbers game, according to John Lastinger, manager of candidate experience for the national recruiting firm Merritt Hawkins. Because computer programs that match candidates with practice opportunities are primarily keyword-based, Mr. Lastinger said, the facility seeking a physician prioritizes the skill set and experience it desires and then the system scans inbound CVs for matches to those keywords. "The more matches within the text of the CV, the higher the match rate and score, and the higher the probability the physician will be interviewed," he said.

That's where the specificity comes in. "Physicians should highlight all key skills and experience that fit the opportunity. For example, radiologists who are certified to read mammography should include that on their CV, as should a cardiologist who performs peripheral interventions," Mr. Lastinger said. At the same time, he added, physicians should choose keywords judiciously and place them strategically, to avoid disseminating a document that's obviously (and intentionally) overfilled with keywords. "We advise physicians to keep focused and be purposeful about their keyword usage," he said. Physicians who are very particular about where they want to practice — whether that's a specific metro area or state, or a particular region — should also ensure they communicate that information in their CV, or in an accompanying cover note.

Brenda Reed, a senior recruitment and retention consultant at Atrius Health in Boston, said that even though computer CV screening is ubiquitous these days, physicians shouldn't be unduly concerned that their CV will be overlooked if it doesn't pass the computer screen. "Do organizations get so many CVs that they sort them only by bot, and not by people? I'd be truly surprised if there's an institution that only uses bots," Ms. Reed said. "There's a recognition in the industry, I think, that CV parsing isn't that advanced yet, and I'm not aware of any applicant tracking systems that do it very well." Applicant tracking systems are software programs that organizations use to help them facilitate recruitment and hiring, by helping HR personnel and recruiters organize and navigate potentially large numbers of applicants.

Assemble a CV "package," including a resume, in advance

Creating a polished, effective CV is the most important task for physicians seeking a practice opportunity, but that's only the first step. All sources interviewed for this article agreed that physicians should have a complete, customizable package prepared before they start actively identifying and applying for open positions. That package, ideally, includes a CV, resume, and draft cover letter or note that can be readily adjusted to fit the opportunity, according to Dr. Angood. "I think it's critically important to create a set of documents, and then tailor them," he said. "There's an ongoing need, in my experience, for physicians to appreciate the intent and purpose of these materials," he said.

The physician resume is a short version of the CV that quickly highlights skills and qualifications for a particular position, and more importantly, provides an opportunity to briefly explain why the candidate is a good fit for the prospective position. For example, if a physician is seeking an opportunity that includes a mix of clinical and administration or leadership roles, a resume might focus the physician's direct experience in the latter two areas. A well-structured resume that includes any business experience or credentials is a must for physicians who want to transition from clinical practice to nonclinical roles, Dr. Angood noted, and the document should also include both specific achievements — even specifics such as increasing patient volumes over time through efficiency — and a forward-looking focus or statement.

"Organizations today are looking for physicians who can demonstrate not just their experience but also how their work made an impact and how their accomplishments have prepared them to contribute to the organization they join," Dr. Angood said, given the changing priorities of and increasing demands on hospitals and health systems today. For example, physicians who have either experience or interest in such areas as patient-centered care models, shared decisions-making, or value-based care should includes those details in a resume. "Hiring organizations are very interested in knowing the opportunities and results physicians accomplished in their position," said Dr. Angood.

Young or early-career physicians likely won't need a resume, Ms. Reed said, unless they have obtained specific skills or experience in business, technology, or organization-wide initiatives. "Sometimes a physician applying for a patient-care opportunity might be a good candidate for an innovation position that include some nonclinical work, so that extra experience in worth noting," she said, in either the CV or a resume.

Be selective — and careful — when using job boards to upload your CV

While physicians can likely expect a personal review of their CV when they send it directly to a hiring organization, that's not necessarily the case when it comes to job boards. Scott Edwards, chief executive officer of Metropolis, a marketplace for health care jobs, advises physicians to be very selective when using job boards and to exercise due diligence before creating an account and uploading their information and documents into a database.

"It's important to check out the job board's reputation and to ensure that you have some control over how your documents are handled. In some cases, you might upload your documents thinking that you're applying for a particular position, when in fact you've simply placed your CV and personal information into a repository that all can see and that's searchable," said Mr. Edwards. When that happens, physicians may quickly be overwhelmed with inquiries regarding positions they're not interested in or opportunities in unsuitable geographic areas — or possibly run the risk that their current colleagues might come across their information.

"Physicians should understand that many job boards aren't private," said Mr. Edwards, whose company uses a private and confidential "match" model that only connects applicants with prospective employers that have subscribed to the service and agreed to be connected if a match is found. He recommends that physicians avoid job boards that don't allow for confidentiality or aren't nimble enough to enable narrowing the search parameters — in terms of practice type, subspecialty, and geographic location — to only those desired.

"Physicians really should understand, before submitting their CV to a job board or repository, exactly how their materials are ingested, dissected, and disseminated once they upload it to a database," said Ms. Reed. In short, in the persisting highly competitive, high-demand market for physician services, CVs are such hot commodities that there are technologies and software programs waiting in the wings to "snatch" the document from the internet and route it to unknown recipients.

Tips for making your CV stand out — in the right way

Be careful about how you label your CV document. Keep the recipient in mind when you create a filename, so that recruiters or others who might be reviewing candidates' CVs can readily identify you, advises Brenda Reed, a senior recruitment and retention consultant at Massachusetts-based Atrius Health. The ideal filename would be ordered like this: Last name, first name, discipline, and specialty. "That way, reviewers can quickly figure out whose CV it is. I've received CVs with document names like 'JoesCV.' That makes it hard for recipients to figure out whose document it is," Ms. Reed said. The same filename structure should also be used for the cover letter, she added.

Don't "over-stuff" the CV. Sometimes, physicians think that because they're trying to cover a lot of ground in a few pages, it makes sense to fill every available inch. That's not helpful to the readers who have to make their way through a densely packed document, according to John Lastinger, manager of candidate experience for Merritt Hawkins. "White space is your friend. Make sure to leave plenty of white space," he said, which makes it easier on readers' eyes when they're navigating the document. He also stresses the importance of including a name header and page number on every page of the CV, so that the document is readily identifiable. "Formatting is very important when it comes to having a document scanned, which it likely will be," he said.

Create and submit your CV in a .pdf format rather than a .doc or other word-processing program format — and protect your personal information. The benefit of using a .pdf format is that the document can't be readily altered by someone in the receiving chain, noted Scott Edwards, chief executive officer of Metropolis. "That might be unlikely, but it can happen if someone who is unscrupulous gains access to your CV, so it's better to be safe," he said. On another note, physicians who plan to submit their CVs and other materials to numerous entities and are engaging in a broad search should consider purchasing a dedicated email address specifically for their search activities. "It's also a good idea to consider getting a dedicated cellphone number for the job search, to avoid being contacted on their personal cellphones while they're at work," Mr. Edwards said.

When physicians "launch" their CV, they should be prepared to respond to the flurry of inquiries that will ensue. Putting the CV out into the universe of potential job opportunities is a serious undertaking, and physicians should be ready to adjust their schedules accordingly to accommodate the responsiveness and professionalism required to manage a search, according to Peter Angood, MD, chief executive officer of the American Association for Physician Leadership. "I often tell physicians that it's close to a $2^1/_2$-time job when they're trying to get a new full-time job, because so many of the activities happen after hours," he said.

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How to Decline a Job Offer Tactfully

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

The job search is hectic and stressful, and we put so much effort into finding the right job and trying to get the job offer that we rarely think about how to decline an offer. And yet, it is prudent to do this well.

Many people mistake dragging their feet on contracts while they entertain other offers, and then just letting the discussions fade away instead of formally telling a potential employer that they're not interested. I've been guilty of this myself. In general, it's always good to close the loop and make sure everyone is on good terms. We know how frustrating it can be when an employer doesn't get back to us about the status of an application, and this goes both ways. Each side invests time and money into the process, and in many cases, other decisions are contingent on the hire.

Additionally, you never know if your paths with the people you interviewed will cross again. Maybe the job you took instead doesn't work out, and this was a close second choice, and you want to approach them again. While you are looking in a particular job market, and the partners at the practice you turned down go to school with your children. Or perhaps you find yourself searching for a new job and someone you interviewed with is now associated with another practice you're interviewing at or happens to have been a co-chief resident with members of the new practice.

In reality, the physician world can seem very small. Although there may be about 1 million practicing physicians in the United States, you'll see that worlds often collide throughout your career. In today's interconnected world, it's more and more likely that someone you interact with in one context will turn up in another. Maybe your practices will be part of the same network, or maybe you'll see people at a conference.

Consequently, it's best to let the other party know as soon as you're sure you're not interested so that they can move on with the hiring process and adjust any related plans accordingly. Furthermore, how you do it, matters. If this is a group you've spent a lot of time talking to who was recruiting you heavily, get on the phone with them and explain why you went in another direction instead of notifying them via an email or text. Take the time to reiterate that you appreciated the offer and their time, and hope to stay in touch, if there's constructive feedback, you can give them about why the job ended up not being the most attractive offer, do so (tactfully). Maybe it's just that your spouse couldn't find a job in that town or you decided you wanted to move closer to family, but sometimes it is about the salary or the call structure or a vibe you got at the practice. Most groups will appreciate the feedback so that they know how to market themselves in the future.

The hiring process is very personal, and chances are, you've gotten to know multiple people on the other side of the process very well, and it likely warrants a few personalized messages to express appreciation, rather than one communication to the head of the group. Maybe there's an HR director or realtor you've worked with extensively, or a partner who really took the time to answer all of your questions or host you at their home for dinner. Take the time to email them separately and let them know how much you appreciated their help. Ideally, don't drag your feet on this because you'll likely forget to do it later. As an added reason to do this, if you ever need to interact with or ask a favor from any of these people in the future, it'll be a lot less awkward to reach out.

When in doubt, think about how you'd like to be treated if you were the one who was being declined in that particular situation. Who would you like to hear from, and what feedback would you have wanted based on your conversations and interactions? Although these things add yet another item to your to-do lists, your networks are your greatest assets, and ensuring positive residual feelings will likely end up being a worthwhile investment.

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CLINICAL PRACTICE

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

Treatment-Resistant Depression in Older Adults

David C. Steffens, M.D., M.H.S.

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 author's clinical recommendations.*

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CME at NEJM.org

A 67-year-old woman with a history of obesity, chronic low back pain, and recurrent episodes of major depression presents with mild depressive symptoms of more than 2 years' duration, with worsening symptoms over the past 4 months. She was receiving sertraline at a stable dose of 100 mg per day until 3 months ago, when she initially presented for her worsening depressive symptoms. At that time, sertraline was tapered off, and treatment with extra-long extended-release bupropion (bupropion XL) was started at a dose of 150 mg daily and was increased to 300 mg daily 3 weeks later. Despite having taken the higher dose of bupropion XL for more than 2 months, the patient continues to have low mood, loss of interest in usual pleasurable activities, trouble falling asleep, wakefulness several times during the night, diminished energy, poor appetite, difficulty concentrating, and intrusive thoughts of being "better off dead," but she does not have active suicidal thinking. Her nine-question Patient Health Questionnaire (PHQ-9) score is 17 (on a scale of 0 to 27, with higher scores indicating greater severity of depressive symptoms). How would you evaluate and treat this patient?

THE CLINICAL PROBLEM

Mood disorders, including major depression, persistent depressive disorder (also known as dysthymia), and subsyndromal depression are common among older adults[1] and are associated with poor health outcomes and poor quality of life.[2] Response to initial antidepressant treatment in clinical trials involving older persons varies from 35 to 73%.[3-5] Factors related to poor response and treatment-resistant depression include chronic medical conditions, presence of cerebrovascular disease, coexisting anxiety, concomitant chronic dysthymia, substance abuse, and bereavement.

There is broad consensus for defining treatment-resistant depression across the lifespan as a lack of response to two or more adequate trials of antidepressants in a single episode.[6,7] Although clinicians embrace a definition specifying treatment failure of at least two different classes of antidepressants, there is no current consensus on this nuance. A sufficient trial of a therapeutic dose is generally considered to be 8 weeks. Definitions of treatment-resistant depression are focused on lack of response to pharmacologic treatment and do not include lack of response to psychotherapy (recommended as initial treatment for mild-to-moderate depression[8]), electroconvulsive therapy (ECT), or transcranial magnetic stimulation (TMS). Diagnostic variation regarding treatment-resistant depression may affect accurate estimates of the prevalence of and prognosis for the condition and may lead to inconsistent treatment

KEY CLINICAL POINTS

TREATMENT-RESISTANT DEPRESSION IN OLDER ADULTS

- Treatment-resistant depression is common in older adults with depression and is associated with several biologic, psychological, and social factors, as well as with adverse clinical and functional outcomes.
- A commonly accepted definition of treatment-resistant depression is a lack of improvement despite adequate trials of two different classes of antidepressants for at least 8 weeks.
- Assessment of treatment-resistant depression includes screening for coexisting medical and psychiatric conditions.
- Measurement-based collaborative care with the use of validated instruments (e.g., the nine-item Patient Health Questionnaire) is recommended for the management of depression, with continuous monitoring and adjustment of treatment until remission is reached and sustained.
- The best evidence for a pharmacologic approach to the management of treatment-resistant depression rests on augmentation strategies, such as the use of second-generation antipsychotic agents, lithium, or another antidepressant agent, or a switch to a different class of agent.
- Referral for a psychiatric evaluation for consideration of electroconvulsive therapy or other treatment is recommended for patients with severe depression, worsening suicidal ideation, psychosis, or coexisting cognitive impairment.

recommendations across guidelines.[9] Levels of response are defined on the basis of guidelines: a decrease in symptom severity of 25% or less indicates nonresponse, a decrease of 26 to 49% indicates partial response, a decrease of 50% or greater indicates response, and the presence of no or very few symptoms indicates remission.[10,11]

STRATEGIES AND EVIDENCE

EVALUATION OF TREATMENT-RESISTANT DEPRESSION IN OLDER ADULTS

Evaluation of treatment-resistant depression comprises confirmation of the diagnosis with validated tools and assessment of coexisting conditions (Fig. 1). The PHQ-9 is a validated tool for use in establishing a diagnosis of major depression and for tracking the progress of treatment; a score below 5 is typically the treatment goal.[12] The Geriatric Depression Scale[13] also is useful for tracking depressive symptoms in older adults.

Coexisting conditions that affect the diagnosis and management of depression include concomitant dysthymia, suicidal ideation, and other major psychiatric disorders and medical conditions. Dysthymia, defined as chronic (≥2 years) depressive symptoms that are insufficient to meet major depression criteria yet impair function,[14] is associated with recurrent depressive episodes. For any depressive disorder, assessment of suicidal ideation is essential because of the increased prevalence of suicide among patients with this disorder and the need for specific further intervention. Screening tools such as the PHQ-9 include questions about suicide; however, further assessment of a patient who reports suicidal ideation should be undertaken as part of a clinical interview.

Depressive symptoms also occur in other major psychiatric disorders that may not be recognized when a patient initially presents with recurrent depressive symptoms. Patients with recurrence of depressive symptoms may have a cyclic mood disorder such as bipolar disorder, and screening for past symptoms of mania[15] should include inquiry about mood swings, episodes of high mood with increased energy and decreased need for sleep, and personal or family history of manic–depressive illness.[14] People with schizoaffective disorder have psychotic symptoms, such as hallucinations or delusions, as well as symptoms of a mood disorder — either bipolar type (episodes of mania and sometimes depression) or depressive type (episodes of depression). A patient who appears to have psychotic symptoms could be having a depressive episode (major depression with psychotic features) or may have a depressed subtype of schizoaffective disorder.

Medical conditions and side effects of medication can masquerade as depressive symptoms, and coexisting psychiatric and medical conditions can contribute to treatment resistance. Common confounding psychiatric conditions include anxiety, dysthymia, and alcohol or substance use disorders. Common confounding medical conditions include coronary heart disease, congestive heart

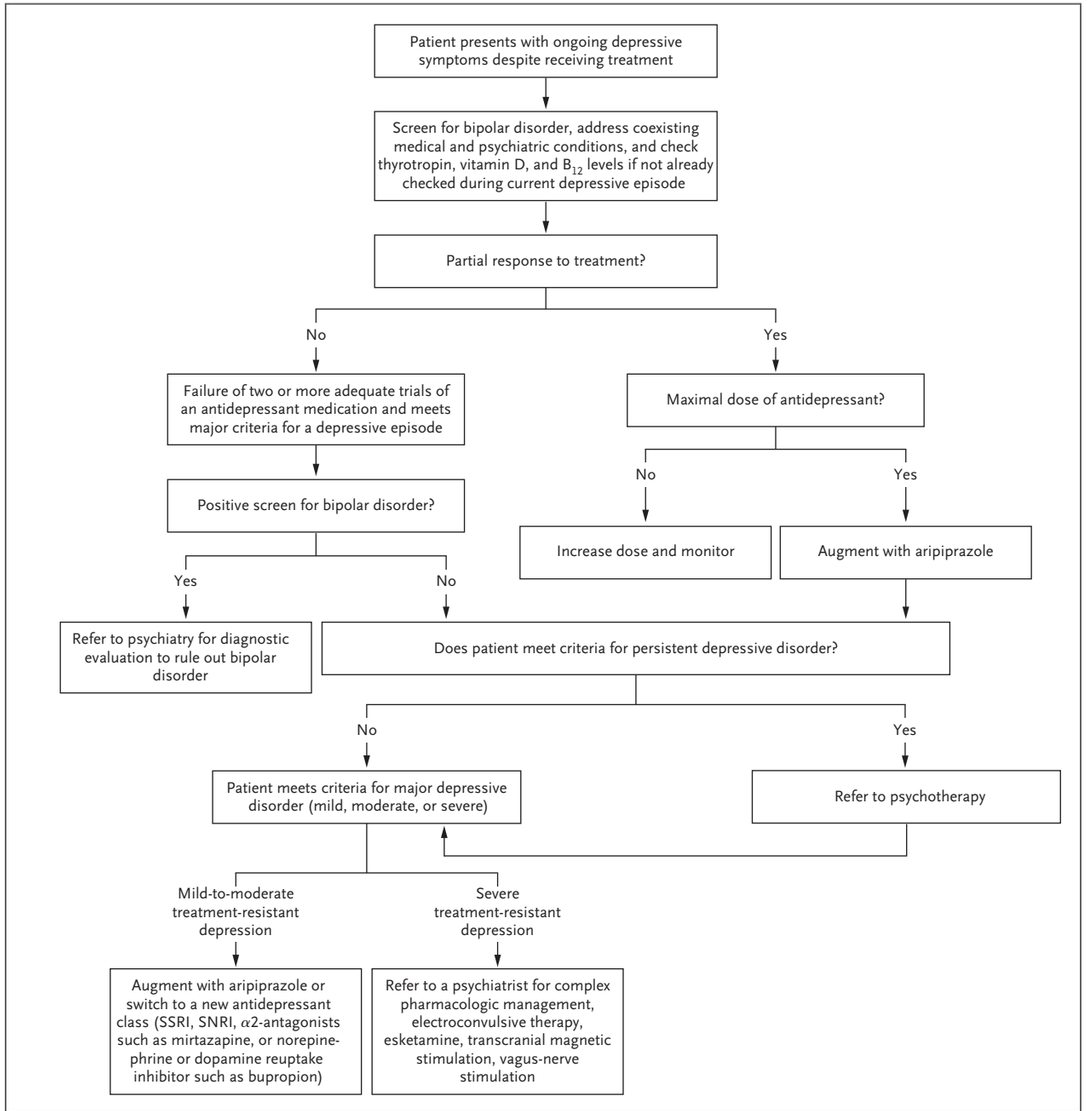

Figure 1. Management of Treatment-Resistant Depression in Older Adults.
SNRI denotes serotonin–norepinephrine reuptake inhibitors, and SSRI selective serotonin-reuptake inhibitors.

failure, diabetes, cancer, and neurologic conditions.[16]

TREATMENT

Patients with treatment-resistant depression generally benefit from consultation with a mental health clinician, preferably a psychiatrist, because decision making around medication is often indicated. Such collaborative care may involve either comanagement of care by a primary care provider and a psychiatrist or a psychotherapist (or both) or referral to a psychiatrist or psychotherapist for consultation or ongoing care.

In a comanagement model, the primary care clinician may seek to optimize medication management by means of dose escalation, a change in therapy to a new antidepressant, or augmentation of therapy with another agent, while concurrently referring the patient to psychotherapy. Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) is an evidence-based care model in which a behavioral health specialist who is embedded with a primary care provider and supervised by a psychiatrist works in collaboration with a primary care clinician to manage geriatric depression with the use of antidepressant medication and psychotherapy.[17] As compared with usual care, this model resulted in significant reductions in depressive symptoms at 3 months that were sustained at 6 months and 12 months.[17] Similarly, in the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT), depression care managers in primary care settings collaborated with clinicians, an approach that showed decreases in geriatric depression and suicidal ideation.[18] Despite these positive outcomes, only approximately half the active-intervention groups both in a trial assessing the IMPACT model and in PROSPECT met the definitions of response at 12 months.[17,18]

Referral to a psychiatrist is indicated for more complex interventions (e.g., ECT, TMS, vagus-nerve stimulation, and ketamine or esketamine therapy) when depressive symptoms are severe or chronic or involve coexisting cognitive impairment, psychosis, or worsening suicidal thoughts. Referral of patients with treatment-resistant depression to a psychiatrist who specializes in geriatric medicine may also be helpful in determining whether treatment with certain psychoactive medications should be stopped. However, provision of treatment will continue to be affected by a limited psychiatry and behavioral health workforce, especially for care of older adults.[19]

Management of Mild-to-Moderate Treatment-Resistant Depression

Regardless of the clinical setting, management of mild-to-moderate treatment-resistant depression often involves consideration of a referral for psychotherapy and changes in medication. Psychotherapy is considered first-line treatment for major depression without psychotic or suicidal features and includes individual and group cognitive behavioral therapy, individual problem-solving therapy, and interpersonal therapy.[8]

Cognitive behavioral therapy targets current problems and symptoms and focuses on the relationship among behaviors, thoughts, and feelings and aims to change those patterns that reduce pleasure and interfere with a person's ability to function at their best. Problem-solving therapy is a cognitive behavioral approach that focuses on addressable problems identified by the patient that contribute to depression. Interpersonal psychotherapy focuses on improving problematic relationships and circumstances that are most closely associated with the current depressive episode.

Evidence for the addition of psychotherapy to the management of treatment-resistant depression specifically is lacking. One small randomized, controlled trial involving 124 participants who had a partial response to escitalopram therapy showed no significant difference in remission when escitalopram treatment was augmented with interpersonal therapy (58%) as compared with depression care management that included support, psychoeducation, and behavioral interventions (45%) (P=0.14).[20]

Pharmacotherapy for Mild-to-Moderate Treatment-Resistant Depression

The appropriate dose of antidepressant medicine for older adults with depression is similar to that for younger adults, and older persons can receive what might be perceived as a high dose without negative side effects (Table 1).[20] However, older patients are more prone to adverse effects associated with antidepressants, especially falls (Table 2).[21] Given high reported rates of medication nonadherence in depression, establishment and maintenance of a therapeutic alliance to support adherence surveillance can improve outcomes in patients with depression.[15]

The evidence base for the pharmacologic treatment of treatment-resistant depression is limited and involves strategies of switching or augmenting antidepressants. One large, multisite platform trial, Sequenced Treatment Alternatives to Relieve Depression (STAR*D), involved a series of randomized, controlled treatment trials involving 3671 adult outpatients with nonpsychotic major depressive disorder who were candidates for medication (citalopram) as a first treatment step.[37] Remission at step 1 in the trial was 36.8%; only 106 adults 65 years of age or older received citalopram monotherapy, and remission of symptoms in that subgroup occurred in 31.1%.[38] Given the

small number of older patients with depression included in the STAR*D trial, we can only extrapolate findings from subsequent steps to older adults. In step 2, patients who did not have remission were randomly assigned to switch to one of three antidepressants (i.e., bupropion, sertraline, or venlafaxine), switch to cognitive behavioral therapy, or continue to receive citalopram therapy with augmentation (bupropion, buspirone, or cognitive behavioral therapy). Overall remission with these interventions was observed in 30.6% of the patients, with none of the medication switch regimens being clearly superior.[37] Overall cumulative remission after multiple steps was observed in 67%.

Although switching from one antidepressant class to another is an approach that is common clinical practice, there is little evidence to support it.[28] Nevertheless, there is guideline-based support for switching antidepressants from a selective serotonin-reuptake inhibitors (SSRI) to either the serotonin–norepinephrine reuptake inhibitor (SNRI) venlafaxine or the monoamine oxidase inhibitor (MAOI) tranylcypromine in nongeriatric patients with depression.[10] A small study assessing the use of venlafaxine as compared with paroxetine in older patients who did not have a response to other treatments showed that 60% of the patients who received venlafaxine and 33% of those who received paroxetine had remission of symptoms after 8 weeks of treatment.[39] A 1996 study involving older adults with depression who did not have a response to an initial trial of nortriptyline showed that 63.6% of the participants had a response to phenelzine (an MAOI) at 6 weeks.[40] SSRIs and SNRIs are the most commonly prescribed classes of antidepressants; however, because MAOIs are prescribed less frequently than SSRIs and SNRIs in both geriatric and nongeriatric patients, treatment with an MAOI in an older adult should be managed by a geriatric psychiatrist.

There is evidence supporting augmentation strategies for use in patients with treatment-resistant depression (Table 2). The use of lithium as an augmenting agent is recommended in two treatment guidelines.[10,15] A meta-analysis of 10 prospective trials involving mostly nongeriatric participants showed that lithium augmentation was superior to placebo in the treatment of unipolar major depression, with 41.2% of the patients in the lithium group having a response, as compared with 14.4% of those in the placebo group.[41] In the STAR*D trial, augmentation with lithium in patients who had not had a response to two adequate trials of antidepressant agents resulted in remission in an additional 15.9% of those patients; however, the mean lithium blood level was only 0.6 mmol per liter (therapeutic range, 0.6 to 1.2), which may have accounted for the modest effect.[42] When considering the use of lithium in older adults, clinicians should be aware of potential drug–drug interactions. The evidence for augmentation with second-generation antipsychotic agents is stronger than that for lithium, with results of randomized clinical trials favoring augmentation with quetiapine, aripiprazole, olanzapine, and risperidone in nongeriatric adults.[43] The recommended doses in patients with unipolar depression are lower than those used in the treatment of patients with schizophrenia,[28] with one guideline recommending aripiprazole at an initial dose of 2 mg to 5 mg per day and a maximum final dose of 15 mg per day.[10] In

Table 1. Antidepressant Medication in Older Adults.*

Medication	Starting Daily Dose	Target Daily Dose	Comments
Selective serotonin-reuptake inhibitors (SSRIs)			As a class, SSRIs should be used with caution in patients with a history of falls[21]
Citalopram	10–20 mg	20 mg	FDA recommends 20 mg as maximal daily dose in patients >60 yr of age owing to risk of prolongation of the QT interval on ECG
Escitalopram	10 mg	10–20 mg	Possible risk of QT prolongation[22]
Fluoxetine	10–20 mg	10–40 mg	Drug interaction based on both CYP450 and protein binding; lack of QT prolongation in most studies[22]
Fluvoxamine	—	50–300 mg	Dose reduction recommended in older adults[23]; lack of QT prolongation in most studies[22]
Paroxetine	10–20 mg	20–40 mg	Some concern about use in older adults owing to anticholinergic effects; lack of clinically significant QTc prolongation in all studies[22]
Sertraline	25–50 mg	50–200 mg	Has mild dopaminergic activity, which may help with motivation; lack of QT prolongation in most studies[22]
Serotonin–norepinephrine reuptake inhibitors			
Desvenlafaxine	—	50 mg	25-mg dose is available for frail older adults or those with renal impairment
Duloxetine	—	60 mg	May help with chronic pain; may increase fall risk among older adults[21]
Levomilnacipran	20 mg	40–120 mg	Limited evidence for use in late-life depression
Venlafaxine XR	75 mg	75–300 mg	At doses >150 mg may have more noradrenergic effects
Other nontricyclic antidepressants			
Bupropion SR	100–150 mg	150–400 mg	Avoid in patients with history of seizures and psychosis
Bupropion XL	150 mg	150–450 mg	Avoid in patients with history of seizures and psychosis
Mirtazapine	7.5–15.0 mg	15–45 mg	Good evidence for mirtazapine monotherapy in older adults with depression[24]; may increase risk of falls[21]
Trazodone	25–50 mg	50–300 mg	Sedating effects often preclude use as monotherapy; may increase risk of falls[21]
Vilazodone	10 mg	20–40 mg	Low potential for drug–drug interactions
Vortioxetine	5 mg	5–20 mg	Low potential for drug–drug interactions; limited data in patients ≥65 yr of age
Tricyclic antidepressants			
Desipramine	50 mg	Depends on plasma level	Monitor ECG; target plasma levels to achieve plasma level of 200–400 ng per milliliter; monitor closely for anticholinergic side effects
Nortriptyline	25 mg	Depends on plasma level	Monitor ECG; target plasma levels to achieve plasma level of 50–150 ng per milliliter; monitor closely for anticholinergic side effects
Augmenting agents			
Aripiprizole	2.5 mg	5–15 mg	Aripiprazole augmentation shown to be more efficacious with respect to psychological well-being than a switch to bupropion[25]
Lithium	150–300 mg	Depends on plasma level; target, 0.6 mmol per liter[25]	Lithium augmentation efficacy for unipolar depression is well-documented; monitor renal function and be alert to potential drug–drug interactions
Methylphenidate	5 mg	5–40 mg	Combination of citalopram and methylphenidate shown to be superior in efficacy for major depression as compared with monotherapy with either agent[26]
Pramipexole	0.125 mg	0.25–2.0 mg	May be helpful in depression associated with Parkinson's disease; dose range for monotherapy or as augmenting agent in major depression is not well-established
Quetiapine SR	50–150 mg	100–300 mg	Limited data on use of quetiapine as an augmenting agent with SSRIs, tricyclic antidepressants, and atypical antidepressants[27]

* CYP450 denotes cytochrome P450, ECG electrocardiogram, FDA Food and Drug Administration, QTc corrected QT interval, SR sustained release, XL extra-long extended release, and XR extended release.

Table 2. Somatic Treatment Approaches to Treatment-Resistant Depression in Older Adults.

Treatment	Comments
Augmentation of antidepressant therapy in patients with partial response to treatment	
Low-dose second-generation antipsychotic agents	The strongest evidence is for aripiprazole[25]; quetiapine is another option if the patient is willing to live with potential sedating effects, although the strength of evidence is low.
Second-generation antidepressants	Certain non-SSRI and non-SNRI antidepressants can be used for augmentation; bupropion may be considered in patients with fatigue, weight gain, or sexual dysfunction, and there is evidence of efficacy in late-life treatment-resistant depression[29]; augmentation with mirtazapine is a reasonable option for patients with insomnia, anxiety, or weight loss but may increase risk of falls.[21]
Lithium	Low-dose lithium targeting blood levels between 0.3 mmol and 0.6 mmol per liter may also be considered[30]; monitor renal function and be alert to potential drug–drug interactions.
Thyroid medications	Triiodothyronine has shown limited evidence as an augmenting agent.[31]
Medications and other treatments to consider switching to in patients with no or minimal response*	
Tricyclic antidepressants	Tricyclic antidepressants with low anticholinergic burden (e.g., nortriptyline and desipramine) may be useful; careful monitoring of blood levels and ECG is warranted.
Monoamine oxidase inhibitors	Usually administered as monotherapy; has a washout period. Dietary restrictions are necessary with tyramine. Transdermal selegiline may be an option owing to minimal dietary restrictions, but data from older adults with depression are limited.[32]
Psychedelics	Esketamine (inhaled formulation) is approved for treatment of depression, and older adults may have improvements in mood similar to those in younger adults.[33] Ketamine (administered intravenously) has been shown to reduce depression. The evidence base is slim for psilocybin, although it may improve cognitive flexibility (the ability to switch between different cognitive operations in response to changing environmental demands) in patients with depression.[34]
Neurostimulation	There is substantial literature supportive of the efficacy and safety of electroconvulsive therapy in older adults; evidence exists for the use of transcranial magnetic stimulation in older adults with depression.[35] Data on the use of vagus-nerve stimulation in older adults are limited.[36]

* Given the lack of evidence for switching in the context of treatment-resistant depression, the recommendations shown are based on evidence from the treatment of older patients with depression. SNRI denotes serotonin–norepinephrine reuptake inhibitor.

treatment-resistant depression in older patients, a trial of augmentation with aripiprazole (target dose, 10 mg per day) as compared with placebo showed greater remission with aripiprazole (in 44% of the patients vs. 28%), although akathisia (in 26.7% of the patients), increased dream activity (in 26.7%), and weight gain (in 19.8%) were commonly reported side effects.[25]

Augmentation with triiodothyronine (T_3) has a modest evidence base, mostly among older adults receiving T_3 augmentation of treatment with tricyclic antidepressants.[43] A review of eight trials of varying quality involving augmentation with T_3 showed that a pooled percentage of 56.8% of the patients who received augmentation had remission, as compared with 23.5% who received placebo; the number needed to treat (for response) was 4.3.[44] However, when analyses were restricted to randomized, controlled trials, there was no difference between augmentation with T_3 and placebo.[44] In the STAR*D trial, T_3 augmentation of citalopram therapy led to remission in an additional 24.7% of the patients.[42]

The choice of augmentation with an antidepressant can be tailored to the patient's symptoms.[45] For patients in an anergic or amotivated state, clinicians should consider switching to or augmenting treatment with an activating agent such as an SNRI or bupropion.[7] Insomnia, diminished appetite, or weight loss may indicate the use of mirtazapine, which has been associated with sedation, increased appetite, and weight gain.[45]

Treatment of Severe Treatment-Resistant Major Depression in Older Adults

Older patients with severe treatment-resistant depression are usually referred to a psychiatrist who typically would recommend trials of medications such as those shown in Table 2. Other approaches to treatment include ECT, esketamine, and TMS. Evidence for the use of ECT comes from the uncontrolled, observational Prolonging Remission in Depressed Elderly trial, in which 240 adults 60 years of age or older with treatment-resistant depression were treated with ECT to the right side of the brain combined with venlafaxine therapy.[46] This intervention resulted in remission in 63% of the patients with severe depression and in 75% of those with moderately severe depression. A randomized, controlled trial of intranasal esketamine plus antidepressant therapy as compared with intranasal placebo plus antidepressant therapy in patients 65 years of age or older with treatment-resistant depression showed no improvement associated with esketamine.[47,48] With regard to TMS, a recent systematic review including seven randomized, controlled trials and seven uncontrolled trials of TMS in geriatric depression showed substantial variation in clinical response, with remission occurring in 6.7 to 54.3% of the patients.[49] Data are limited with regard to the effects of intravenous ketamine or psilocybin for treatment of older adults with treatment-resistant depression.

AREAS OF UNCERTAINTY

There is little evidence with regard to how long an older adult with depression should continue treatment with an antidepressant once remission is reached. Further studies, including longer term clinical trials, are needed to guide maintenance treatment, especially for patients with a history of recurrence of severe depression. In addition, more evidence is needed with regard to antidepressant augmentation and switching strategies. The use of brain imaging and genetic markers in the management of treatment-resistant depression in older patients also requires more study.

GUIDELINES

Although no guidelines have been developed solely for the evaluation and management of treatment-resistant depression in older adults, there are published guidelines regarding treatment-resistant depression in adults and guidelines for management of late-life depression more broadly. Both U.S.[8,15,50] and non-U.S.[51-54] guidelines mention treatment approaches for use in patients with treatment-resistant depression. Recommendations in this article are generally consistent with these guidelines.

CONCLUSIONS AND RECOMMENDATIONS

With regard to the patient described in the vignette, I would begin with a review of her current depressive symptoms and investigate possible coexisting conditions, such as anxiety and dysthymia. Her chronic depressive symptoms appear to have been exacerbated by worsening lower back pain, causing her to curtail many of her activities; therefore, I would refer her for problem-solving therapy to develop strategies to motivate her to engage in physical therapy and help her identify enjoyable activities in which she can participate and thereby improve her mood. I would also continue to monitor her suicidal ideation. Owing to her moderately severe symptoms (PHQ-9 score of 17), ongoing use of pharmacotherapy is warranted. Because she has had two unsuccessful trials of antidepressants, I would switch treatment to an SNRI such as duloxetine at a dose of 30 mg daily, with a plan to increase to 60 mg daily after a week. Duloxetine may relieve some of her chronic low back pain, and it is unlikely to cause weight gain. Ideally, management of her depression would occur in the context of a collaborative care model that would involve visits every 2 weeks, measurement-based monitoring of symptoms and severity, and a goal of remission. If her depression does not remit after 8 weeks of treatment with duloxetine at the 60-mg dose, I would step up care with augmentation using a second-generation antipsychotic such as aripiprazole. Should her condition deteriorate to include severe symptoms or active suicidal ideation, I would refer her for ECT.

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

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REFERENCES

1. Steffens DC, Fisher GG, Langa KM, Potter GG, Plassman BL. Prevalence of depression among older Americans: the Aging, Demographics and Memory Study. Int Psychogeriatr 2009;21:879-88.
2. Defrancesco M, Pechlaner R, Kiechl S, et al. What characterizes depression in old age? Results from the Bruneck Study. Pharmacopsychiatry 2018;51:153-60.
3. Culang ME, Sneed JR, Keilp JG, et al. Change in cognitive functioning following acute antidepressant treatment in late-life depression. Am J Geriatr Psychiatry 2009;17:881-8.
4. Schatzberg A, Roose S. A double-blind, placebo-controlled study of venlafaxine and fluoxetine in geriatric outpatients with major depression. Am J Geriatr Psychiatry 2006;14:361-70.
5. Newhouse PA, Krishnan KR, Doraiswamy PM, Richter EM, Batzar ED, Clary CM. A double-blind comparison of sertraline and fluoxetine in depressed elderly outpatients. J Clin Psychiatry 2000;61:559-68.
6. Gaynes BN, Lux L, Gartlehner G, et al. Defining treatment-resistant depression. Depress Anxiety 2020;37:134-45.
7. Lenze EJ, Mulsant BH, Roose SP, et al. Antidepressant augmentation versus switch in treatment-resistant geriatric depression. N Engl J Med 2023;388:1067-79.
8. American Psychological Association. Clinical practice guideline for the treatment of depression across three age cohorts. February 2019 (https://www.apa.org/depression-guideline/guideline.pdf).
9. Gabriel FC, Stein AT, de Melo DO, et al. Recommendations for the pharmacological treatment of treatment-resistant depression: a systematic review protocol. PLoS One 2022;17(4):e0267323.
10. Bauer M, Pfennig A, Severus E, Whybrow PC, et al. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for biological treatment of unipolar depressive disorders, part 1: update 2013 on the acute and continuation treatment of unipolar depressive disorders. World J Biol Psychiatry 2013;14:334-85.
11. Coley RY, Boggs JM, Beck A, Hartzler AL, Simon GE. Defining success in measurement-based care for depression: a comparison of common metrics. Psychiatr Serv 2020;71:312-8.
12. Spitzer RL, Kroenke K, Williams JBW. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. Primary Care Evaluation of Mental Disorders. JAMA 1999;282:1737-44.
13. Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. In: Brink TL, ed. Clinical gerontology: a guide to assessment and intervention. New York: Hawthorn Press, 1986:165-73.
14. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington, DC: American Psychiatric Association, 2022.
15. American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder. 3rd ed. October 2010 (https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf).
16. Subramanian S, Oughli HA, Gebara MA, Palanca BJA, Lenze EJ. Treatment-resistant late-life depression: a review of clinical features, neuropsychology, neurobiology, and treatment. Psychiatr Clin North Am 2023;46:371-89.
17. Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA 2002;288:2836-45.
18. Bruce ML, Ten Have TR, Reynolds CF III, et al. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: a randomized controlled trial. JAMA 2004;291:1081-91.
19. Institute of Medicine. The mental health and substance use workforce for older adults: in whose hands? Washington, DC: National Academies Press, 2012.
20. Reynolds CF III, Dew MA, Martire LM, et al. Treating depression to remission in older adults: a controlled evaluation of combined escitalopram with interpersonal psychotherapy versus escitalopram with depression care management. Int J Geriatr Psychiatry 2010;25:1134-41.
21. Sobieraj DM, Martinez BK, Hernandez AV, et al. Adverse effects of pharmacologic treatments of major depression in older adults. J Am Geriatr Soc 2019;67:1571-81.
22. Funk KA, Bostwick JR. A comparison of the risk of QT prolongation among SSRIs. Ann Pharmacother 2013;47:1330-41.
23. Orlando R, De Martin S, Andrighetto L, Floreani M, Palatini P. Fluvoxamine pharmacokinetics in healthy elderly subjects and elderly patients with chronic heart failure. Br J Clin Pharmacol 2010;69:279-86.
24. Schatzberg AF, Kremer C, Rodrigues HE, Murphy GM Jr, Mirtazapine vs. Paroxetine Study Group. Double-blind, randomized comparison of mirtazapine and paroxetine in elderly depressed patients. Am J Geriatr Psychiatry 2002;10:541-50.
25. Lenze EJ, Mulsant BH, Blumberger DM, et al. Efficacy, safety, and tolerability of augmentation pharmacotherapy with aripiprazole for treatment-resistant depression in late life: a randomised, double-blind, placebo-controlled trial. Lancet 2015;386:2404-12.
26. Lavretsky H, Reinlieb M, St Cyr N, Siddarth P, Ercoli LM, Senturk D. Citalopram, methylphenidate, or their combination in geriatric depression: a randomized, double-blind, placebo-controlled trial. Am J Psychiatry 2015;172:561-9.
27. Hashimi H, Andersen M, Sessa M. Predictors of quetiapine extended-release formulation add-on in older patients exposed to antidepressant drugs: a Danish register-based cohort study. Int J Geriatr Psychiatry 2020;35:1156-62.
28. Dold M, Kasper S. Evidence-based pharmacotherapy of treatment-resistant unipolar depression. Int J Psychiatry Clin Pract 2017;21:13-23.
29. Dew MA, Whyte EM, Lenze EJ, et al. Recovery from major depression in older adults receiving augmentation of antidepressant pharmacotherapy. Am J Psychiatry 2007;164:892-9.
30. Kok RM, Vink D, Heeren TJ, Nolen WA. Lithium augmentation compared with phenelzine in treatment-resistant depression in the elderly: an open, randomized, controlled trial. J Clin Psychiatry 2007;68:1177-85.
31. Cooper-Kazaz R, Lerer B. Efficacy and safety of triiodothyronine supplementation in patients with major depressive disorder treated with specific serotonin reuptake inhibitors. Int J Neuropsychopharmacol 2008;11:685-99.
32. Alexopoulos GS. Pharmacotherapy for late-life depression. J Clin Psychiatry 2011;72(1):e04.
33. Ochs-Ross R, Wajs E, Daly EJ, et al. Comparison of long-term efficacy and safety of esketamine nasal spray plus oral antidepressant in younger versus older patients with treatment-resistant depression: post-hoc analysis of SUSTAIN-2, a long-term open-label phase 3 safety and efficacy study. Am J Geriatr Psychiatry 2022;30:541-56.
34. Doss MK, Považan M, Rosenberg MD, et al. Psilocybin therapy increases cognitive and neural flexibility in patients with major depressive disorder. Transl Psychiatry 2021;11:574.
35. Kaster TS, Daskalakis ZJ, Noda Y, et al. Efficacy, tolerability, and cognitive effects of deep transcranial magnetic stimulation for late-life depression: a prospective randomized controlled trial. Neuropsychopharmacology 2018;43:2231-8.
36. McDonald WM. Neuromodulation treatments for geriatric mood and cognitive disorders. Am J Geriatr Psychiatry 2016;24:1130-41.
37. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006;163:1905-17.
38. Steiner AJ, Recacho J, Vanle B, et al. Quality of life, functioning, and depressive symptom severity in older adults with major depressive disorder treated with citalopram in the STAR*D study. J Clin Psychiatry 2017;78:897-903.
39. Mazeh D, Shahal B, Aviv A, Zemishlani H, Barak Y. A randomized, single-blind, comparison of venlafaxine with paroxetine in elderly patients suffering from resistant depression. Int Clin Psychopharmacol 2007;22:371-5.
40. Flint AJ, Rifat SL. The effect of sequential antidepressant treatment on geriatric depression. J Affect Disord 1996;36:95-105.
41. Crossley NA, Bauer M. Acceleration and augmentation of antidepressants with lithium for depressive disorders: two meta-analyses of randomized, placebo-controlled trials. J Clin Psychiatry 2007;68:935-40.
42. Nierenberg AA, Fava M, Trivedi MH, et al. A comparison of lithium and T(3) augmentation following two failed medication treatments for depression: a STAR*D report. Am J Psychiatry 2006;163:1519-30.
43. Voineskos D, Daskalakis ZJ, Blumberger DM. Management of treatment-resistant depression: challenges and strategies. Neuropsychiatr Dis Treat 2020;16:221-34.
44. Aronson R, Offman HJ, Joffe RT, Naylor CD. Triiodothyronine augmentation in the treatment of refractory depression: a meta-analysis. Arch Gen Psychiatry 1996;53:842-8.
45. Watanabe N, Omori IM, Nakagawa A, et al. Mirtazapine versus other antidepressive agents for depression. Cochrane Database Syst Rev 2011; (12):CD006528.
46. Østergaard SD, Speed MS, Kellner CH, et al. Electroconvulsive therapy (ECT) for moderate-severity major depression among the elderly: data from the PRIDE study. J Affect Disord 2020;274:1134-41.
47. Ochs-Ross R, Daly EJ, Zhang Y, et al. Efficacy and safety of esketamine nasal spray plus an oral antidepressant in elderly patients with treatment-resistant depression-TRANSFORM-3. Am J Geriatr Psychiatry 2020;28:121-41.
48. Di Vincenzo JD, Siegel A, Lipsitz O, et al. The effectiveness, safety and tolerability of ketamine for depression in adolescents and older adults: a systematic review. J Psychiatr Res 2021;137:232-41.
49. Cappon D, den Boer T, Jordan C, Yu W, Metzger E, Pascual-Leone A. Transcranial magnetic stimulation (TMS) for geriatric depression. Ageing Res Rev 2022;74:101531.
50. Alexopoulos GS, Katz IR, Reynolds CF III, Carpenter D, Docherty JP, Expert Consensus Panel for Pharmacotherapy of Depressive Disorders in Older Patients. The expert consensus guideline series: pharmacotherapy of depressive disorders in older patients. Postgrad Med 2001;Spec No Pharmacotherapy:1-86.
51. Ijaz S, Davies P, Williams CJ, Kessler D, Lewis G, Wiles N. Psychological therapies for treatment-resistant depression in adults. Cochrane Database Syst Rev 2018;5(5):CD010558.
52. Davies P, Ijaz S, Williams CJ, Kessler D, Lewis G, Wiles N. Pharmacological interventions for treatment-resistant depression in adults. Cochrane Database Syst Rev 2019;12(12):CD010557.
53. Bennabi D, Charpeaud T, Yrondi A, et al. Clinical guidelines for the management of treatment-resistant depression: French recommendations from experts, the French Association for Biological Psychiatry and Neuropsychopharmacology and the fondation FondaMental. BMC Psychiatry 2019;19:262.
54. Baba H, Kito S, Nukariya K, et al. Guidelines for diagnosis and treatment of depression in older adults: a report from the Japanese Society of mood disorders. Psychiatry Clin Neurosci 2022;76:222-34.

6 reasons residents and fellows should consider locum tenens

Before you accept a permanent position as an attending physician, you may want to consider locum tenens as a career option after residency or fellowship. Locums offers a more flexible schedule, excellent pay, and the opportunity to continue learning valuable new skills. Here's what locums professionals say are the top reasons residents and fellows choose locums.

Pay off your student loans more quickly

Dr. Lee Green, a hospitalist, has been working locums for more than five years. He says the higher pay he earns from locums assignments will help him pay off his medical school debt and fulfill his goal of working in underserved areas.

"The opportunity locums affords me is one where I can make a bit more money than I would have in an office setting. I'm hoping to pay off my student loans. Once I pay off my loans, my wife and I want to go back to South Africa — where I'm originally from," he explains.

Since Dr. Green knows he would not earn enough in South Africa to pay off loans, he says he plans to continue working locums indefinitely because it will allow him to earn additional compensation while he's practicing outside the U.S.

Enjoy a flexible schedule

For Dr. Matthew Dothager, a hospitalist, working locums means setting his own schedule. "If you want to take two, three, four weeks off or longer, you can easily do that," he explains. "You don't have to worry about contractual obligations to a hospital." He notes that his Weatherby Healthcare consultant helps him set his schedule at different hospitals when he wants to work.

After Dr. Franklin Mikell, a hospitalist, finished his residency and a year of work in a permanent position, he decided to transition to locums to be closer to family. The flexible schedule allowed him to work toward another goal as well. "I realized an undiscovered desire to pursue fellowship," he says. "It's great to have that flexibility and the freedom."

Locums is also a great option when you want to take more time for maternity leave or to care for a child, Dr. Simran Kalra, who specializes in pediatrics, says. She says, "I could choose how much time I wanted to take off, and I could go back to work as fast or as slow as I wanted to."

Gain new skills

Dr. Kalra also says locums has helped her become a better doctor. She explains that the "jump-right-in" mentality of locums has taught her to become more adaptable and a quick learner.

"It helps me acclimatize to different clinical situations. You have to work with people and work with the tools they have. It definitely keeps you on your toes," she says.

Dr. Kalra says that learning a new electronic medical record platform at each assignment also ensures she stays on top of the latest technology.

Sponsor Profile

Try out different work settings

As a pediatrician, Dr. Kalra has honed her skills in different clinical settings. Sometimes she welcomes babies into the world, and other times she does well-child exams and watches those babies grow. "I like clinic work and I like hospital work, and locum tenens means working in different set-ups," she says.

Dr. Mikell says working in numerous settings makes you a better clinician. "Medicine is an ever-evolving field," he says. "Sometimes certain healthcare facilities will be somewhat more advanced in implementing those than others."

Avoid hasty, long-term commitments

Brian McCormick, pediatrics team manager at Weatherby Healthcare, says working in a variety of settings helps to remove the urgency of finding a job right out of fellowship or residency.

"Urgency can put a doctor at a position of vulnerability ... they may accept an opportunity not in the location they prefer or get kind of beat up in initial negotiations because of this expectation that they need to be employed in July," he explains. "Locums removes the urgency from them. They do not need to sign the first opportunity, but they can be patient enough to sign the right opportunity."

Expand your professional network

One big benefit of locums work for Dr. Dothager has been meeting many different clinicians throughout the country. "Locum tenens has allowed me the opportunity to work in multiple facilities and make contacts in various parts of the country. ... It's really provided networking opportunities for the future," he says.

Conclusion

There are many more reasons residents and fellows choose locums work. And most times, it's a combination of benefits.

As a radiation oncologist in Alaska, Dr. Larry Daugherty now hires locums physicians when he takes time off, but he was first introduced to locums as a resident.

"Locums not only helped me make ends meet as a resident and help me pay off some bills, but with hindsight became extremely valuable because I was able to see the diversity of different practices, what I liked, what I didn't like," he says. "As a resident you kind of become biased. You really only see one or maybe two different types of practices."

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LOS ANGELES, HEMATOLOGY/ONCOLOGY — $550,000 Starting base salary. Private Oncology Practice with multiple locations in Los Angeles area looking for BC/BE Oncologists to join our thriving and rapidly growing practice. Excellent compensation and benefits, including malpractice, health/dental, bonuses. Nice work schedule (99% office or Telemed) and easy weekend calls. Your application will be kept strictly confidential. CV To: Socalonc@gmail.com; or Text/Call: (323)-691-0990.

Infectious Disease

BC/BE INFECTIOUS DISEASE PHYSICIAN — Triple O Medical Services, PA, is seeking a BC/BE Infectious disease physician. Must have MD or equivalent and completion of residency in Internal Medicine and fellowship in Infectious Diseases. Possesses or eligible for Florida medical license. Call schedule is every other weekend. Compensation $220,000 plus bonus. Benefit package includes insurance, vacation, and 401k. Locations: West Palm Beach, (Palm Beach County) Florida. If interested, e-mail resume to: drtripleomedical.com. J-1 Visa welcome.

Internal Medicine (see also FM and Primary Care)

HIGH QUALITY NEPHROLOGY PRACTICE IN WASHINGTON DC SUBURBS — Looking for a motivated and dynamic physician. Competitive compensation package. E-mail CV to: janiced@nanvonline.com

Nephrology

NEPHROLOGIST FOR SEACOAST KIDNEY HYPERTENSION SPECIALISTS, PLLC — Requires medical degree; completion of Internal Medicine Residency and a Fellowship in Nephrology; BC/E in Internal Medicine and Nephrology; eligibility for NH medical license. Send CV to: Barbara Parsons, Practice Manager, Seacoast Kidney & Hypertension Specialists, PLLC, 875 Greenland Rd, Bldg C, Unit 10, Portsmouth, NH 03801; email: b.parsons@seacoastkidney.com

KIDNEY CARE CENTER — Is seeking full-time BC/BE Nephrologists to join our growing practice. With over 30 offices in 6 states we have opportunities in Illinois, Indiana, and Tennessee. www.kidneycares.com. H1-B/J-1 eligible positions. Please submit your CV to: cvneph@kidneycares.com

Positions Sought

EXPERIENCED FEMALE MALIGNANT HEMATOLOGIST IN CANADA SEEKING US POSITION — Associate Professor in a prominent university hospital in Ontario. Heavily published. Passionate about both patient care and clinical research. Seeking a position in the Southeast. CV and references available. Contact: hemequeen1@gmail.com; 843-483-6981.

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DOWNSTATE HEALTH SCIENCES UNIVERSITY

SUNY Downstate Health Sciences University in Brooklyn, NY is the only SUNY academic medical center in New York City dedicated to health education, research, and patient care for the borough's 2.7 million residents.

The Department of Medicine at Downstate is looking for academic physicians at the rank of Assistant Professor or higher in the following areas:

• Gastroenterologist • Rheumatologist • General Nephrologist • Transplant Nephrologist • Hospitalists

Board certifications in subspecialty is a requirement. Salary will be commensurate with rank and AAMC benchmarks.

Candidates interested in exploring these positions should send their CV to:

Moro O. Salifu, MD, MPH, MBA, MACP
Professor and Chair, Department of Medicine
moro.salifu@downstate.edu
or call (718) 270-2030 for more information

Executive Order:
Pursuant to Executive Order 161, no State entity, as defined by the Executive Order, is permitted to ask, or mandate, in any form, that an applicant for employment provide his or her current compensation, or any prior compensation history, until such time as the applicant is extended a conditional offer of employment with compensation. If such information has been requested from you before such time, please contact the Governor's Office of Employee Relations.

Equal Employment Opportunity Statement:
SUNY Downstate Health Sciences University is an affirmative action, equal-opportunity employer and does not discriminate on the basis of race, color, national origin, religion, creed, age, disability, sex, gender identity or expression, sexual orientation, familial status, pregnancy, predisposing genetic characteristics, military status, domestic violence victim status, criminal conviction, and all other protected classes under federal or state laws.

Women, minorities, veterans, individuals with disabilities and members of under-represented groups are encouraged to apply.

If you are an individual with a disability and need reasonable accommodation for any part of the application process, or in order to perform the essential functions of a position, please contact Human Resources.

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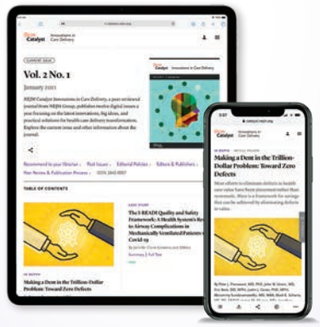

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Vital Roles in a Vibrant Community
Physician Opportunities

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

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

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

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

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

Interested candidates are invited to contact:

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

Berkshire Health Systems

Come join our team of Hospitalists!

(day and night, teaching and non-teaching opportunities)
Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center - Boston, MA

The Hospital Medicine team at Beth Israel Deaconess is seeking **Physicians** and **Advanced Practice Professionals (APPs)** for day and night, teaching and non-teaching opportunities at its Harvard-affiliated teaching hospital in Boston and at community hospitals in Milton, Needham and Plymouth. We are also seeking an **Associate Site Director** at our hospital in Plymouth. A medical school faculty appointment may also be possible. To learn more or apply, please contact Dr. Li and Dr. Phillips below.

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

Scan this **QR Code** to learn more about our group and our professional development opportunities.

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, gender identity, sexual orientation, pregnancy and pregnancy-related conditions or any other characteristic protected by law.

Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center | HARVARD MEDICAL SCHOOL TEACHING HOSPITAL
and at our affiliates Beth Israel Lahey Health

CMC CATHOLIC MEDICAL CENTER

Non-Invasive Cardiologist
New England Heart & Vascular Institute
Manchester, New Hampshire, United States
(On-Site)

Description
The **New England Heart & Vascular Institute**, a nationally renowned, single specialty Cardiology practice located in beautiful, tax-free southern New Hampshire seeks a Non-Invasive Cardiologist.

- This Cardiologist would practice at our main campus in Manchester at Catholic Medical Center (CMC).
- This hospital owned practice offers the latest advances in non-invasive cardiology, interventional, and electrophysiology.
- We offer an extremely competitive compensation with sign-on bonus, comprehensive benefits, attractive call schedule, and a collegial environment with supportive administration.
- Less than one hour to Boston, the Atlantic Ocean, and fabulous lakes and mountains.
- CMC was the only hospital in New Hampshire to be named to *Forbes* Magazine's 2022 & 2023 America's Best Employers list.
- CMC ranked second overall in New Hampshire by *U.S. News and World Report* to its 2023-2024 Best Hospitals
- Ranked one of America's 50 best hospitals for Cardiac Surgery by HealthGrades (2023).

ABOUT CATHOLIC MEDICAL CENTER
Catholic Medical Center is a nonprofit 330-bed full-service regional health system committed to delivering the highest quality and most advanced healthcare to patients across New Hampshire. CMC offers full medical-surgical care with more than 25 subspecialties, from our primary care offices to the operating room, nursing units to community outreach programs. We are driven by our mission to offer health, healing, and hope to every individual who seeks our care, and we live by our values of Respect, Integrity, Compassion, and Commitment.

CMC is home of the nationally-renowned New England Heart & Vascular Institute, an award-winning destination for cardiac care. CMC is the place to practice quality medicine and grow your career.

ABOUT MANCHESTER, NEW HAMPSHIRE
Manchester, New Hampshire is a very desirable four-season community is ranked by top publications like Fortune and Money Magazines as the best place for raising children with comfortable neighborhoods, affordable housing, excellent public schools and No State Income/No Sales Tax!

Vacation where you live! The ocean, mountains and Boston are all within a short driving distance offering numerous cultural and outdoor activities. Enjoy Skiing, boating, hiking, biking, museums, concerts, and theatre and professional sports. The Manchester-Boston Regional Airport is just minutes away making traveling a breeze!

Interested & want to learn more? Contact Susan Martinen at susan.martinen@cmc-nh.org.

Catholic Medical Center is an equal opportunity employer and we embrace diversity. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity and expression, age, national origin, mental or physical disability, genetic information, veteran status, or any other status protected by federal, state, or local law.

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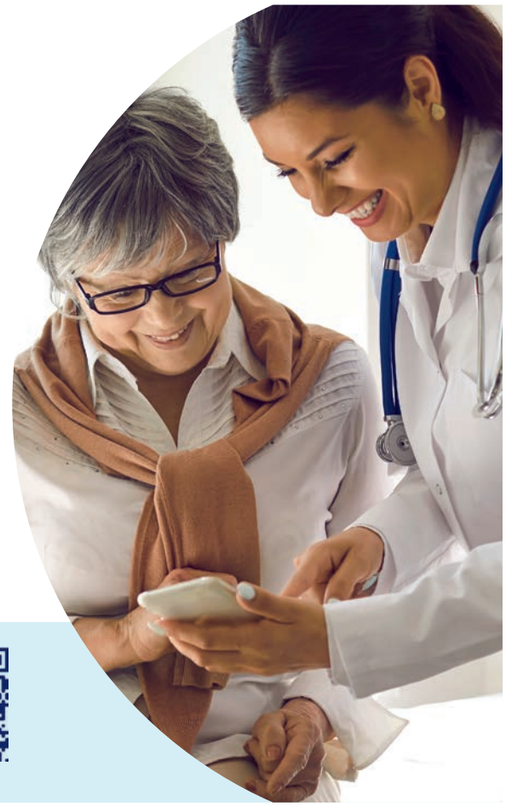

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We're expanding our Neurology footprint in Phoenix, Tucson, and Northern Colorado!

Banner Medical Group (BMG) & Banner University Medical Group (BUMG) are actively recruiting NEUROLOGY Residents & Fellows to join our growing teams in Phoenix, Tucson, and Northern Colorado.

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 Tucson, 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.**

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- Leadership & career advancement with optimal work/life balance

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UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Director of Early Phase Clinical Trials (3-309-1208)

The Department of Medicine of the University Of Maryland School Of Medicine and the Marlene and Stewart Greenebaum Comprehensive Cancer Center (UMGCCC), located in Baltimore, MD, are recruiting for a full-time faculty member to be the Director of Early Phase Clinical Trials working on novel oncology compounds in the early stages of development, from First-in-Human/Phase 1 until Proof of Concept. The desired candidate will demonstrate clinical expertise within Thoracic or GI cancers.

Our program emphasizes the multimodality care of oncology patients and clinical and translational research. The essential functions of the position include inpatient/outpatient consultations and longitudinal patient care, teaching and possible mentoring of Hematology/Oncology fellows, residents and medical students. Active participation in clinical research is expected.

The ideal candidate will be responsible for the development and execution of early-stage clinical programs as a member of the cross-functional asset development teams and leader of clinical study teams. Additionally, they will have experience in oncology clinical drug development, clinical trial design, and execution, with a strong understanding of translational medicine and clinical biomarkers. This individual will play an essential role in a broad range of activities necessary to drive and manage critical strategic and operational aspects of a dynamic early clinical development team.

Candidates with a strong interest in and/or published literature relating to conducting clinical/translational research are preferred. Interaction with basic and translational scientists is strongly encouraged. Furthermore, candidates must possess an M.D. or D.O. degree and must be board certified or board-eligible by the ABIM in Internal Medicine and hematology and/or medical oncology and be eligible for a medical license in Maryland.

Expected rank is Assistant Professor or higher, however, rank and tenure status is dependent on selected candidate's qualifications. Qualified candidates should apply online at the following link: **https://umb.taleo.net/careersection/jobdetail.ftl?job=240000K8&lang=en** when applying, please submit a CV and names of four references. Though not required, candidates are also invited to include a perspective statement on equity, diversity, inclusion, and civility.

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

If you need a reasonable accommodation for a disability, for any part of the recruitment process, please contact us at **HRJobs@umaryland.edu** and let us know the nature of your request and your contact information. Please note that only inquiries concerning a request for reasonable accommodation will be responded to from this email address.

For additional questions after application, please email **facultypostings@som.umaryland.edu**

PRISMA HEALTH℠

PRISMA HEALTH. Children's Hospital

Inspire health. Serve with compassion. Be the difference.

Pediatric Hospitalist Opportunity
Seneca, SC

Prisma Health Medical Group-Upstate Department of Pediatrics seeks a full-time Pediatric Hospitalist, BE/BC in General Pediatrics or Hospitalist Medicine to provide care at Prisma Health Oconee Memorial Hospital, a satellite of Children's Hospital.

Division Specifics:

- Responsibilities include providing inpatient and newborn services for infants and children, rounding in a level I nursery, stabilization of critically ill newborns and children while awaiting transfer, providing coverage for high-risk deliveries and ER consultation. Additional responsibilities will include level II nursery in the near future.
- The position is supported by pediatric subspecialists at the regional Children's Hospital via local telemedicine and satellite clinics.
- You will join a team of pediatric hospitalists with 1:4 weekend call coverage.
- Candidates should have an interest in teaching, as the Oconee hospitalist service provides education to medical students, as well as pediatric and family medicine residents.
- The position will include a teaching appointment with the University of South Carolina School of Medicine.
- Family medicine residents participate in providing care for the hospitalist and newborn services. The newborn service has 600 deliveries annually and 300 admissions to the pediatric inpatient unit.

Highlights:

- Competitive salary
- Paid Relocation and Malpractice with tail coverage
- Professional allowance
- Generous benefits including retirement, health, dental and vision coverage.
- Public Service Loan Forgiveness Employer
- Epic EMR

With nearly 30,000 team members, 18 hospitals, 2,984 beds and more than 300 physician practice sites, Prisma Health serves more than 1.2 million unique patients annually. Our goal is to improve the health of all South Carolinians by enhancing clinical quality, the patient experience and access to affordable care, as well as conducting clinical research and training the next generation of medical professionals. For more information, visit PrismaHealth.org.

Just outside of Greenville, SC, Oconee County is an outdoorsman's paradise. The region boasts numerous whitewater rivers, waterfalls, mountain lakes and hiking trails. The Mountain Lakes Region also offers three larger, public lakes — Hartwell, Jocassee and Keowee. Seneca is conveniently located on the interstate corridor between Atlanta and Charlotte. We are also proudly located near Clemson University, home of the College Football National Champion Clemson Tigers.

Competitive salary and generous benefits package including relocation and malpractice with tail coverage.

We are a Public Service Loan Forgiveness (PSLF) Program Qualified Employer!

Qualified candidates should submit a letter of interest and CV to: **Lexy Doane, Physician Recruiter, Lexy.Doane@prismahealth.org**

Editorial Fellowship
The New England Journal of Medicine

The *New England Journal of Medicine* invites applications from physicians at any career stage for a one-year, full-time, paid editorial fellowship beginning in July 2025. Several fellows will be selected for the 2025–26 year; applications are due by August 1, 2024. The editorial fellows review and edit Images in Clinical Medicine submissions and write Clinical Decisions columns under the supervision of senior editors. The fellows also suggest topics for the Review Article series and contribute to the work of the *Journal* — including the production of videos and podcasts — according to their skills and inclinations. One fellow will be selected to spend a portion of the year working with the *NEJM Evidence* team. The fellows participate in the day-to-day editorial activities of the *Journal* and attend the weekly editorial meetings, where they have the opportunity to gain a deeper understanding of the analyses and considerations that guide decisions about which articles to publish.

For a more in-depth look at the experience of an NEJM editorial fellow, please visit **editorialfellows.nejm.org** and click the link to view reflections by prior NEJM fellows.

We are looking for candidates who have good medical judgment, who can work independently, and who have a good command of written English. Applicants are not required to be U.S. citizens, but successful candidates must reside in the Boston area for the duration of the fellowship. Please visit **editorialfellows.nejm.org** to upload your curriculum vitae and a required letter of interest addressed to Dr. Eric Rubin. If you have any questions, please email **editorial@nejm.org** with the subject line "NEJM Editorial Fellowship Application 2025–26."

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