



CAREER GUIDE for RESIDENTS



Featuring:

- Prevent, recognize impairment
- How (and why) to clean a stethoscope
- Doctors of a certain age
- Health care in 2030
- IMGs face uncertainty amid politics, rhetoric
- Coaching program builds resilient residents
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Prevent, recognize impairment

By Mollie Frost

Professional duties require physicians to recognize and address physician illness and impairment, but it is often difficult to recognize a colleague's condition and find an appropriate way of reporting and resolving it.

Alisa Duran, MD, FACP, had been promoted to her dream job as residency program director and was having one of the most successful times of her career. But after a couple of years, she was starting to lose control outside of work.

More and more, the stress of the job led Dr. Duran to drink alcohol to ease her anxiety at the end of the workday. Colleagues had no idea it was becoming a problem. "It was totally innocent," she said. "You never, of course, have an intent to develop any type of an issue with it."

Physicians have a reputation for being superhuman, but like the general population, about 8% to 13% of them have substance use disorders, said addiction medicine subspecialist Chwen-Yuen Angie Chen, MD, FACP. Rates of alcohol use disorders are even higher among female compared to male physicians, at 21.4% versus 12.9%, according to a study published in March 2015 by the *American Journal on Addictions*.

"Physicians are equally, if not more, susceptible to addictions and mental health disorders and need to be diagnosed and treated," said Dr. Chen, a clinical assistant professor at Stanford University School of Medicine in California.

Substance use disorders and other health issues can cause a physician to become impaired, or unable to carry out patient care responsibilities safely and effectively. In these cases, physicians should be rehabilitated and reintegrated into medical practice whenever possible without compromising patient safety, according to a recent ACP position paper, published in June by *Annals of Internal Medicine*.

Although there are barriers to recognizing impairment, physician health advocates underscored the importance of seeking help and talking about the stigmatized causes, such as substance use disorders, mental health diagnoses, and age-related cognitive decline.

Recognizing impairment

Professional duties require physicians to recognize and address physician illness and impairment, according to the position paper, which was developed by ACP's Ethics, Professionalism, and Human Rights Committee. Of importance, the distinction between functional impairment and potentially impairing illness should guide identification of and assistance for the impaired physician, the paper said.

But it is often difficult to recognize a colleague's substance use disorder, Dr. Chen said. "Often, the first symptoms are family life that is suffering," she said. "It has to get fairly dysfunctional before the workplace is affected. Physicians often try to hold it together, at least at work."

While this was true for Dr. Duran, she was able to address the problem before it impacted her patient care by recognizing

the signs of addiction and the fact that she had a family history. "I think it is important to recognize the signs early, before a physician reaches the point of impairment," she said.

Early warning signs of a substance use disorder can include missed work, unusual interpersonal struggles or unprofessional behavior, social isolation, and withdrawal and may co-occur with increasing anxiety and depression, although they are not always indicative, noted Dr. Duran, now an associate professor of medicine at the University of Minnesota in Minneapolis. "We're trained professionals," she said. "We can recognize these signs and symptoms in our patients. We certainly can recognize them in each other. ... People should reach out and ask, 'Are you OK? Is something going on, and can I help?'"

However, the factors that often stop physicians from reporting impairment in colleagues include fears of professional consequences, interpersonal issues, and being wrong, said Philip A. Masters, MD, FACP, ACP's Vice President of Membership and Global Engagement.

In addition, substance use disorders are strongly associated with mental health conditions, which are often stigmatized. Some medical licensure questions may also be a barrier to recognizing physician impairment because they neglect to determine the functional impact of mental health diagnoses, the ACP paper said. After all, illness does not necessarily indicate impairment.

Literature hasn't shown that having a mental health diagnosis affects a physician's care of his or her patients, said Eileen Barrett, MD, MPH, FACP, an ACP Regent who has advocated for modernizing licensure questions as they relate to physician health. Often, these questions (which vary by state) do not even ask whether the illness has affected one's practice, she said. ACP recommends that licensure questions address current status (rather than history), not distinguish between mental and physical health, and elicit objective information about functional status.

These questions can affect physicians' plans to seek help due to concerns about ramifications to their medical licensure, noted Dr. Barrett, a hospitalist at the University of New Mexico in Albuquerque and an ACP Well-being Champion. One study asked 5,829 practicing physicians if they would seek mental health care if they needed it, and nearly 40% said they would be reluctant to do so. Physicians were less likely to say that they would seek help in states where they are asked about mental health diagnoses on licensure application forms, according to results published in the October 2017 *Mayo Clinic Proceedings*.

Answers to these questions may not even be accurate. Another survey study of 2,106 female physicians found that almost 50% believed they had met criteria for mental illness but had not sought treatment. Only 6% of those with a formal diagnosis or treatment of mental illness had disclosed it to their state, according to results published in the November-December 2016 *General Hospital Psychiatry*.

ACP's position paper is a step in the right direction to help practices and state medical boards remove stigmatizing



Factors that often stop physicians from reporting impairment in colleagues include fears of professional consequences, interpersonal issues, and being wrong. Image by David Cutler

questions from job and credentialing and recredentialing applications, said Dr. Barrett. “Physicians and patients want the same thing. We’re not at odds when we want to destigmatize physician help-seeking; patients want healthy physicians, as well,” she said.

Another cause of physician impairment is age-related cognitive decline. However, it is not clear how patient care may be affected by the complex changes in cognitive function over time, said Dr. Masters.

Research shows that as physicians get older, their way of thinking changes. On one hand, they incorporate less new knowledge in their practice and may be less flexible in diagnostic decision making; on the other, their accumulated wisdom and judgment may be better than that of younger doctors, he said. “And probably the biggest thing is that it’s highly variable from one person to another.”

As with other causes of impairment, age-related cognitive decline is underreported, Dr. Masters said. “If you talk to the Federation of State Medical Boards, they don’t get a lot of complaints about cognitive impairment,” he said. “Generally, whenever they see them, it’s gotten to the point where ... some incident has occurred, as opposed to getting reports proactively.”

Some health systems have started to use general assessments of cognitive function in older physicians (at age 70 years, for example), but these measures do not necessarily correlate with the ability to practice medicine, said Dr. Masters, who in 2016 represented the College as part of an American Medical Association (AMA) meeting on senior physician assessment. “A lot of institutions and organizations are saying we should be doing something about this, but ... there are no standardized ways of assessing cognitive concerns, so it can be very inconsistent,” he said.

Peer evaluation is another way to assess performance. “It’s easier to determine effect on practice when there are physical signs, such as if it’s a surgeon who has a diagnosis such as Parkinson’s because you can see their tremor,” said Dr. Barrett. “But this highlights the role of us doing ... ongoing professional evaluations of our peers” as required by The Joint Commission. However, in practice settings where individuals may be more independent with less direct collegial interaction, peer assessment is often less formal and may be based simply on indicators such as whether a physician attends medical staff meetings or follows up on consult requests, Dr. Masters noted.

The AMA meeting concluded that while physicians should be allowed to remain in practice as long as patient safety is not endangered, evidence-based guidelines should be developed for any potential screening programs and for assessing senior and late-career physicians for whom there is concern. “But it’s harder than it seems. What are you going to require to assess somebody’s cognitive competency?” said Dr. Masters. “And not everybody who’s [cognitively impaired] is old.”

Several U.S. professions have mandatory retirement ages—commercial airline pilot (65 years), Federal Bureau of Investigation agent (57 years), National Park Service ranger (57 years), air traffic controller (56 years), and lighthouse operator (55 years)—but physicians do not, a February 2019 *JAMA* viewpoint noted. ACP is opposed to arbitrary rules that would cancel or limit the hospital privileges of physicians based on the age of 65 years or more unless there is good evidence to do so, a 2017 Board of Regents resolution stated.

Getting help, healing together

While cognitive detriments may lead to noticeable changes in practice, Dr. Barrett said physicians with substance use disorders or mental health diagnoses often continue to provide excellent care. “Their lives may be falling apart around them,” she said. “Their marriages may be falling apart, their interpersonal relationships may be strained, and yet their care may be unaffected because physicians are highly dedicated to our patients.”

Of course, this was true with Dr. Duran’s experience as well. “I was not at a point where I was in any way impaired in my clinical practice, but I recognized it early and got help,” she said. Dr. Duran took a leave of absence for about two months while she sought outpatient treatment and later joined Minnesota’s Health Professionals Services Program.

Programs like these vary by state. As of July 2019, 45 states and the District of Columbia have programs that are members of the Federation for State Physician Health Programs (FSPHP). A physician health program is a confidential resource for physicians, other licensed health professionals, and trainees who have addictive, psychiatric, medical, behavioral, or other potentially impairing conditions, according to the FSPHP. Studies have shown these programs, which coordinate detection, evaluation, treatment, and continuing care monitoring, to be effective, especially for those with substance use disorders. In one 2008 study of 904 physicians admitted to 16 programs, about 79% of physicians were still licensed and working after five years of follow-up, compared to six-month relapse rates of 40% to 60% in general addiction treatment programs, according to results published in *The BMJ*.

The high success rate with these programs is partly due to how they support clinicians, said Dr. Duran. The way they interact with licensing agencies is highly variable from state to state, “But here in Minnesota, I felt supported,” she said, adding that she interacted directly with her state’s program. “You are not required to report anything about your substance use on your licensing documents. They handle that process, so it really does take some of the fear out of that situation,” Dr. Duran said.

In California, it’s a different story, said Dr. Chen, who treats and consults on physicians with substance use disorders in the state. “There’s no physician health program that’s set up by the medical board,” she said. “It’s still a rather punitive process and not something that encourages treatment as first line; it can often be suspension of licensures or severe monitoring and litigation.”

For example, one physician went through a physician health program for alcohol use disorder in another state and wanted to move to and practice in California. For five years, the physician had remained abstinent and sober and had passed all drug testing. Despite the physician's recovery, California issued a probationary license, which hampers the job search and, if a physician appeals or turns it down, converts to a denial of licensure, said Dr. Chen, who has called for standardization through ACP's Council of Early Career Physicians. "Why would we treat a physician differently in this state versus another state?"

When physicians are impaired due to substance use disorders, it is important to not simply fire them or report them to the medical board, exposing them to long, costly legal battles in order to retain their licenses, she added. "It is essential to encourage and support treatment and then reintegrate the physician back into practice."

By the time Dr. Duran got involved with her state's health program, she had about six months of recovery under her belt. "I was going to [mutual help group] meetings almost every day. I would go at 6:30 in the morning before I went to work so it wouldn't impact my job," she said. Joining the program took her efforts up a notch by adding quarterly reports to a case manager, a worksite supervisor, and random urinalysis monitoring.

About a year and a half into recovery, Dr. Duran made the difficult decision to step down from her role as program director. "It was very clear to me that I needed to prioritize my health. The program director job was so busy, you never had down

time," she said, adding that she took on new teaching and research roles at the university and continued to see patients in the outpatient setting.

This December will mark six years in recovery for Dr. Duran. "Facing my issues with substance use really allowed me to take a look at some harmful patterns in myself with regard to perfectionism ... and being kinder with myself and allowing myself some time and permission to create some space for relaxation," she said. "I was a total workaholic, and I'm not anymore."

ACP also advocates for the promotion of physician well-being among colleagues and learners. As Dr. Duran healed from her struggles with alcohol, she opened up during a wellness program for trainees, where she sat on a panel about physician wellness and burnout. "I did not go in there planning to share everything. ... I started talking about how very slowly over time I was using alcohol to medicate stress and anxiety, and it all just came pouring out," she said.

Afterward, trainees and colleagues started crying and having open discussions with each other. "I think in that moment, I realized how important it is for people who are health professionals, who are in roles where you're teaching and mentoring others, to really be vulnerable and share your truth," Dr. Duran said.

Since then, she hasn't stopped sharing. After she wrote a January 2019 perspective piece about her experience in *JAMA*, physicians have contacted her from all over the world. "They've written me letters, they've written me emails, and it's made me realize how important it is to have these conversations," Dr. Duran said.

Dr. Chen agreed that it's essential to ask and talk about substance use with colleagues and learners. "Especially alcohol, which is so ubiquitous and acceptable, and encouraged," she said. "We particularly don't like to talk about alcohol. I'm probably perceived as a party pooper: I talk about it, and everybody walks away."

Medical school and residency orientation is a particularly good time to address these issues, Dr. Chen said. In the anesthesiology department, where clinicians are disproportionately affected by opioid use disorders due to access, she and a colleague have given presentations about addiction to fellows and residents. "It's a very informal gathering, a retreat where we invite spouses and family members to come because it affects the whole family," Dr. Chen said. "I advise them to be open and ask for help, that it will be held in confidence and to trust the in-house departmental process."

For many physicians, it is difficult to be in a sick role, she noted. But those who go through addiction treatment and receive compassionate care may become even better doctors, Dr. Chen said. "They can pass all that information and experience of self-care and well-being on to their patients and disseminate that," she said. "That's powerful."

Retaining physicians in practice is especially important because the U.S. is projected to face a shortage of up to 122,000 physicians by 2032, according to estimates published in April 2019 by the Association of American Medical Colleges. "We can't afford to lose people," said Dr. Duran. "Ideally, we want to get everybody back out into the community practicing and taking care of patients." ■

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Additional reading

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How (and why) to clean a stethoscope

Research has found that stethoscopes harbor microbes and that many clinicians never clean theirs.

By Mollie Frost

Ever wondered how many germs you're wearing around your neck? Studies show that the microbial community on a stethoscope is robust and sometimes includes drug-resistant pathogens like *Staphylococcus aureus*.

In one recent study, microbe samples taken from stethoscope bells and diaphragms found *S. aureus*, *Acinetobacter*, and *Klebsiella pneumoniae*, according to results published in the January 2019 *Journal of Infection Prevention*. Out of 62 hospital staff members surveyed as part of the study, 33 (53.2%) said they had never cleaned their stethoscopes.

"This study is from India, but I bet that's probably pretty close to the case in the U.S. The stethoscope is so commonly used, but people just don't think about it," said Michael B. Edmond, MD, FACP, MPH, MPA, chief quality officer and associate chief medical officer at the University of Iowa Hospitals & Clinics in Iowa City.

Dr. Edmond and other infection control experts explained why stethoscope decontamination is especially important in the hospital and offered tips for spotless stethoscoping.

'The third hand'

As part of standard precautions, the CDC categorizes stethoscopes as noncritical patient-care items because they only touch intact skin. While this category poses the least risk of infection transmission among clinical equipment, stethoscopes should be cleaned between patients and, if visibly soiled, disinfected with an Environmental Protection Agency-registered hospital agent, the CDC recommends.



Image by Getty Images

The risk of a patient getting sick from a dirty stethoscope hasn't directly been documented, per se, because the bacteria carried by the devices are common and found in many other areas of the health care environment, said Aneesh K. Mehta, MD, an infectious diseases subspecialist and associate professor of medicine at Emory University School of Medicine in Atlanta. "But at least we believe that the theoretical risk is there, and just as we clean our hands, cleaning anything that might contact the patient would be potentially beneficial to the patient," he said.

"Some may not be aware of guidelines that we clean our stethoscopes in between patients, as this was not something we were originally taught."

—Jurgen L. Holleck, MD, ACP Member

Stethoscope hygiene is more important in the hospital than in outpatient practice because hospitalized patients have more risk factors for infection, such as central lines, said Dr. Edmond. "If you're seeing outpatients who are relatively healthy, I think the risk is going to be much less," he said.

Despite the CDC's recommendations and higher stakes in the hospital, adherence to appropriate stethoscope hygiene remains low. One research letter, which refers to the stethoscope as "the third hand," found that only about 5% of trainees at three hospitals performed stethoscope hygiene in non-isolation rooms, according to results published in the July 2015 *Journal of Hospital Medicine*.

With the aim of increasing stethoscope hygiene, another study tested the effect of an educational intervention at the start of clinical rotations for housestaff, medical students, and attendings. Despite receiving a brief PowerPoint presentation, reminders, and access to cleaning supplies, the intervention group still had zero stethoscope hygiene by the end of the quality improvement project, according to results published in the July 2017 *American Journal of Infection Control*.

"Some may not be aware of guidelines that we clean our stethoscopes in between patients, as this was not something we were originally taught," said lead author Jürgen L. Holleck, MD, ACP Member, a hospitalist at Veterans Affairs Connecticut Healthcare System in West Haven and assistant professor at Yale University School of Medicine in New Haven. Surveying clinicians on their beliefs around stethoscope hygiene, his group found that forgetfulness, time constraints, and limited access to supplies were perceived barriers.

Overall, stethoscope cleanliness is a habit that is best formed the very first time a medical student sees a patient, said Dr. Edmond, also a clinical professor of infectious diseases at the University of Iowa. Dr. Holleck said that medical students at his institution now receive a checklist when learning the physical exam that includes wiping the stethoscope in addition to performing hand hygiene.

To increase awareness of stethoscope hygiene, Dr. Edmond models the behavior and speaks to residents about infection control, which is particularly salient on the infectious diseases consult service. "It's interesting because if I do it, they'll do it. I don't know how that habit carries over, though, after they move on to their next rotation," he said. "I don't think most doctors are in the habit of doing it yet."

Keeping it clean

Establishing the habit may be the trickiest part of stethoscope hygiene, but there's also the challenge of choosing from the wide range of cleaning options. Ultimately, clinicians have their choice, as studies have found that various cleaning techniques, such as alcohol swabs, hydrogen peroxide wipes, and alcohol-based hand sanitizers, all work, said Dr. Holleck, adding that a bleach wipe should be used if there is suspicion of *Clostridium difficile*.

In one study, researchers asked physicians to clean their hands, then either use alcohol-based hand sanitizer on their palms to clean their stethoscope diaphragms or use alcohol wipes. Overall, both methods were very effective, although the wipes provided a more consistent decrease in bacteria, according to results published in the August 2010 *Infection Control & Hospital Epidemiology*.

Perhaps more important than effectiveness, however, is whether clinicians perform stethoscope hygiene at all, said Dr. Mehta, lead author of the study. At his hospital, hand sanitizer is generally easier to use, quicker, and more readily available compared to wipes, he said. "We get better compliance, so that is my suggested strategy."

With hand sanitizer available on the walls outside every patient room, it is easy to remember to perform hand hygiene when entering and to perform both hand and stethoscope hygiene when exiting, Dr. Mehta said. Once Dr. Mehta cleans his hands after a patient encounter, his strategy is to rub the surface of the stethoscope diaphragm (the area of most concern because it touches the patient) for about 30 seconds with either the hand sanitizer or a wipe. "By rubbing it for that amount of time, you can really get the product into all of the areas of the diaphragm and ensure a good amount of contact time," said Dr. Mehta.

At Dr. Edmond's hospital, there has been a concerted effort to make sure there are disinfectant wipes readily available. "Like anything that we're asking health care workers to do, you have to make it easy for them to actually do it, or your compliance rates will be low," he said. The wipes contain quaternary ammonium compounds, commonly called "quats," and do not require gloves to use, as bleach wipes do, Dr. Edmond said.

When using the wipes, wipe them across the entire surface of the stethoscope and then allow it to air dry (which happens quickly), said Dr. Edmond, who prefers the wipes to hand sanitizer because they can cover a larger surface area. "I just wipe down the entire scope and then do the bell, so I find the wipes to be a lot easier to use. . . . Now I'm at a point where when I walk out of the room, if I don't immediately go to get the wipe, I get that feeling of something isn't quite right, like I'm forgetting something," he said.

In a study of stethoscopes in the ICU, a standardized 60-second cleaning with a hydrogen peroxide wipe got about half of stethoscopes to the level of a brand-new clean stethoscope, while the rest still had considerable reductions in the total amount of bacteria, according to results published in the February 2019 *Infection Control & Hospital Epidemiology*.

The study authors also asked clinicians to clean the stethoscopes in the usual way that they would between patients. "In that case, a lower proportion achieved the threshold level of a brand-new clean stethoscope," said senior author Ronald G. Collman, MD, a pulmonology and critical care subspecialist and professor of medicine at the University of Pennsylvania Perelman School of Medicine in Philadelphia.

In the ICU where he works, virtually all patients have an individual stethoscope hanging in their rooms. "We here feel that the single-patient stethoscope is really the best answer" in that setting, said Dr. Collman, who prefers to use hydrogen peroxide wipes for cleaning. However, one downside is that single-patient stethoscopes are not of the same quality as the more expensive ones that individual physicians have attuned their ears to over their careers, he noted.

Overall, although cleaning appears beneficial, physicians and patients should not be panicked about stethoscopes, said Dr. Collman, whose study showed that the overwhelming majority of bacteria on stethoscopes were common oral, skin, and gut bacteria much like those on door handles. "We are always in flux with microbes from people in our environment, so while it is important to apply infection control practices and stethoscope decontamination in settings where particularly dangerous pathogens may be present, I think the notion that we have to fear coming in contact with a stethoscope would be overblown," he said. ■

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Other Dirty Devices

Stethoscopes aren't the only potentially contaminated item brought into patients' rooms. For example, certain articles of clothing, such as neckties and white coats, may be rarely washed, said Michael B. Edmond, MD, FACP, MPH, MPA, chief quality officer and associate chief medical officer at the University of Iowa Hospitals & Clinics in Iowa City. "I have felt for a long time that we could think about a personal bundle for infection control," he said.

In 2009, Dr. Edmond and the infection control committee at VCU Medical Center in Richmond, Va., started to recommend a three-part "bare below the elbows" approach for all clinicians in the inpatient setting. As part of the bundle, clinicians were asked to remain bare below the elbows (nylon vests are easy to clean and warm in the winter), to perform hand hygiene before and after patient contact, and to wipe down their stethoscopes after every patient exam.

That wiping should also be applied to other devices clinicians carry, noted Aneesh K. Mehta, MD, an infectious diseases subspecialist and associate professor of medicine at Emory University School of Medicine in Atlanta. For example, after he uses his pen light or a pen while in the room with a patient, he performs hand hygiene and then uses the hand sanitizer to clean his pen light and pen, just as he does with his stethoscope.

Dr. Mehta also tries not to take his cell phone out of his pocket in the patient room, but sometimes he needs to

use it, for example, to take a photo of a wound or a rash. "For those occasions, I immediately clean my phone off, either with a hand gel or an alcohol wipe, whatever is more readily accessible at that moment, before I put it back in my pocket," he said.

Certain cell phones may have special cleaning instructions, noted Jürgen L. Holleck, MD, ACP Member, a hospitalist at Veterans Affairs Connecticut Healthcare System in West Haven and assistant professor at Yale University School of Medicine in New Haven. For example, iPhone cleaning instructions recommend using a slightly damp, lint-free cloth rather than cleaning products, due in part to the device's oleophobic coating.

A moist cloth can be an effective disinfectant, as evidenced by a study that compared three cleaning methods to reduce iPad contamination with *Clostridium difficile* and methicillin-resistant *Staphylococcus aureus* (MRSA). Bleach wipes removed *C. difficile* spores completely, while a moistened microfiber cloth was significantly more effective than alcohol wipes at removing spores, according to results published in the November 2013 *American Journal of Infection Control*. All three cleaning methods removed 100% of MRSA.

There are also more drastic cleaning options. "I had one resident who placed his cell phone in an ultraviolet box every night," Dr. Holleck said. ■

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Doctors of a Certain Age

By Vincent Quagliarello, MD

You know who we are, but you don't really know us. We're old physicians now—advancing into our fourth, fifth, or sixth decade of doctoring—and you see us everywhere. We grew up in a different environment, with different priorities, but we recognize that evolution happens for a reason. You hear us talk about our experiences, but often just the ones we want you to know about.

You hear us talk about how we learned medicine before electronic health records. Before smartphones, e-mail, the Internet. About how we looked up literature in the medical library, photocopied papers, and read them. Most of them, anyway. How for many of us, overnight call was every third night, with no caps on admissions or numbers of patients. No 80-hour workweek, no mandatory weekdays off. No Health Insurance Portability and Accountability Act.

We talk about how we did rectal examinations and tested stool for occult blood on the wards. How we measured blood pressure with a manual cuff. How we loved physical diagnosis but sense that it's lost some respect, something that's often cut and pasted online each day—a series of findings overwhelmed by more trusted diagnostic imaging procedures that are only a mouse click away. How saddened we are when our cardiac examination is discordant with an echocardiogram and the echocardiogram drives decision making. We don't like to admit that our cardiac examination has limits.

During our training, we had fewer diagnostic tests, fewer drugs, different expectations. There were no pop-up best-practice alerts, mandatory medication reconciliations, or laboratory results online. We talk about how many of us examined urine, blood smears, Gram stains on the hospital floors to make management decisions. How we weren't laboratory certified but felt a valuable intimacy with our patients when we viewed their bodily fluids under a microscope. We rarely talk about how, as observers without formal training, our interpretations might have been inaccurate.

We talk about how we drew blood, inserted central lines, intubated patients. How many thoracenteses, paracenteses, and lumbar punctures we performed. How there were no procedure competency documentations—"see one, do one, teach one" was the cultural motto. But we don't talk about the complications we witnessed. Or caused. Or failed to disclose.

We talk about how we made rounds in the radiology suite to view films, on light boxes, separated out onto large surface areas with a radiologist to interpret live. How, in our current era of electronic imaging reports, there seems to be less interest in person-to-person opinions; with the conflicting demands of modern patient care, efficiency almost always wins. What we don't say is that we like the efficiency of electronic images and their accompanying interpretations. Though impersonal and silent, the documentation is immediate and accountable.

We talk about how, as young physicians with evolving careers, we had to deal with leaders—mostly white men—who were often intimidating and demanding. How, for many of us, there were no specified program directors for residency training, program evaluation committees, or formalized mentoring for young attendings. How the department chair ruled, often through chief residents and subspecialty section chiefs serving as loyal lieutenants. How we listened and obeyed. And how we admired the tough love, because we somehow still felt supported. But we don't talk about the human dysfunction that slipped through the cracks. The preventable mental health issues of training with less oversight. So, we're gratified that the hierarchy is changing now, albeit at a slow pace. Leaders who are more diverse are not just more inclusive, they're more effective. We need more of them.

We talk about how, as trainees, we felt like doctors with a cause, a mission, a meaning. But we don't talk about how we made mistakes. Or how we were publicly quiet about the chaos around us. Or how we accepted things we wouldn't tolerate now. Patient safety, physician wellness, and collegial respect have renewed focus these days. We're thankful for the progress, the growth. And we want to be part of the solution.

At this point in our careers, we're a heterogeneous group. Some of us have been fortunate to retain a status of reverence. Of productivity and leadership at local and national levels. But for many of us, our prime has passed. We are no longer the idolized clinician, investigator, educator. Our career accolades are known to fewer and fewer persons in our workplace. Our imprint is being washed away with each annual wave of new physicians. We see fewer patients and give fewer lectures, so we tell more stories. Stories that are often embellished, though rooted in some distant truth. Stories that educate, mentor, and entertain have become our reliable contribution to our professional colleagues. We seek relevance as our careers reach the final act in our play.

We still love medicine, but we know that our level of factual knowledge has faded a shade or two. After decades of building the highest level of skill and expertise, we recognize the slip before anyone else, like a concert violinist who misses one day of practice. We cover it up by avoiding situations that expose us, that place our knowledge erosion under an oil immersion lens. We try to keep up reading the literature, attending local conferences, flying to national meetings, but we know we've lost a step. A younger generation is rising, passing us by in ability, innovation, ideas. But we want to stay in the game. Have a chair at the table. Contribute to the cause.

For many of us, the world of multitasking seems to increasingly challenge our waning skills. We feel more stressed caring for patients, navigating the electronic health record, squeezing in time to teach, renewing research protocols, meeting billing

requirements, completing mandatory online training, dealing with the rapid workflow in the office and hospital. We've always felt our professional privilege and obligation, but we disdain the constant need to document, attest, certify. It feels as if we aren't trusted anymore. And maybe we shouldn't be. So, we try to adjust to the digital world around us—the incessant e-mails, text messages, voicemails, in-basket queries in the electronic health record—but we don't like it. It sifts the joy out of our work caring for patients, teaching, creating new knowledge: the work we cherish.

We're held more accountable for our skills now. Neurocognitive testing has been added to the standard metrics of continuing medical education credits, grant dollars, clinical income, relative value units, publications. Some hospitals mandate such testing for physicians over age 70 to remain credentialed for patient care. We understand and respect the premise, but the idea of having to prove we're not dangerous has a wind of indignity to it. The test scares us because the questions seem elementary, reminiscent of those we've asked patients to assess mental impairment, but the answers have powerful consequences. Consequences for our professional identity, our life-space diameter. It causes anxiety in some, depression in others, worry in most. But, in the final analysis, we realize it's necessary.

You may notice we're more brash with public comments during meetings and clinical conferences. As our cognition declines, our boldness increases. If a question or comment

comes to mind, the urge to recall an anecdote is almost impossible to control; our filter from cortex to brainstem has worn thin. If you think we're merely waxing nostalgic for the past—a past that we know was flawed—you're right. But it was a past when we were young, choices were many, and the future was limitless. So, we yearn to view our younger days through a lens of optimism, a kaleidoscope of great experiences.

Through it all, we plod along. Hoping to pitch in and not embarrass ourselves. Some of us develop new avenues to supplement our diminished traditional role: community activity, working abroad, abstract painting, writing poetry. But the truth is we're envious of you. Your youth. Your better working climate. The improved outcomes and patient experiences that stem from enhanced accountability, more skill development, better mentoring. We yearn for your unbounded opportunity in the setting of relentless scientific discovery, new diagnostics, innovative interventions, uncharted careers. Some of us want to start all over.

So, if you see us, try to understand our history. Remember, we love to tell you how we got here. Why we stayed. How we love medicine and want you to love it. We may lament that some things have been lost. But we know that more has been gained. ■

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Health Care in 2030: Will Artificial Intelligence Replace Physicians?

By Nirav R. Shah, MD, MPH

In 2016, the world chess champion was a computer program named Stockfish 8. That a computer was the reigning champion is no surprise—Stockfish is programmed with centuries of accumulated human knowledge of chess and can examine 70 million positions per second. This changed in 2017 with the introduction of Google's AlphaZero (1).

Coders gave AlphaZero just 1 input: the rules of the game. After only 9 hours of training, AlphaZero scored 28 wins and 72 draws in a 100-game match against Stockfish. It did not lose a game.

Instead of building on centuries of human knowledge, it started with a clean slate. It then used machine learning to play 44 million games against itself to generate new insights and become the best in the world (2). Grandmasters described AlphaZero's playing style playfulness.

What might this tell us about what medical practice will look like in the not-so-distant future? Will Google algorithms beat out physicians? I don't think so. Algorithms, such as AlphaZero, cannot articulate what they are thinking. We do not know why they work and therefore do not know whether they can be trusted. Humans want more than answers. They want insight, particularly in medicine. This is a source of tension in physicians' interactions with computers. Algorithms perform well when there are rules; they do not do as well when there is imperfect information or less structure, as in medicine. Self-driving cars may do well in a small city, but they could not move an inch in the chaos of New Delhi traffic. The reality of medical practice—particularly primary care practice—resembles a New Delhi traffic jam. How can we make things better as we look ahead?

Adeptus Health, a company of approximately 100 free-standing emergency departments (EDs) in Texas and Arizona that are located close to residential communities, offers some instructive examples (3). Adeptus reimagined freestanding EDs as the "front porch" of the hospital rather than the "front door." At a given time, a physician, nurse, radiology technician, and receptionist staff each ED. By seeing approximately 10 patients over 24 hours, an Adeptus ED can earn a profit. They use standardized workflows for common presenting problems and efficient team-based care where the radiology technician also performs phlebotomy and electrocardiography. Flexible staffing enables each ED to scale from 8 to 80 patients in 1 day. During flu season, a single Adeptus ED saw up to 120 patients in 24 hours.

Adeptus EDs collectively break many traditional rules to function well. Do EDs have to be part of a hospital? Should we hand off patients among multiple teams and providers, in the process matching each organ to a specialist? Should ED physicians multitask across many patients simultaneously? In this model, the answer to all of these questions is "no."

The outcomes speak for themselves. The average door-to-electrocardiography time is 4 minutes compared with 30 minutes in most hospital-based EDs. Without hand-offs in care, fewer errors occur. Not diluting expensive physician time across dozens of patients enables these EDs to best align patients' needs with their preferences. Standardized care pathways facilitate evidence-based care. Physicians and nurses triage and discharge patients jointly, and 2 clinicians can better catch potential mistakes, reinforce patient learning, and develop trusting relationships with patients. Physicians or nurses also telephone many patients within 24 hours of ED discharge to check that they are safe. Feedback loops enable continuous quality and service improvement.

The commitment to optimizing each component of care telescopes: Just as the ED is outsourced from the hospital, radiology is outsourced through teleradiology. Further, the job satisfaction of the physicians involved—some of whom fly in from other parts of the country for a week of service each month—is off the charts.

Patient satisfaction is also high. Although this experiment is still relatively new, it and other novel models around the country show promise.

CityMD has thriving urgent care clinics in New York City. Patients looking for care can visit the CityMD Web site to see actual wait times at each location (4). Millennials, who value convenience and access over nearly everything else, are not willing to wait the average 29 days needed to obtain a primary care appointment. CityMD sees patients in minutes and controls where they go afterward. Owning that downstream channel is big business.

Based in San Francisco, Forward is another practice targeting Millennials (5). For \$149 each month, members receive unlimited visits, genetic testing, cardiac screening, and more. There is a cool app, an iPad that shows patients their "playlist" of tests and visits for the day at check in, and more gadgets and monitors than an electronics store. Although Forward is unlikely to replace most practices, it has elements that physician practices must understand and incorporate to remain viable. The sensors, platforms, and screens are noise behind what really matters to patients: convenience, access, and no hidden fees.

ChenMed in Miami believes that workflow should be based on the complexity of the patient (6). Typical patients receive a 15-minute appointment, and atypical patients receive a 1-hour appointment. As such, ChenMed physicians spend 189 minutes per year per patient compared with an average of 21 minutes for Medicare patients in traditional primary care practices. Studies suggest that more time spent with primary care physicians is associated with lower costs.

Oak Street Health was started in Chicago and aims to

deliver the world's best primary care to the poorest, sickest elderly patients (7) by being evidence-based, equitable, and accountable while focusing on social determinants of health. For Oak Street, this focus means covering patients' transportation to and from the clinic, among other things. Their model is a full-risk, globally capitated one that primarily includes dual-eligible patients. Their quality metrics are impressive: a 92% Net Promotor Score, Healthcare Effectiveness Data and Information Set 5-star ratings, and a 40% reduction in hospitalizations. Knowing your patients and redefining health care to match their needs make a big difference. These practices are financially viable, whereas many other practices struggle.

Common elements of these and other promising care models include hiring the right clinicians, using data analytics to better target patient needs, and being willing to try new things. However, none of these examples offers the complete answer. So, is there a secret sauce for high-value primary care?

Arnold Milstein, Director of Stanford University's Clinical Excellence Research Center, has identified characteristics that high-value primary care practices share. After ranking more than 50 000 practices on quality and cost, his research team identified consistent highest performers and compared them with average practices (8). They found that the best performers create deeper patient relationships through extended hours and thoughtful use of tools, such as e-mail. They practice "conscientious conservation of resources," adhere to guidelines, leverage decision support, aggressively close care gaps, and use morning team huddles to match patient needs to services. They practice informed shared decision making and good advance care planning. They use patient complaints to guide improvement. They perform more of the basic services, such as stress tests, in-house. When referral is necessary, they coordinate care and choose specialists who also embrace conscientious conservation. They keep overhead low with modest offices. Finally, regardless of how they are reimbursed, they are thoughtful about how they pay themselves (for example, they share bonuses with the frontline staff).

I have not really said much about technology, which you might have thought would be the focus of a commentary on the future of health care. The reality is that I cannot say where we will be.

Twenty years ago, they said that electronic health records would be the silver bullet; look where we are today. Five years ago, artificial intelligence was predicted to render every radiologist, dermatologist, and pathologist obsolete; that has not happened. However, by 2030 physicians may have digital assistants that listen in on health care encounters and simultaneously write notes for clinical care, the patient, and billing purposes. These digital assistants will create referrals on the fly and arrange preventive and other evidence-based care. However, the physician will remain important, especially to manage the complex tasks left behind after technology addresses the easy stuff. This complexity will demand a higher-level performer who can understand what is right for the patient in ways that no algorithm can.

General internists are such high-level performers. Educators suggest that the next generation of students should focus on critical thinking, communication, collaboration, and creativity

(9). These are already the superpowers of internists. Google's AlphaZero may have helped create a new philosophy of chess. It is up to us to imagine a new practice of medicine. ■

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IMGs face uncertainty amid politics, rhetoric

Residency leaders report delays, worries due to immigration policies.

By Charlotte Huff

The arrival of the next crop of internal medicine residents was less than two months away at Bassett Healthcare Network in Cooperstown, N.Y., when the residency program director contacted Doug DeLong, MD, FACP, in a panic.

"All of a sudden six of our 10 incoming residents in internal medicine were having their visas delayed or denied," said Dr. DeLong, chief of the division of general internal medicine at Bassett.

That holdup posed both an educational and a patient safety problem, according to Dr. DeLong, who also serves as Chair-elect of ACP's Board of Regents. "There just aren't enough bodies to do all of the work otherwise," he said. "This would have major repercussions for us."

Bassett was among a number of residency programs reporting similar delays in the processing of H-1B visa applications, a situation that led leaders at the American College of Physicians and other physician groups to write a May 30, 2018, letter to U.S. Citizenship and Immigration Services, alerting them that the holdup could put patient care at risk. The delays, which involved a change in how federal officials reviewed wage data for the incoming residents, were resolved, and all of Bassett's residents did eventually arrive, though not necessarily by the July 1 start date, Dr. DeLong said.

The situation came amid a climate of rhetoric and potential policy changes that some worry will erode the caliber of international medical graduates (IMGs) who choose to train and sometimes stay on to practice in the United States.

Physicians, trainees, and students from certain Muslim-majority countries are particularly affected. The series of executive orders and related court decisions handed down in the last two years have created uncertainty and confusion about their ability to live and travel in the U.S.

At this point, all incoming residents are still eligible to apply for H-1B or J-1 visas, with the exception of individuals who are from Syria or who are part of the Venezuelan government, said William Pinsky, MD, president and chief executive officer of the Educational Commission for Foreign Medical Graduates. Even so, when visiting medical programs elsewhere, Dr. Pinsky has picked up on some wariness about training in the U.S.

"They still look at the United States as really the gold standard of where they would like to strive to come to for training," Dr. Pinsky said. "But there's a 'however.' And the 'however,' when I speak with people, is they're very concerned about how welcome they will be in the country."

A key workforce component

International medical graduates, a group that includes both people born outside the U.S. and U.S. residents or citizens who studied elsewhere, comprise about one-fourth of practicing physicians and physicians in residency training in the United States, according to an analysis published in April 2018 in the *Journal of Graduate Medical Education*. Among practicing physicians, IMGs make up a large portion of the physicians practicing internal medicine in the U.S. (39%), followed by neurology (31%), psychiatry (30%), and pediatrics (25%), the analysis found.

IMGs typically travel to the U.S. for residency training on an H-1B or a J-1 visa. The H-1B visa is sponsored by an employer, in this case the residency program, and those who hold it can stay in the country as long as the visa is active. Those with a J-1 visa are required to return home after training for at least two years, unless they get a waiver to serve in an underserved urban or rural area of the U.S.

In 2018, 46.4% of foreign-trained graduates—a category that includes both U.S. citizens and non-U.S. citizens graduating from international medical schools—matched in internal medicine, and 15.5% matched in family medicine, according to National Resident Matching Program data published in April 2018.

Even with the opening of new allopathic and osteopathic medical schools in recent years, the number of residency slots will continue to substantially exceed the number of U.S. medical school graduates, with a surplus of 13.5% projected by 2023-2024,

according to an analysis published on Dec. 17, 2015, in the *New England Journal of Medicine*.

Perhaps less frequently noted is the influential role that IMGs play in academic medicine, including teaching and research, said Anupam Jena, MD, PhD, an associate professor at Harvard Medical School and a physician at Massachusetts General Hospital in Boston. Working with the database Doximity, Dr. Jena and colleagues determined that among the nearly 83,000 academic physicians in the U.S., 18.3% are IMGs, according to findings published Oct. 17, 2017, in *Annals of Internal Medicine*.

"Any policy that attempts to reduce immigration," Dr. Jena said, "seems like a bad policy from the perspective of scientific development and patient care."

Vijay Rajput, MD, FACP, who has written about his transition from India to U.S. medical practice and customs with some humor in *JAMA*, said there are certainly adjustments for doctors who have studied outside of the United States. For instance, physicians must learn the complexities of U.S. insurance and the



Image by Getty Images

often more detailed documentation required for patient care, he said.

But IMGs also bring with them a strong work ethic and commitment to practicing medicine, said Dr. Rajput, a co-editor of "The International Medical Graduate's Guide to US Medicine & Residency Training," published by ACP in 2008, and chair of medicine at Ross University School of Medicine, which is based in Miramar, Fla., but maintains its medical sciences campus in Bridgetown, Barbados. Moreover, there's some indication, based on a *JAMA* study, that IMGs are less vulnerable to burnout, he said.

The analysis, which looked at burnout rates among more than 16,000 internal medicine residents, found that 45.1% of IMGs experienced burnout compared with 58.7% of U.S. medical school graduates, according to the 2011 findings. One possible explanation for the difference, the authors wrote, is that IMGs who have been able to navigate the competitive process to get into a U.S. residency program might be inherently more resilient.

Reaching underserved areas

When Dr. DeLong completed his residency at Bassett in the early 1980s, all of his colleagues were U.S. medical graduates. But the backgrounds of applicants have shifted over time, as they have at other smaller, more rurally based residency programs, he said.

The visa application holdup this past summer, as described in the letter sent by ACP, involved heightened scrutiny of the wage data incoming IMGs were providing. Federal officials had previously accepted data from the Association of American Medical Colleges but were now either asking for additional data or denying applications outright, according to the letter. (H-1B visas have been in the news recently because of concerns raised by some that companies can use them to bring in workers to fill U.S. jobs, for example in the tech field, at a lower cost.)

Physicians who want to stay in the U.S. after completing their training face other delays in the process of obtaining permanent residency, said Varun Malayala, MD, FACP, an internist practicing in Milford, Del., and a board member of the recently formed group Physicians for American Healthcare Access. Given that current immigration laws only allow 7% of the visas issued each fiscal year to be allotted to people from any one independent country, doctors from some countries that frequently train in the U.S., such as those from India, may end up waiting for decades, he said.

The nonprofit group, formed in 2018, is advocating for physicians to have a separate path for immigration, given the need for more doctors in underserved and rural areas, Dr. Malayala said. Otherwise, some of those physicians will give up on the continuing limbo and move to a country like Canada or the United Kingdom with a shorter path to residency, he said.

"It's like an ever-lasting anxiety about what the future is going to be," Dr. Malayala said. "What's the future of their kids going to be? Can they buy a house in that community?"

Dr. Malayala recently conducted a survey that reached a total of 1,050 physicians and physician residents practicing on a visa in the U.S. According to the yet-unpublished data, slightly more than two-thirds of the respondents reported working in underserved areas. Nearly all, 96.1%, felt like they couldn't advance in their careers because of their immigration status. Nearly 80%

were contemplating returning to their home country or another country because of the immigration backlog.

Future uncertainties

Dr. Pinsky is closely watching the number of applications to the residency matching program from non-U.S. IMGs, which has ticked downward a bit in the last two years, from 7,460 in 2016 to 7,067 in 2018. It's not yet clear, Dr. Pinsky said, whether that represents a statistical wobble or early signs of declining interest in U.S. training.

But perception matters, Dr. Pinsky said, as IMGs make career choices. News of a more hostile climate, such as the 2017 shooting of two Indian tech workers in a Kansas bar, can reverberate many time zones away, he said. Moreover, some IMGs worry that future travel restrictions might slow or prevent them from returning if they visit family back home, thus forcing them to live apart from loved ones during the years of their residency, Dr. Pinsky said.

He's also heard reports from some directors of small or medium-size residency programs that they're ranking applicants from Muslim-majority countries lower than they would have previously because of concerns that their arrival could be delayed or denied.

"I understand why," Dr. Pinsky said. "In these small or medium programs, if one or two people can't get into the country, that really is a problem in terms of the program."

But, he added, "Not only is it unfair for applicants, it also has the potential of diluting the quality of individuals in the [residency] program."

Only time will tell if more uncertainty will curtail the number of IMGs who both train and choose to remain practicing in the United States. But if there's a dent in their numbers and practice skills, Dr. Pinsky has no doubt which patients will be impacted first. "Clearly it's going to be the underserved areas," he said.

Charlotte Huff is a freelance writer in Fort Worth, Texas. This article also appeared in ACP Internist. ■

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Coaching program builds resilient residents

Trainees are matched with volunteer coaches outside of their discipline to help them navigate the highs and lows of residency.

By Mollie Frost

Where: *Massachusetts General Hospital, a 1,011-bed teaching hospital of Harvard Medical School in Boston.*

The issue: *Improving the well-being of internal medicine residents.*

Background

As chief resident of Mass General's internal medicine residency program, Kerri Palamara, MD, FACP, saw a need for residents to receive emotional support from more experienced clinicians who have little impact on their careers. So in 2012, she started the Professional Development Coaching Program, which matches trainees with volunteer coaches outside of their discipline to help them navigate the highs and lows of residency. A trainee interested in pursuing cardiology, for example, might be matched with a gastroenterologist. "That creates this opportunity for a safe space for the resident to have a conversation . . . about a number of insecurities that everybody has as they're going through training," said residency program director Jatin M. Vyas, MD, PhD, FACP.

How it works

While this may sound like a simple buddy system, "what [Dr. Palamara] added to that was to provide the faculty members training on being a coach," he said. The volunteer coaches, many of whom are teaching faculty, receive training in positive psychology and coaching principles.

The program is strongly encouraged, but it isn't mandatory (with 199 trainees, there are always a few who aren't interested), said Dr. Vyas, also an associate professor of medicine at Harvard Medical School. When residents join the program, each one is assigned a coach and expected to check in a minimum of three times a year, he said. At each meeting, the coaches help trainees reflect on their experiences, set goals, and engage in dialogue that encourages positive emotions and strengths.

Results

After the first year of the program was linked to a reduction in interns' emotional exhaustion, Dr. Palamara and colleagues decided to study its impact more formally over three years. Each year, the pairs were encouraged to focus their initial meeting on specific ways to encourage professional and personal success. In the first year, they worked on exploring strengths, building resilience, and finding meaning in work. The second year fostered leadership development and emotional intelligence, and the third year focused on leading authentically, finding passion and purpose, and cultivating life's lessons.

Of 179 residents who were assigned a coach in the 2014-2015 academic year, 56% fully participated in the program, and 73.1% of them reported good or excellent experiences with their coaches. Participation in the program was significantly associated with opportunities for reflection, a positive residency experience, and increased coping and relationship skills, according to results published online in July by the *Journal of General Internal Medicine*. Dr. Vyas views the program as complementary to traditional mentorship, which "focuses more on the career; the coaching program focuses more on the person."

Challenges

The biggest challenge was normalizing discussions about personal challenges, as many trainees hide their insecurities to guard against perceptions of weakness, Dr. Vyas said. "Part of the difficulty is really to try to get residents, and interns especially, to recognize that this is part of growing as a physician," he said. Other challenges included the administrative burden of tracking participation in a large residency program and the amount of time spent training the coaches.

A final barrier is that the faculty members are already very busy and aren't specifically compensated for participation, Dr. Vyas noted. "But we see this as necessary to creating the right learning environment and promoting this kind of positive psychology for the next generation of physicians," he said. Retention of coaches has been high, and the program currently has more coaches than coaching positions, Dr. Vyas reported.

Next steps

In the future, Dr. Palamara hopes to analyze the program's impact on residents who have graduated, according to Dr. Vyas. She has also helped other residency programs start their own professional development initiatives, he said. "It's actually moved beyond internal medicine to many other disciplines of medicine," such as Mass General's anesthesiology residency program.

Words of wisdom

The newest generation of physicians faces an intense work environment, Dr. Vyas noted. "There are certain elements of patient care in the 21st century that require a resilient physician, and we need to ensure that training programs are in a position to permit that type of growth," he said. "In my mind, this is a program that is a great tool in our arsenal to combat burnout." ■

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Physicians' obligations under EMTALA

Some examples explain the Emergency Medical Treatment and Labor Act (EMTALA).

By Venkata Dontaraju, MD, FACP

Hospitals participating in Medicare must comply with the Emergency Medical Treatment and Labor Act (EMTALA) statute. This is commonly known as the "anti-dumping law" and was enacted in 1986.

Even though the law has been around for many years, many physicians don't fully understand their individual obligations and liability under it. The hospital, as well as the individual physician, is subject to a civil monetary penalty for each separate EMTALA violation. Physician fines go up to \$50,000 per violation (\$25,000 at a hospital with fewer than 100 beds).

These monetary penalties are not covered by professional liability insurance and are the physician's personal responsibility. If the violation is gross or is repeated, physicians may be excluded from participation in Medicare and state health programs.

Thus, it's important for every physician in the hospital, including hospitalists, to understand the law's requirements. As the chairman of the department of medicine at an institution receiving many transfers from nearby community hospitals, I have seen how imperative it is for all our physicians to comply with the EMTALA obligations.

Anyone who comes to the ED requesting an examination or treatment should undergo appropriate medical screening by a qualified medical provider to determine if the individual has an emergency medical condition (EMC). If a patient has an EMC or is in active labor, he or she should be given stabilizing treatment or an appropriate transfer if the hospital does not have the capability or capacity to stabilize the individual.

Examination or treatment should not be delayed to inquire about the individual's insurance or payment status. Also, any participating hospital is required to accept appropriate transfers if the receiving hospital has specialized capabilities not available at the transferring hospital.

Geographically, the law includes patients not only in the ED but also on hospital property, including the main hospital campus, parking lot, sidewalk, driveway, and any building owned by the hospital within 250 yards of the main hospital campus.

Ground or air ambulances can be hospital property if they are hospital-owned and -operated.

An appropriate medical screening examination must be conducted by a physician or qualified medical personnel. A physician is ultimately responsible for screening done by a nonphysician clinician. The medical screening exam involves a brief history, physical examination, diagnostic tests, and procedures. It is an ongoing process, beginning with triage but typically not ending there.

So, what is an EMC? It is any condition manifested by acute symptoms of sufficient severity (including severe pain), in which the lack of immediate medical attention would place the health of an individual or unborn child in serious jeopardy or cause serious dysfunction of bodily organs or serious impairment to bodily functions. Stabilizing treatment is defined as treatment provided to a patient that leads to resolution of the EMC.

What is an appropriate transfer? The patient should be stable for transfer. The treating physician should have determined that no deterioration is reasonably likely to occur during or as a result of the transfer between facilities. Hospitals may transfer unstable patients at their request if they have been informed of the risks of transfer and the hospital's EMTALA obligations, or if a

physician determines that the benefits of the transfer outweigh the risks.

Obviously, these definitions leave room for physicians to interpret them differently. The following patient scenarios may help illustrate the use of the statute.

Case 1

A 60-year-old woman presents to a community hospital ED with hematemesis shortly after midnight. The ED physician suspects acute variceal gastrointestinal bleeding and requests to admit the patient under the hospitalist service. The hospitalist calls the on-call gastroenterologist to come and evaluate the patient. The gastroenterologist says he is tired and has a full day of



Photo courtesy of Dr. Dontaraju

procedures tomorrow. He says, "If the patient is that ill, you need to send her to the university hospital," then hangs up.

In this case, the gastroenterologist is on call and if he can treat variceal bleeding and has the hospital privileges for the procedure, then he is clearly violating the EMTALA by not doing so. Not only the hospital but the on-call gastroenterologist is subject to civil monetary penalty and sanctions.

If a physician is listed as on call and is asked to make an in-person appearance to evaluate and treat an individual with an EMC, the physician must respond in person in a reasonable amount of time. EMTALA applies to consulting and admitting physicians as well as ED physicians.

Case 2

A 75-year-old woman with stage 4 chronic kidney disease is dismissed by Nephrologist A from his practice because of lack of payment and no-shows. This patient is now being followed by Nephrologist B from a competing medical group. Tonight, she presents to the ED not feeling well along with nausea and vomiting. Evaluation reveals end-stage renal failure and hyperkalemia not responding to standard treatment. The ED physician calls Nephrologist A (listed as on call for the hospital). He replies back saying, "I am on call for my group only, and besides, I am not going to come at 11 p.m. to see a patient I dismissed from my practice."

In this case, Nephrologist A may be in violation of EMTALA and subject to penalty and sanctions.

If a physician is on call for a hospital, that means she or he is an on-call doctor for the hospital, not for her or his group alone. Exceptions include hospitals with physicians from competing groups on call for the same specialty at the same time, so all physicians should familiarize themselves with the call structure at their hospitals.

Case 3

A 45-year-old man presents to a rural hospital's ED with acute respiratory failure secondary to a flare-up of interstitial lung disease. The ED physician requests a transfer to a tertiary hospital for a higher level of care. The on-call physician at the tertiary hospital refuses, saying that there are other, closer hospitals that should be called instead.

If the larger institution has empty beds and is capable of taking care of the patient, the transfer should be accepted. The on-call hospitalist who said the patient should be transferred to another hospital may be found to be in violation of EMTALA.

Refusal to accept a valid transfer from another hospital is an EMTALA violation. There is no EMTALA rule stating that the closest facility must be contacted for transfer.

Case 4

A 62-year-old man presents to the ED of Hospital A with acute chest pain, and acute coronary syndrome is suspected. Hospital A has the capacity to treat the patient. The ED physician, however, calls the on-call hospitalist at Hospital B and wants the patient to be admitted to Hospital B (located in a different state). His reason for transfer is that his hospital does not accept the patient's state medical insurance card and Hospital B does.

The ED physician may be found in violation of EMTALA as he has identified an EMC and it is not clear if the EMC is stabilized. If the transfer were to occur, the on-call hospitalist might also have violated EMTALA.

Insurance should never be a part of risk/benefit consideration for a transfer. Not reporting an inappropriate transfer is itself an EMTALA violation. If a patient is inappropriately transferred, it needs to be reported to CMS within 72 hours.

Case 5

A 44-year-old man is brought to the ED of a community hospital after a brief cardiac arrest from which he was successfully resuscitated. He is diagnosed with acute ST-elevation myocardial infarction. Telemetry reveals ventricular ectopic beats. The ED physician calls the nearest university hospital to transfer him.

The patient clearly has an EMC and will be in an unstable condition when he is transferred because his potential to deteriorate en route is high. However, this is acceptable under EMTALA, because the small hospital lacks the resources to fully stabilize the patient.

The medical screening examination should be clearly documented, along with stabilization efforts and a physician certification that the medical benefits expected from the transfer outweigh the risks. In addition, the transferring hospital must provide ongoing care within its capability until transfer to minimize transfer risks; it must also provide copies of medical records, and the transfer must be made with qualified personnel and appropriate medical equipment.

Conclusion

These cases highlight the importance of every hospital physician's understanding and utilizing EMTALA appropriately. I highly recommend that hospital leaders provide EMTALA education to residents, fellows, and new physician recruits. Department chairs may also need to evaluate their individual physicians' compliance with EMTALA from time to time and provide the necessary training and resources.

Dr. Dontaraju is a hospitalist and chairman of the department of medicine at Rockford Memorial Hospital, a division of Mercyhealth, in Rockford, Ill. He thanks Swapna Aradhyula, MD, ACP Member, and Maryanne Miller, MD, FACP, for their comments and suggestions on this article. ■

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Additional Resources

State Operations Manual. Appendix V-Interpretive Guidelines-Responsibilities of Medicare Participating Hospitals in Emergency Cases. Available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf.

American College of Emergency Physicians. EMTALA Factsheet. Available at www.acep.org/life-as-a-physician/ethics-legal/emtala/emtala-fact-sheet. ■

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The new Executive Medical Director will direct all aspects of ACUTE patient care and safety, clinical quality, best practices, evidence-based research and overall patient experience. Because this is a medical stabilization unit, qualified candidates will be an MD/DO and must be Board Certified in either Internal Medicine, Gastroenterology, Endocrinology or Cardiology and eligible for medical licensure in Colorado. The ideal candidate will be a recognized leader in the field, a member of the Academy for Eating Disorders, and be eligible for an academic appointment at the level of Associate Professor or Professor through the University of Colorado School of Medicine.

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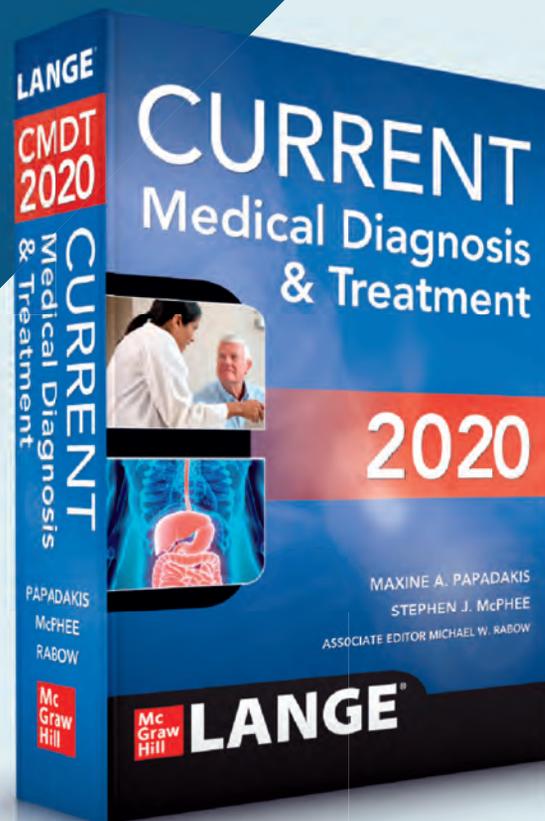
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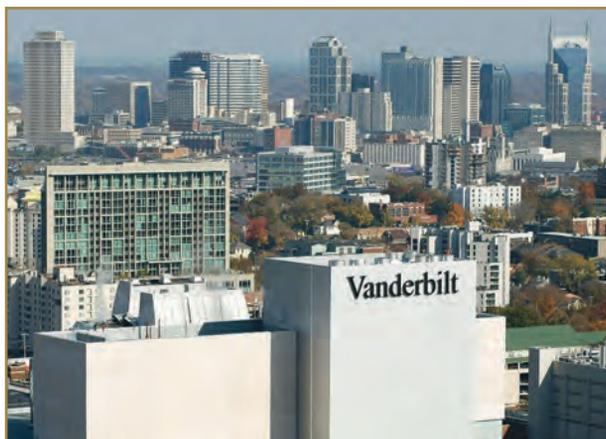
Penn State Health Milton S. Hershey Medicine Center invites applications and nominations for the position of Division Chief, Hospital Medicine. The successful candidate will be a nationally recognized academic leader with a substantial record of leadership, clinical and administrative accomplishments, education scholarship and/or research productivity and teaching experience. We are seeking candidates with prior administrative and leadership experience gained within a Department of Medicine, strong interpersonal and communication skills and demonstrated ability to effectively inspire, manage, mentor and develop faculty and staff. Candidates must hold the degree of MD, DO, or equivalent, or MD/PhD, be Board-certified in Internal Medicine, and possess qualifications for appointment.

The Division of Hospital Medicine at Penn State Health is made up of five teaching teams, five attending teams, two nocturnists, one consult team and one triage team. Together, they provide inpatient care to 140+ hospitalized patients per day. The discipline of hospital medicine grew out of the increasing complexity of patients requiring hospital care and the need for dedicated clinicians to oversee their care. There are plans to further expand the number of providers, presenting a tremendous opportunity for a visionary leader to establish a national presence.

Inquiries, nominations and expressions of interest, including a curriculum vitae and cover letter, should be submitted confidentially via email to Heather Peffley, PHR FASPR: hpeffley@pennstatehealth.psu.edu.

Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer - Minorities/Women/Protected Veterans/Disabled.

VANDERBILT UNIVERSITY
MEDICAL CENTER



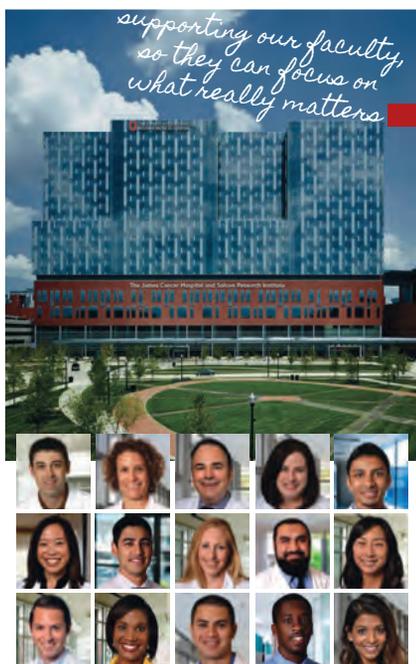
Hospital Medicine
Faculty Position
Nashville, Tennessee

The Section of Hospital Medicine at Vanderbilt University seeks talented BC/BE Internal Medicine physicians to join the full-time faculty at the level of Assistant, Associate, or full Professor, on a clinical, academic, or research track.

Clinical positions, including daytime, nocturnist, and mixed roles, are available for well-trained physicians who wish to focus on direct patient care and medical consultation. We offer flexible scheduling, access to top specialists, and opportunities to engage in teaching, quality improvement, and scholarship. An academic clinician-educator track position is 80% clinical, with additional responsibilities in teaching, scholarship, quality improvement, and administration for qualified candidates. A physician-scientist track provides 80% time for research in collaboration with established investigators in health services research, quality improvement, patient safety, behavioral sciences, and biomedical informatics.

Vanderbilt University Medical Center is a leader in providing high-quality, cost-effective care. With robust programs in quality improvement and clinical research, a highly-developed electronic health record, Magnet Recognition for nursing care, competitive salaries and benefits, and a highly supportive environment for faculty, Vanderbilt is a great place to work. With a booming economy and friendly environment, Nashville, TN is a top place to live.

Interested candidates who are legally authorized to work in the US and BE/BC can submit a letter of interest and CV to:
Anne Axon, Program Manager, Vanderbilt Hospital Medicine
anne.axon@vumc.org



<http://go.osu.edu/hospitalmedicine>



The Ohio State University Wexner Medical Center

Join a Leader in Hospital Medicine

As one of the nation's largest academic hospitalist programs, we lead a variety of teaching and non-teaching inpatient and consultative services. OSUWMC Division of Hospital Medicine is dedicated to the health and well-being of our patients, team members, and our OSUWMC community. Our mission is to improve the lives of our patients and faculty by providing personalized, patient-centered, evidence-based medical care of the highest quality. Our clinical practice meets rigorous standards of scholarship, and we are devoted to serving as expert educators and mentors to the next generation of physicians.

Preferred candidates are BC/BE in Internal Medicine or Internal Medicine-Pediatrics, have work experience or residency training at an academic medical center, and possess excellent inpatient, teamwork, and clinical skills.

OSUWMC is an equal opportunity/affirmative action employer and encourages applications from women and minorities. This is not a J-1 opportunity.

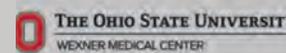


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- University Hospital East
- James Cancer Hospital & Solove Research Institute
- Richard M. Ross Heart Hospital
- Dodd Rehabilitation Hospital
- OSU Harding Hospital
- Nationwide Children's Hospital (Med-Peds)



UNIVERSITY OF MICHIGAN
DIVISION OF HOSPITAL MEDICINE



The University of Michigan Division of Hospital Medicine seeks board certified/board eligible internists to join our growing and dynamic division. Hospitalist duties include teaching of medical residents and students, direct patient care in our non-resident and short-stay units, and involvement in quality improvement and patient safety initiatives. Novel clinical platforms that feature specialty concentrations (hematology/oncology service, renal transplant service and bone marrow transplant teams) as well as full-time nocturnist positions are also available. Our medical short stay unit provides care for both observation and inpatient status patients and incorporates advanced practice providers as part of the medical team.

The ideal candidate will have trained at, or have clinical experience at a major U.S. academic medical center. Sponsorship of H1B and green cards is considered on a case-by-case basis for outstanding individuals. Research opportunities and hospitalist investigator positions are also available for qualified candidates.

The University of Michigan is an equal opportunity/affirmative action employer and encourages applications from women and minorities.

HOW TO APPLY

Interested parties may apply online at www.medicine.umich.edu/hospital-medicine or email cover letter and CV to Vineet Chopra, MD, MSc, Chief, Division of Hospital Medicine at HospMed-Recruitment@med.umich.edu

WWW.MEDICINE.UMICH.EDU/HOSPITAL-MEDICINE



Hospitalist position available in reputable hospital in Metro Detroit. Days only. Prefer early 2020 start.

Please send CV to: iulniculescu@yahoo.com

Division Director of Hospital Medicine

Hennepin Healthcare/HCMC, a 470 bed safety net hospital, in Minneapolis, Minnesota is seeking a Division Director of Hospital Medicine.

- This is a .40 fte Division Director and .60 fte clinical position with 34 physicians and 10 APPs on the team.
- Responsible for interdisciplinary collaboration, quality and financial performance of the division.
- Members of the HCMC medical staff hold academic appointments at the University of Minnesota and train over 200 medical students, residents and fellows annually.
- Candidates must be licensed in the State of Minnesota and board certified in Internal Medicine.
- Prefer MPH or MBA plus 5 years of experience post training.

Contact: Jerry.Hess@hcmcd.org • 612-873-7405



Full or Part-time Hospitalist

Encompass Physicians is seeking a Hospitalist to join our group based in Chicago, IL. Position includes rounding on daily census of approximately 10 patients, code/rtrts, intubation, and collaboration with ICU team.

- Flexible shift scheduling
- Productivity bonus
- Full benefits: PPO health insurance, dental/vision, retirement allocation, worker's compensation



Please send cv to encompassphysicians@gmail.com



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Hospitalist Position in North Texas - \$350,000

La Magna Health is a physician-led hospitalist group committed to providing excellent inpatient care with compassion, consistency and respect. We are locally owned and provide services at a 340 bed award-winning hospital located in Wichita Falls, Texas, and an easy drive to Dallas, Fort Worth and Oklahoma City. We were established with 26 physicians and 6 advanced practitioners serving 300,000 friendly Texans in a 9 county service area.

Compensation

- Full time: \$300,000 - \$350,000 a year

Shifts

- Day Shift: 7 on/7 off, 7 am-7 pm
- Swing Shift: Mon-Fri, 11 am-9 pm
- Night Shift: 7 on/7 off, 7 pm-7 am

Benefits

- Visa Sponsorship (all required filing fees and filing services covered)
- No call
- No procedures required
- Critical Care Code Team runs codes
- Open ICU with intensivists onsite 24 hours

Hospital

- H1-B eligible facility
- J-1 Visa eligible facility (2021 grad)
- Advanced technology
- Epic EHR
- Level II Trauma Center
- 80,000 ER visits per year
- Leapfrog 2018 Hospital Safety Grade "A"
- Not for Profit
- Local Board of Directors

Community

- Ranked 6th in the Nation for Best Cost of Living (Forbes Magazine)
- Ranked as Top 5 Cities in Texas for Working Parents (Credit Donkey)
- Ranked Top 10 in the Nation for Growth for Most Affordable
- Average commute to work is 10 minutes
- Exceptional public and private education

For additional information or to apply contact:

Natalie Stary, Physician Recruiter, 940-764-3016 (O), NStary@unitedregional.org
 Vicki Finnell, FASPR, Director, Physician Recruitment and Retention, 940-764-3028 (O), VFinnell@unitedregional.org



Hospitalists

Call This "Top 10" Community Home

McFarland Clinic is seeking a BE/BC Hospitalist and a Nocturnist to join our extraordinary team and provide exceptional care within Iowa's largest multidisciplinary clinic. Consistently ranked in the top 10 "Best Places to Live" by Money Magazine and CNNMoney.com, this thriving town has been ranked in the top 3 cities in the country for job growth.

- 220 bed hospital
- Epic EMR System
- Excellent support staff
- Highly educated patient base
- Physician owned and governed
- Large, established referral network
- One of the least litigious states in the country
- Will consider J1 candidates
- "#1 Best State to Practice Medicine" - *Wallet Hub*



Ames, Iowa is a family friendly town that offers top-quality education with the best school district in the state. This Big 12 city has been voted the "Best College Town" by Livability.com. Our proud community boasts the cultural, recreational and entertainment amenities of a big city while maintaining the charm that you would expect from small-town living. Become part of Ames, a place that will quickly become your hometown.

EEO/AA Employer/Protected Vet/Disabled

Contact **Doug Kenner**

866.670.0334 or dkenner@mountainmed.net



Extraordinary Care, Every Day

Washington University School of Medicine is seeking full-time hospitalists, nocturnists and oncology hospitalists for our expanding program at Barnes-Jewish Hospital and Barnes-Jewish West County Hospital. MD/DO, internal medicine board certification or eligibility, and eligibility for licensure in the state of Missouri required.

OFFERING

- Comprehensive liability insurance (no tail required)
- 403b Retirement, with match
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Barnes-Jewish Hospital is a 1,300-bed Level-I trauma center serving the St. Louis metropolitan and outlying areas. It is ranked as one of the nation's top 12 hospitals by *US News & World Report*.

All qualified applicants will receive consideration for employment without regard to sex, race, ethnicity, protected veteran, or disability status.

Interested candidates should apply: facultyopportunities.wustl.edu
 Select "Internal Medicine" and see "Hospitalist".



CALIFORNIA

Hospitalist and Intensivist opportunities available in the Los Angeles area. The City of Angels provides countless entertainment and cultural experiences and is host to professional sports teams. Northern & Central California opportunities also available.

For additional details contact:

Intensivist: Mimi Hagan mhagan@vephealthcare.com 925-482-8231
Hospitalist: Jennifer Scheetz jscheetz@vephealthcare.com 925-482-8235



Sunrise Medical Associates is looking for full time /part time Hospitalists to join our ambitious team in the Los Angeles and Inland Empire areas. Successful candidates will demonstrate skills in inpatient medicine and teamwork and be an MD or DO BE/BC in IM/FP. Great Incentives available. Please send CV to smamedoffice@gmail.com or fax to 951-339-8461 for consideration. (Multiple positions available)

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Opportunities in California



NORTHERN CALIFORNIA

HOSPITALISTS

- SMG is hiring Hospitalists in Auburn, Davis, Roseville, & Sacramento, CA. Ideal candidates must be willing to work a minimum of 4 night shifts per month.
- Nocturnist and Float Opportunities are also available.
- Flexible scheduling (17-18 shifts per month)

HOSPITALIST FELLOWSHIP

Sutter Medical Center Hospitalist Fellowship Program provides a rich educational with a core curriculum based on the Society of Hospital Medicine clinical core competencies. Fellowship applicants should have completed a Family Medicine or Internal Medicine residency program.

JOIN US AND ENJOY:

- Advanced practice technology, including EMR
- Base salary income guarantee, signing bonus, relocation assistance, and more for qualified roles
- Great benefits, including medical, dental, vision, and 401(k)

Send CV to: develops@sutterhealth.org | sutterhealth.org

ADVENTIST HEALTH PORTLAND

Adventist Health Portland is seeking a Board Certified internal medicine physician to join the OHSU-Adventist Hospitalist Service group in Portland, Oregon. Current residents planning to take the boards right after residency are also welcome to apply. The qualified candidate will join a practice of 21 Hospitalists who provide comprehensive inpatient care to all medical patients in the hospital. We have an open ICU and are looking for candidates excited about critical care and being the primary attendings for most medical ICU patients. The Pulmonary/critical care service is highly involved in the ICU and is available for assistance 24/7. The hospitalist candidate must be interested in procedures, occasional night shifts, and working 12-16 shifts per month. Our scheduling is not a set 7on/7off and offers some flexibility for physician preference.

The mission of those who serve at Adventist Health Portland is living God's love by inspiring health, wholeness and hope. Located in the magnificent Pacific Northwest, the Portland area offers a high quality of life, gorgeous scenery, a vibrant downtown, and year-round outdoor activities.

All inquiries will be kept in confidence. **This is not an H1B or J1 eligible opportunity.**

Candidates are strongly encouraged to submit a cover letter with the CV and application.

Adventist Health Portland is part of the OHSU Health System.

Additional Application Instructions

For more information, including other opportunities with Adventist Health, please contact our **Provider Recruitment Team** at **916-406-0121** or **phyjobs@ah.org**.

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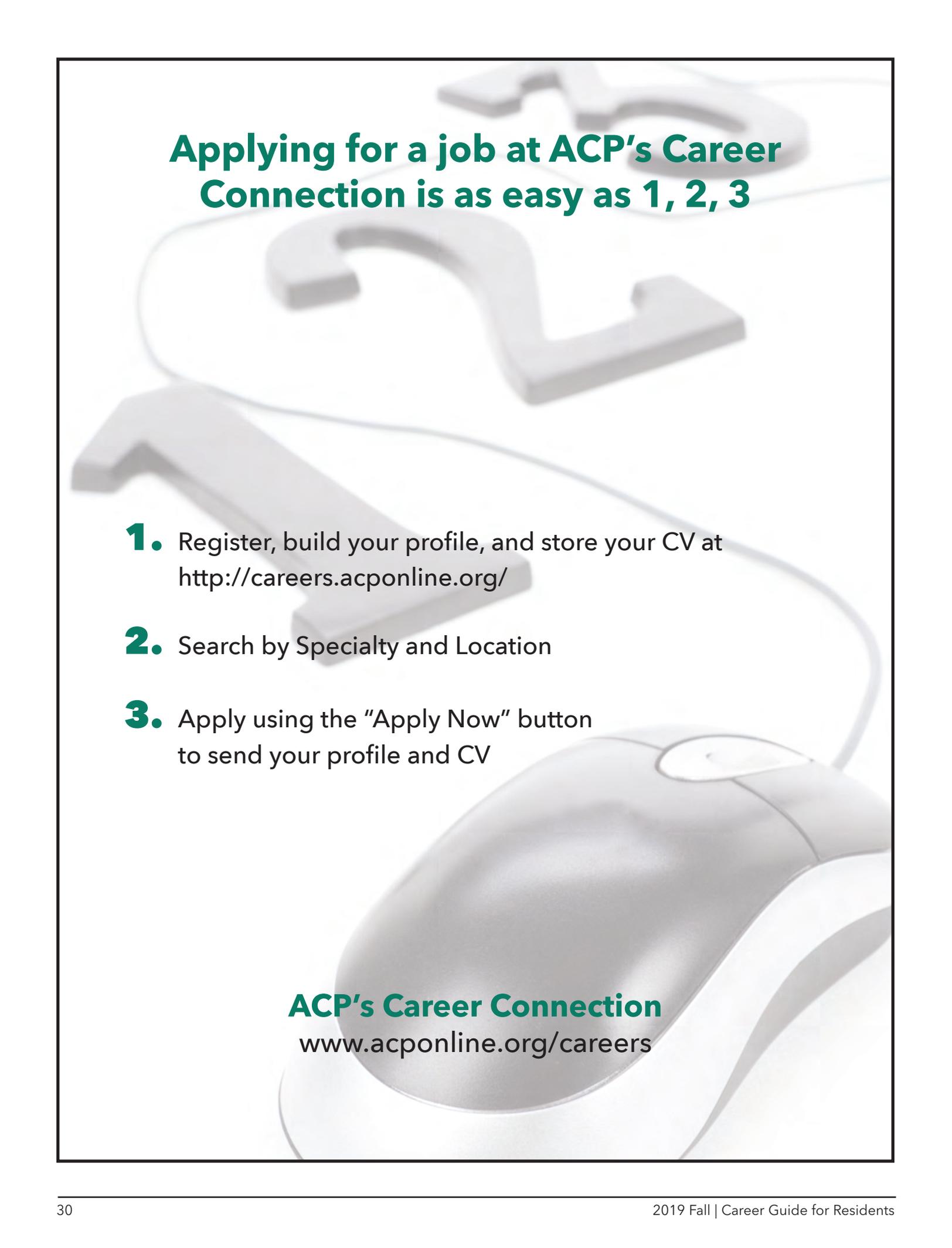
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The background of the slide features a soft-focus image of a computer mouse and keyboard. The mouse is in the lower right foreground, and the keyboard is visible in the upper left and middle ground. The overall aesthetic is clean and professional, with a light gray and white color palette.

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Primary Care Physicians

Orlando Health Physician Associates is one of the largest multi-specialty primary care groups with locations throughout Central Florida. This includes over 130 doctors practicing Family Medicine, Internal Medicine, Pediatrics and Obstetrics and Gynecology. As a member of the Orlando Health Medical Group, Physician Associates prides itself on providing high quality, easy access to healthcare for families.

We are seeking to hire primary care physicians to join our Orlando area practices. We are conveniently located with access to world class restaurants and entertainment, public and private schools, diverse neighborhoods, outdoor activities, beautiful beaches, and an international airport. Not to mention no state income tax! We offer a highly competitive salary package and our physician benefits package includes time away for vacations and meetings/conferences, health insurance, disability coverage and retirement savings options.

As a hospital owned medical group, we provide patient care services in collaboration with Orlando Health's network of 8 hospitals across Central Florida. Our physicians are committed to practicing collaborative, evidence-based care. Our practice model is patient centric. We offer strong administrative support and our physicians have autonomy when it comes to clinical decision making and day to day practice operations.

We are seeking candidates with the following qualifications for primary care:

1. Florida license
2. Graduate of a United States residency program
3. Active board certification.
4. Active DEA.

Want to know more about Orlando Health Physician Associates? Text **OrlHealth** to 25000 or visit www.orlandohealth.com/physicianrecruitment

Christian D. Mattila, MHRM, PHR, ASPR
 Physician Recruiter
 Christian.Mattila@orlandohealth.com
 Tel: 321.841.1790
 Fax: 321.843.1596



Metro/Portland, OR Vancouver, WA
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- Generous benefits including: health, dental, life, disability, and vision insurance, generous vacation allowance, CME reimbursement, 401K with company contribution, moving allowance, and much more
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Whether you are looking for a home on country acreage or a high rise condo downtown, Vancouver boasts excellent schools, an affordable cost of living, and ready access to both outdoor activities and world class arts and restaurants, minutes from downtown Portland.

We welcome the interested candidate to reply with CV, cover letter and salary requirements to jhemmer@creeksidemed.com



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Become a member of a well established growing team of 26 academic internists at Upstate University Medical Center, Syracuse, New York. If you enjoy mixing patient care with a broad array of teaching opportunities, or you're an excellent clinician looking for a change, consider joining our diverse group. Primary responsibilities will include direct patient care and supervision of residents at an outpatient ambulatory practice, inpatient service or both. Responsibilities also include teaching of students and residents. MD or foreign equivalent, BC/BE internist, NYS license or eligible. We are committed to high quality patient care, excellence in teaching and faculty development.

Send CV to Deborah J. Tuttle, PHR, SUNY Upstate Medical University, Department of Medicine, 550 East Genesee Street, Suite 201, Syracuse, NY 13202 or email to tuttled@upstate.edu SUNY HSC is an AA/EEO/ADA employer committed to excellence through diversity. Women and minorities are encouraged to apply.



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- Purely ambulatory practice with a Monday through Friday daytime schedule

Preadmissions

- Monday through Friday daytime schedule – no nights, no weekends, no call
- Work collaboratively with the support and collegiality of our anesthesiology, surgery, primary care, subspecialty consultative services, nursing and pharmacy teams to assess risk and medically optimize patients prior to undergoing procedures

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- Purely ambulatory (at our La Crosse, Onalaska or Boscobel, Wis. Clinics):
 - Monday through Friday daytime schedule. No inpatient work, minimal at-home call with no overnight coverage.
- Traditional/hybrid (outpatient and inpatient mix – La Crosse, Wis.):
 - When in clinic - Monday through Friday daytime schedule. No inpatient work, minimal at-home call with no overnight coverage.
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For more information, contact:

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Psychiatry	• Geriatrics
General Surgery	• Rheumatology
Emergency Medicine	• Neurology
Hospitalist	• Hematology/Oncology
Physician Assistants	• Nephrology
Nurse Practitioners	• Pulmonary / Critical Care

Please visit our web site for more information on positions in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming as well as the Cherokee Nation, Veterans Affairs, Indian Health Service and Saipan.

www.3rnet.org

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Visit our website at
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Please contact:
Jan Reid, Director of Provider Relations
(503) 221-0161 x4600
JReid@tpclp.com

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Visit www.parknicollet.com/careers
for complete list of opportunities.

North Carolina 

Hospitalists and outpatient internists needed in family community 35 minutes from Pinehurst, 45 minutes from Fayetteville and less than 2 hours from beaches, Raleigh, and Charlotte. Likely loan assistance.

For more information or to apply contact Melisa Ciarrocca by phone at 800-764-7497 or fax 910-291-7093 Melisa.

CALL 910-280-1337 or email Melisa.ciarrocca@scotlandhealth.org

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Cambridge & Somerville, MA**

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- CHA primary care clinics are NCOA certified level 3 Patient-Centered Medical Homes and our providers work in team based settings
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- Opportunities exist to teach medical students and residents from Harvard Medical School, and academic appointments are available for those meeting HMS criteria
- Competitive, guaranteed base salaries commensurate with experience
- Comprehensive, generous benefits package including health/dental insurance, retirement, generous paid time off, CME dollars/time, and more!

Please visit www.CHAproviders.org to review our available opportunities and apply confidentially. Candidates may also submit CV and cover letter confidentially to Melissa Kelley at ProviderRecruitment@challiance.org. CHA's Department of Provider Recruitment may be reached by phone at (617) 665-3555 or by fax at (617) 665-3553.

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

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For more information, contact **Danny Richardson** at (916) 691-3155 or CentralizedHiringUnit@cdcr.ca.gov · www.cchcs.ca.gov

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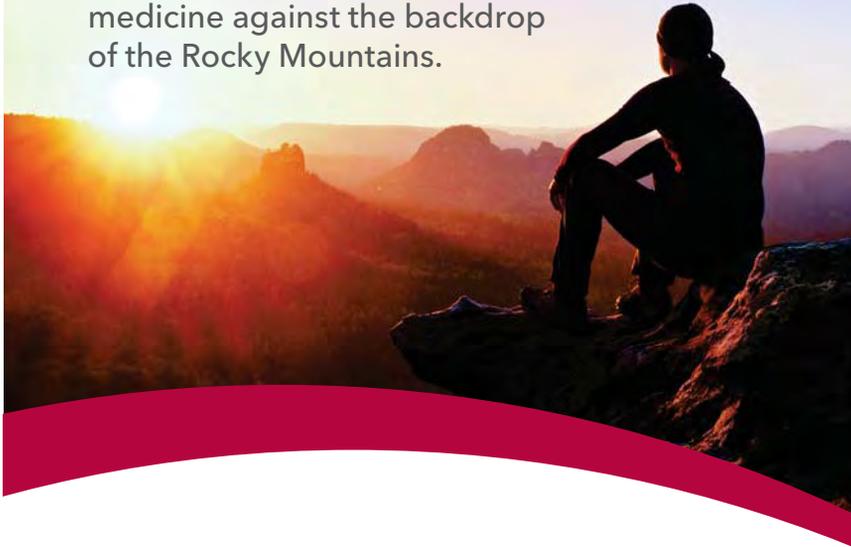
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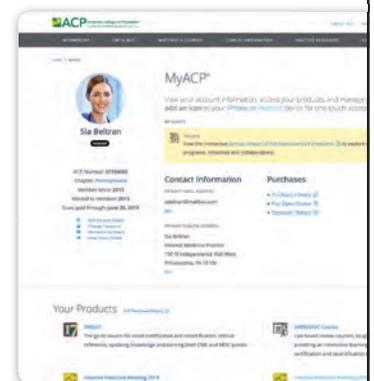
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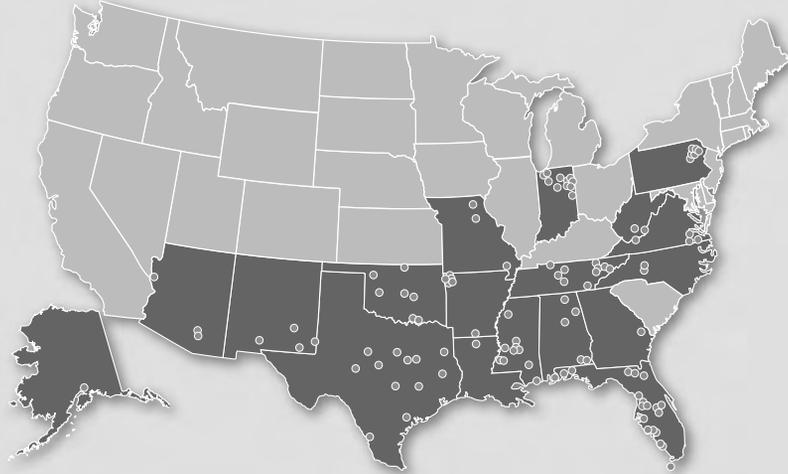


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- Hematology/Oncology
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- Infectious Disease
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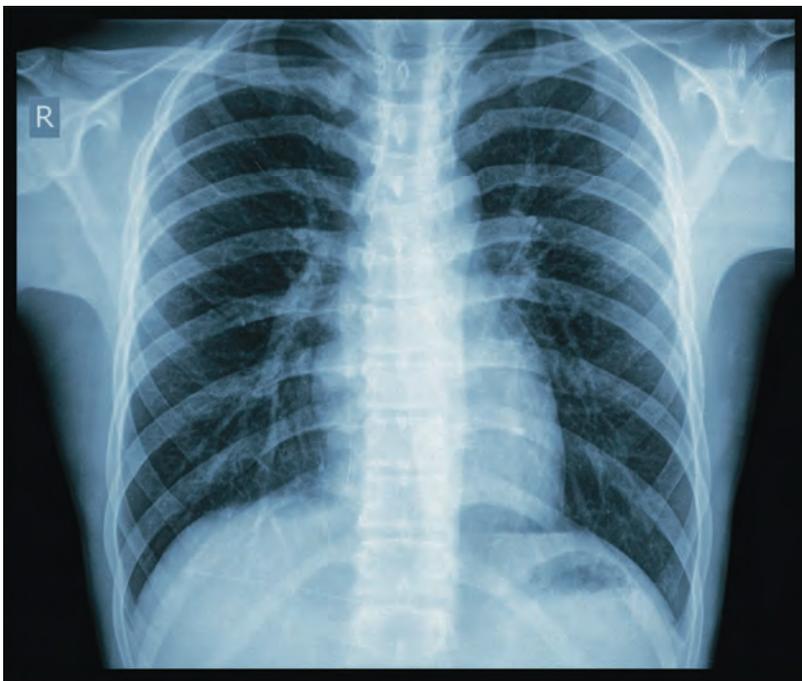
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