Gastroenterology
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# Gastroenterology compensation on the rise

## The future looks bright for the specialty

By Bonnie Darves

The combination of an aging population and a shortage of gastroenterologists are contributing to steady increases in compensation for the specialty, based on survey results. The trend shows no signs of abating, based on survey findings nationally.

Of the national surveys, the one conducted annually by the American Medical Group Association found the largest uptick in total compensation for gastroenterologists last year: 5%. From 2024 to 2025, the AMGA Medical Group Compensation and Productivity Survey, which represents more than 184,000 providers, found that median annual compensation for gastroenterologists rose from $603,157 to $633,422. In the previous year's AMGA survey, 2024 delivered an unusually high average compensation increase of 8.1% over 2023—from $557,914 to $603,157.

On a geographic level, the 2025 AMGA survey found significant average compensation differences across the regions, for the 2,040 gastroenterologists included in findings. Here is the breakdown:

North—$683,205
South—$646,456
East—$567,181
West—$627,306

The 2025 MGMA Provider Compensation survey, which reports data on more than 220,000 physicians and advanced practice providers (APPs) nationwide, found a smaller but still notable gastroenterology compensation increase of 0.90%—and an impressive 12.40% hike over the past five years. That steady increase, MGMA analysts noted, is even more positive in context: the pandemic resulted in a considerable decline and resulting backlog in two of the mainstays of gastroenterologist practice: colonoscopies and endoscopies.

That procedure backlog cleared for many GI practices in 2023, according to MGMA survey findings, but two years of lower volumes negatively impacted practice revenues and likely slowed income increases in the specialty. Analysts also noted that the increased use of noninvasive colorectal screenings, combined with fewer hospital consults during peak illness (flu and COVID) seasons, may have contributed to the lower demand for colonoscopies in 2023.

The 2025 survey conducted by Doximity, a digital platform whose physician members and contributors include approximately 80% of all U.S. physicians, reported average compensation of $537,870 for gastroenterologists last year. For pediatric gastroenterologists, average reported income was $298,457. Overall, adult gastroenterologists earned 80% more than their pediatric counterparts. In terms of pay gaps, the Doximity survey findings also illustrate the persisting pay gap between male and female gastroenterologists: women in the specialty earned $468,061, compared to $554,378 for men.

### Shortage driving salary upticks

On a surprise note, Doximity identified high demand for gastroenterologists who work as locum tenens; the survey listed gastroenterology as the seventh-most in-demand specialty.

Although the gender pay gap exists throughout the specialties, in most practice settings, the 2025 Medscape Physician Compensation Report found that the gap is shrinking in some specialties: last year, pay

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# Gastroenterologist compensation

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gaps under 10% were seen in 12 specialties, compared to only two in 2022. The Medscape survey reported average total compensation of $513,000 for gastroenterologists.

AMN Healthcare, which produces an annual compensation survey, reported a wide income spread among its gastroenterologist respondents, from $475,000 to $575,000 annually, with early-career gastroenterologists earning 15% to 20% less on average than their colleagues who have practiced 10 years or longer. ANM Healthcare's Gastroenterologist Salary Guide, released in 2025, predicts continued compensation growth in the specialty not only because of the aging population but also because of the shortage of gastroenterologists, and improved reimbursement rates and expanded coverage for certain preventive services.

That shortage has positioned gastroenterology as the second-most in demand specialty, after hematology/oncology, and is resulting in attractive signing incentives and bonuses, according to AMN Healthcare's 2025 Review of Physician and Advanced Practitioner Recruiting Incentives. That report found average starting compensation of $563,000 for non-academic gastroenterologists and included employment offers topping $750,000.

Physician Side Gigs, an organization that primarily focuses on physicians' sidelines as its name implies, regularly surveys its physician members on their practice compensation levels. Gastroenterologist respondents reported average compensation of $625,000, with median earnings at $600,000, for specialists who work full-time. The organization's data set shows the highest reported gastroenterologist compensation was $1.6 million, and the lowest $230,000.

In general, gastroenterologists who specialize in advanced endoscopy procedures reported higher income than their less-specialized counterparts per the Physician Side Gig data set. And expectedly, gastroenterologists in group practices (not private-equity backed) reported higher incomes—an average of $719,000—compared to their academic-practice colleagues, at $471,000. Hospital-employed gastroenterologists practicing in non-academic facilities had average compensation of $686,000.

## Productivity findings vary

If you ask gastroenterologists if they think they're working harder for their compensation than they did a few years ago, most would likely say yes. The survey findings, however, paint a mixed picture, based on tallied Work Relative Value Units (wRVUs), the most commonly used productivity measure.

The 2025 AMGA survey reported median annual wRVUs of 9,008, up from 8,868 in 2024, for an increase of 1.6%. From 2023 to 2024, however, gastroenterology productivity was up 11.4%. This may have been a bounce-back from the sluggish pandemic patient and procedure volumes. But overall, AMGA noted, the past three years have seen gastroenterologists' productivity increase at a faster rate (6.4%) when compared with other medical specialties (4.2%).

On a regional level, the AMGA survey found productivity based on average annual wRVUs highest in the South (10,050), followed by 9,018 in the West, 8,495 in the North, and 8,373 in the East. Compensation per wRVU did not follow suit; the West region led with $78.37, followed by $73.95 in the North. In the South and East regions, the figures were $66.26 and $65.48, respectively.

MGMA, on the other hand, reported a decline of -4.80% in median wRVUs for gastroenterologists in its 2025 survey. This might prove a single-year aberration going forward, as MGMA data shows that median wRVUs increased 22.99% from 2020 to 2024. Notably, gastroenterologists' compensation per RVU rose substantially last year, from $67.93 per RVU to $70.45 in the 2025 MGMA report.

In a recent gastroenterology webinar, MGMA analysts contended that although the procedure volume declines during the pandemic years accounted for the attendant decrease in gastroenterologists' wRVUs, specialists whose primary compensation component is a base salary likely fared better than some of their counterparts working under compensation models largely based on productivity. In short, the base salary worked as a buffer against caseload decline.

Overall, MGMA found that many medical groups continue to experiment with compensation models with the objectives of moving away from 100% productivity or 100% salary structures and incorporating more quality metrics. Those metrics are based on patient satisfaction, outcomes, and performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures, among other metrics.

While progress in tying care quality to compensation has been slower than experts projected, it's making headway. A recent MGMA Stat poll found that 50% of respondents said that their organization's compensation plan includes quality performance metrics. By comparison, the percentage of groups that used hybrid compensation models (that incorporate quality measures) increased from 26.08% in 2020 to 38.28% in 2024.

*Ms. Darves, editor of Gastroenterology Market Watch, is an independent medical writer and editor based in St. Petersburg, Florida.*

## PRACTICE PROFILE

# Houston Gastro Institute: Combining traditional practice with holistic approach

**By Bonnie Darves**

Vivian Asamoah, MD, founder of Houston Gastro Institute in Katy, Texas, didn't start out with the intention of building a non-traditional gastroenterology practice when she completed her fellowship at Johns Hopkins 13 years ago. It was, instead, her encounters with patients that prompted her to dig deeper into the root causes of their illness and to look beyond the pharmaceutical arsenal at her disposal for treatment, to develop a more integrative approach.

"It was an organic process, really. I started realizing the amount of time I was spending talking about nutrition and life-style and why those are important and can make a difference, and it occurred to me that I needed to offer a more holistic approach to diagnosis and treatment," Dr. Asamoah recalled, to help patients obtain not just near-term relief but long-lasting health improvements. "I realized that I couldn't just hand patients a sheet of paper and write a prescription, and then say good-bye."

Today, a decade after its founding, Houston Gastro has become a sort of poster child for the benefits of incorporating functional and integrative medicine in any specialty practice. Dr. Asamoah first embraced a personal learning curve—pursuing courses and certifications in integrative and functional medicine, and seeking counsel from one of her Hopkins mentors, Gerard Mullin, MD. Dr. Asamoah then built out a staffing model and patient resources to support her newfound knowledge.

The two-physician practice, supported by a team of advanced practice providers (APPs), has two registered dieticians and a nutritionist/wellness coach. The gastroenterology practice is insurance-based, and the Dr. Vivian Asamoah Integrative & Functional Medicine program operates separately as a self-insured entity.

Houston Gastro also offers workshops and seminars on common GI conditions that have proved effective in both helping her current patients and obtaining new ones. Dr. Asamoah also sometimes sees patients jointly with her nutritionists and dieticians. By offering community education and maintaining an active social media presence, and combining traditional care with integrative and functional medicine, Houston Gastro has become a sought-after resource.

> **"To build an integrative gastroenterology practice, I think you have to start with education because it's really lacking in our training as gastroenterologists. Take some courses or pursue certifications and really dive into it."**
>
> – Vivian Asamoah, MD, Houston Gastro Institute

"This is what patients are wanting now. They're kind of fed up with prescription medications. They're fed up with having to have disease before they get treated. They're very much into two things: personalized and customized approaches," Dr. Asamoah said, and they also want prevention and transformation.

That's a tall order, of course, but it's working for Dr. Asamoah and her staff. The practice is financially successful, and Houston Gastro also offers a cash-pay, concierge option for patients seeking highly personalized treatment and counsel. It's possible to offer both models side by side, she notes, but that becomes a sort of balancing act. The traditional insurance-based practice and procedures pays the bills and keeps operations and revenues steady and ensures that local patients of any means can seek treatment. The concierge program and the practice are primed for growth, and Dr. Asamoah is seeking like-minded. gastroenterologists and APPs to help expand.

Dr. Asamoah admits that some of her colleagues in traditional practice have at times called her (behind her back, mostly) on practicing what they consider "woo-woo medicine," but in recent years, that's happening less frequently, she suspects. "Today, I sometimes receive DMs (direct messages) from colleagues who want to know more about what I'm doing," she said.

For physicians interested in replicating her hybrid practice model, Dr. Asamoah cautions that it's important to legally separate the traditional and cash-pay components, per her attorney's advice. Dr. Asamoah also advises her colleagues who want to expand their practice's holistic scope to start with education in integrative and functional

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## DEVICE & TECHNOLOGY HIGHLIGHT

# iLivTouch®—Transforming liver disease management

For decades, liver biopsy has been the standard tool for diagnosing and creating treatment plans for the management of chronic liver disease. Unfortunately, biopsy has many recognized downsides and limitations. It's expensive, invasive, and prone to sampling errors and inter-observer variability. In addition, procedure complications, although relatively rare, can and do occur, and can be severe.

Serological tests developed to address biopsy risks and limitations have emerged as a less invasive alternative but produce inconsistently reliable results regarding fibrosis staging. In recent years, non-invasive imaging advances—such as transient elastography (TE), magnetic resonance elastography, and shear wave elastography—have emerged as a promising arena for improving liver disease staging and, by extension, long-term disease management.

In this article, Gastroenterology Market Watch looks at a relatively new technology that taps into advanced imaging techniques: the Hisky iLivTouch® Transient Elastography Technology. Gastroenterology Market Watch recently asked Ray Dong, MD, chief medical officer and co-founder of NexGen Therapeutics LLC, to provide his perspective on how iLivTouch®, an internationally patented mobile device, may benefit gastroenterologists treating chronic liver disease.

***Editor's note:*** *In this new, recurring feature, Gastroenterology Market Watch will highlight devices and technological developments that are expected to alter the day-to-day practice of gastroenterologists by improving diagnosis or management of the diseases and conditions that gastroenterologists treat.*

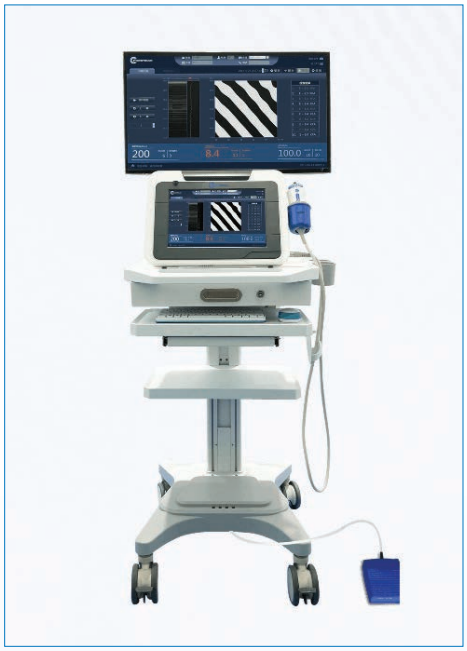
**Q: How did the iLivTouch® concept emerge, and how did its innovators take the concept from idea to market-ready device?**

**A:** The concept developed from the recognized need for a more reliable, non-invasive way to assess liver stiffness by using shear-wave velocity measurement. The iLivTouch® tracks propagation of a mechanically induced 50 Hz shear wave via a probe to allow qualitative evaluation of tissue stiffness throughout the liver—making it ideal in both the initial diagnosis and longitudinal monitoring settings. Its deliberate design, which ensures that the shear wave's propagation throughout the tissue is accurately captured, means that it's effective in evaluating fibrosis, cirrhosis, and steatosis.

The innovation that moved the iLivTouch® technology from concept to market readiness is its design as a mobile, user-friendly device that can be used in a variety of settings.

**Q: In the liver-disease diagnostic arena, what previously unmet need does the iLivTouch® fulfill—and why in your view does it break new ground?**

**A:** For years, the biggest challenge that gastroenterologists, primary care physicians, and endocrinologists faced was not awareness of transient elastography as a powerful diagnostic tool but rather access to it. FibroScan was the only widely available option, but its high cost, large footprint, and limited portability made it impractical for most non-hepatology settings. As a result,



many clinicians who wanted to screen and monitor patients with chronic liver disease could not integrate elastography into everyday practice.

Because iLivTouch® is compact and operator-friendly, it can be deployed in community clinics, not just tertiary hospitals. This increased access also enables scalability. At-risk populations—patients with obesity, diabetes, and metabolic syndrome, for example—can be screened and monitored more cost effectively.

For patients with liver disease, the technology's reproducible quantification of liver stiffness and fat content eliminates the need for many biopsies. For clinicians, the tool provides easy workflow integration, and because results are delivered quickly and seamlessly, physicians can make real-time decisions about referrals, interventions, and follow-up.

In short, iLivTouch® fulfills the long-standing unmet need for a non-invasive,

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# Transforming liver disease management

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accurate, and accessible liver diagnostic tool that bridges the gap between specialized hepatology practices and front-line care. This could potentially transform how clinicians detect and manage liver disease at scale.

**Q: In what treatment settings—academic, community practice, or both—might this device gain traction? What hindrances might there be to widespread use, if any, and how will those be addressed?**

**A:** I expect that iLivTouch® will gain traction in both settings. In academic centers, researchers and hepatology specialists will be quick adopters because the tool is ideal for clinical studies and patient stratification. It also offers an affordable complement or alternative to existing FibroScan units, thus expanding access for research and teaching.

The device's greatest disruptive potential is in community practices because specialists and primary care physicians can readily integrate elastography into routine visits without having to refer patients to tertiary centers.

As with any new device or technology, there are hindrances to widespread use. The chief ones are awareness and education: Many non-hepatologists are not yet comfortable with interpreting elastography data. To address this issue, we have created training modules and have built in robust clinical-decision support.

Another issue is reimbursement concerns—coverage for elastography varies by region and payer. We are countering this by publishing robust clinical validation data and supporting advocacy for broader reimbursement codes.

Finally, some institutions may be hesitant to shift from the long-established brand (FibroScan). We expect that by demonstrating equivalent or superior accuracy, ease of use, and cost-effectiveness through head-to-head studies, we will see organizations switch to iLivTouch®.

iLivTouch® is poised to gain traction in both academic and community settings, but its true breakthrough lies in democratizing elastography for everyday practice. We are confident that with education, supportive evidence, and favorable economics, the barriers to widespread use can be systematically overcome.

# CONTRIBUTORS WANTED!

**Gastroenterology Market Watch welcomes submissions of articles of potential interest to practicing gastroenterologists. We are particularly interested in opinion articles about how trends occurring in the gastroenterology marketplace or in the health policy arena might affect the practice environment.**

To discuss a potential idea, please contact Bonnie Darves at **bonnie@darves.net**

## CODING CORNER

# Maximizing reimbursement: detailed documentation is key

**By Angie Whitten**

When it comes to achieving maximum reimbursement for the services you provide to your patients, almost everything points back to the documentation. Have you heard the phrase, "If it wasn't documented, it wasn't done"? That old axiom still holds true today, in my experience. Comprehensive documentation is the basis for accurate billing and coding of office visits as well as procedures.

What I tell physicians is "paint me the prettiest picture you can." That might sound a bit odd when applied to medical care, but it's not. What it means is this: Be as detailed as possible in your documentation, so much so that almost anyone in the office can pull up your documentation and be able to discern how sick a patient is. This strategy leads to more accurate leveling of the office visit and could mean the difference between a level 3 office visit and a level 4 office visit—and in some cases, even a level 5 office visit.

If your documentation is vague and your descriptors of a medical illness/disease are incomplete, appropriate diagnoses can't be coded to the highest level of specificity. For instance, if a patient comes in for colonoscopy, and your documentation only states "three polyps found scattered in the colon," it's too vague. Because the specific location of polyps isn't identified, the procedure would have to be coded as K63.5 polyp of colon.

In contrast, if patient has a colonoscopy, and your documentation states "three polyps found in the colon, one in the ascending colon, one in the transverse colon, and one in the sigmoid colon. Pathology shows these to be adenomatous polyps," your documentation is both detailed and complete. We know what type of polyps they were, how many were found, and where they were located. These findings could now be coded to the highest level of specificity: D12.2 polyp of the ascending colon, D12.3 polyp of the transverse colon, and D12.5 polyp of the sigmoid colon. And because all were adenomatous, we would code based on the location of the polyp.

This not only helps with maximizing reimbursement but also helps avoid denials. Unfortunately, a lot of payors are denying claims submitted with unspecified codes. If patient comes in with right upper quadrant abdominal pain and you just document abdominal pain, what should be coded as R10.11 can only be coded as R10.9, which is an unspecified code. Thus, the claim has a greater chance of getting denied by the payor. As more and more specific codes are added every year, we see an increasing number of payors denying payment due to lack of specificity in coding.

Let's switch gears and look at who does your coding or reviews your coding. Are they capturing the codes supported by the documentation? Are they using R10.9, when the documentation clearly states "right upper quadrant abdominal pain"? When auditing provider documentation and comparing it to what was billed, we see this all too often.

A different, more problematic scenario is when no documentation is found to support what you claim you did. For instance, you or your coder bills for "EGD with biopsy, CPT 43239." When an auditor reviews the documentation, however, it only states "EGD performed through the esophagus down to the level of the duodenum." In this case, no evidence is provided that a biopsy was taken, except that a specimen was sent to

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**"Another way to maximize reimbursement and prevent billing errors so that claims go out clean the first time is to implement a checks-and-balances approach. This basically means that you have a process in place to ensure that an auditor reviews a specific percentage of charges on a regular ongoing basis."**

# Coding Corner

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pathology. Even with a pathology report, without the documentation stating that an EGD with biopsy was performed, only a simple EGD code may be billed. Even though the pathology report is available, the specimen isn't always accompanied by information describing how it was obtained; therefore, the auditor has no way of knowing if a lesion was biopsied or if it was removed in its entirety.

"Painting a pretty picture" (a detailed and accurate one) with your documentation and using descriptive words helps to clear up any confusion, cuts down on queries, and allows for maximizing reimbursement.

## Auditing is essential

Another way to maximize reimbursement and prevent billing errors so that claims go out clean the first time is to implement a checks-and-balances approach. This basically means that you have a process in place to ensure that an auditor reviews a specific percentage of charges on a regular ongoing basis. Auditors are trained to look for incomplete documentation, incorrect assignment of diagnoses and procedure codes, and improper use or lack of modifiers that are essential to ensuring proper reimbursement. Auditors can also provide necessary training or retraining of coders—and physicians—in assigning codes and identifying opportunities for more complete and proper documentation.

The goal should always be to send clean claims that have a smaller chance of getting denied when the payor receives them. Quality coding and auditing are essential.

It's also important to establish a process for routinely checking your office claim denial vs. acceptance rate. This provides a clear picture of the quality of coding and auditing in your practice.

Is your coding and billing performed by your computer software? If so, do you have human interaction to review that coding and billing for accuracy? Most software scans documentation looking for certain key words on which to base the level of visit to be billed. This can lead to both undercoding and overcoding, both of which are a problem. Undercoding leaves money on the table, and overcoding likely means paybacks, especially to Medicare and Medicaid. It's imperative to have an outside audit performed at least twice a year, or more frequently if the provider has low claim-acceptance scores on audit. In short, auditors function as a sort of insurance policy against both denials and paybacks. Having both comprehensive documentation processes and highly trained coders in place are essential in maximizing reimbursement.

*Ms. Whitten is a certified medical coder and auditor with over 30 years of experience in the medical field. She has extensive experience in many aspects of the revenue cycle, including 10 years as a Professional Coder and Auditor. She can be reached at Whitten.hismcas@outlook.com Angie Whitten, RHIT, CPC, CEMC, CPMA*

# Houston Gastro Institute

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medicine—and then seek out relationships with alternative medicine practitioners.

"To build an integrative practice, I think you have to start with education because it's really lacking in our training as gastroenterologists. Take some courses or pursue certifications and really dive into it," she said. And then start collaborating. "I think that collaboration is key in 2025, because being able to run a multidisciplinary team is the best kind of care for gastroenterology."

## Resources

**Functional Medicine**. The Institute for Functional Medicine provides certification and offers educational programs that are accredited by the Accreditation Council for Continuing Medical Education (ACCME). The Cleveland Clinic Center for Functional Medicine also operates a comprehensive program.

**Integrative Medicine**. In addition to the longstanding Andrew Weil Center for Integrative Medicine at the University of Arizona, several academic institutions, including Icahn, Beth Israel, and Northwestern, among others, now offer courses in IM, and the Institute of Integrative Medicine offers medical specialty-specific modules in GI health.

*Bonnie Darves is an independent Florida-based healthcare writer and editor and is editor of Gastroenterology Market Watch.*

# How to recruit new talent while retaining internal equity

By Katie Cole

The recent results of the 2025 physician compensation data reports clearly show that compensation continues to increase for gastroenterologists. What does this mean for internal equity within current GI practices? How do practices align new offers to be competitive and attract new talent with their existing employment contracts with GIs?

While attracting new physicians, it's crucial for practices to avoid losing their current staff by offering higher compensation to newly signed gastroenterologists than their current physicians receive. In a market that's undersupplied, gastroenterologists' salaries and compensation have continued to climb, as organizations struggle to attract prospective GIs.

Offers to new candidates must be competitive, of course, but it's also important to align offers with the terms and general framework and salary/compensation ranges in existing contracts. In the current information-accessible environment, it's prudent to assume that physicians' compensation data will get out into the marketplace—regardless of access constraints or requests that employed physicians refrain from sharing such data. And when those numbers become "public," organizations risk internal conflict at the least and potential loss of valuable physician team members.

When attempting to attract new talent, open-mindedness and flexibility are critical. Competitive compensation is a must for any GI seeking a new opportunity, but it's not the only important factor when a physician signs on with a new practice. After all, most specialists have either experienced or heard horror stories about high-paying jobs that turn out to be nightmares when the practice culture is toxic, or the productivity demands are unsustainable. If your compensation is competitive but on par with other offers your prospective GI is considering, be prepared to highlight positive attributes within the practice. Work/life balance is very important to many GIs, particularly those coming out of training. As such, if you can be flexible on schedule hours and how full-time commitments are configured, your offer can stand out and might be more competitive in the big picture.

How do you distinguish your practice from other gastroenterology practices and other potential employers? Organizations that successfully attract and retain talent do so by strategically communicating, both within the organization and in job posting, their market differentiating attributes and assets: These might be collegial culture, collaboration, community reputation, sub-specialty niche marketing, robust APP support, or any other factors that might be "soft" perks that physicians are seeking. In short, be clear and consistent regarding mission and values, and ensure that you always practice what you preach.

Lastly, when bringing on new talent and recruiting for open positions, include the current gastroenterologists in the process in a meaningful way. Make sure that contract provisions and promises made during the recruitment process are followed through, so that your current physicians can assure potential hires that the organization delivers on its promises.

**"In today's information-accessible environment, it's prudent to assume that physicians' compensation data will get out into the marketplace—regardless of access constraints or requests that employed physicians refrain from sharing such data. And when those numbers become 'public,' organizations risk internal conflict at the least and potential loss of valuable physician team members."**

*Katie Cole is the founder of Harlequin Recruiting, a boutique firm she has operated for more than 20 years, and publisher of Market Watch newsletters.*



# UPCOMING U.S. GASTROENTEROLOGY EVENTS

**The Liver Meeting 2025**
❏ November 7-11
Washington DC

**2025 Upper Gastrointestinal Malignancy Symposium**
❏ November 12
Danbury, CT

**1st Annual Digestive Health Symposium**
❏ November 15
Bellevue, WA

**Women in GI Regional Workshops**
❏ November 15
Boston, MA

**Liver Symposium 2025**
❏ November 21-22
Napa, CA

**Advances in Liver Disease 2025: A Year in Review + Update from AASLD The Liver Meeting**
❏ December 6
Philadelphia, PA

**2nd Annual NYC Pancreas Consortium**
❏ December 12
New York, NY

**Women in GI Regional Workshops**
❏ January 31
Atlanta, GA

**Orlando Live Endoscopy 2026**
❏ February 5-6
Celebration, FL

**Women in GI Regional Workshops**
❏ February 14
San Diego, CA

**Expert Strategies in Endoscopy, Gastrointestinal and Liver Disorders**
❏ March 14-15
Kansas City MO

**2026 ACG's Hepatology School & ACG/FGS Annual Spring Symposium**
❏ March 20-22
Naples, FL

**Digestive Disease Week (DDW) 2026**
❏ May 2-5
Chicago, IL

# UPCOMING INTERNATIONAL GASTROENTEROLOGY EVENTS

**Asia Pacific Digestive Week (APDW 2025)**
❏ November 18-22
Suntec, Singapore

**Egypt GastroHep 2025**
❏ December 11-13
Cario, Egypt

**2026 EASL Liver Cancer Summit**
❏ January 22-24
Edinburgh, UK

**Fibrosis: Cross Organ Pathology and Pathways to Clinical Development**
❏ February 2-5
Banff, Canada

**Canadian Digestive Diseases Week (CDDW) 2026**
❏ February 27-March 1
Toronto, Canada

▶ To submit Gastroenterology event in Gastroenterology Market Watch, please send details to Katie Cole at ***katie.cole@harlequinna.com***.

# Why your personal brand is your best investment

By Olivia Morris

While you're focused on treating IBD and screening for colon cancer, some of your GI colleagues are quietly building something else. They're becoming the names people know and the experts who are in demand. The opportunities are starting to find them, instead of the other way around.

It's because they stopped treating their personal brand like a vanity project, and that's putting them ahead of the pack.

## Let's talk about what's really happening

Gastroenterology is in trouble, and I'm not talking about patient volumes. You already know the numbers. Your specialty faces the second highest physician shortage in internal medicine, reimbursements for your core procedures keep dropping, and a third of gastroenterologists are burned out.

But while you're dealing with all of this, there are GI docs out there making thousands an hour for consulting, speaking at conferences, and advising companies. They're the ones who are building practices that patients drive long distances to reach.

They're not superhuman, they just understood something you might have missed.

## Patients changed the game without telling you

Remember when patients just went wherever their primary care doc sent them? Well, those days are mostly gone.

Today's patients research everything. They Google their symptoms, read about their conditions, and research their doctors before making appointments. They want to know who you are, what you've written, where you've spoken, and what other patients say about you.

If they can't find you online, they'll find someone else who took the time to be visible.

Today, 20 million Americans deal with chronic digestive diseases. They're not just looking for any gastroenterologist; they want the gastroenterologist who clearly understands their specific problem. The one who's talked about it, written about it, and built a reputation around it.

## Your expertise deserves to be known

You spent years learning to master complex procedures. You can diagnose conditions other doctors miss, and you have probably saved more lives than you can count. But if nobody outside your immediate circle knows what you're capable of, you're essentially invisible.

This isn't about ego; it's about maximizing impact and opportunity. For example:

- When pharmaceutical companies need advisors, they don't search hospital directories.
- When medical device companies want thought leaders, they look for physicians who've established themselves as experts.
- When patients need specialists, they research who's talking about their condition with authority.

Building your personal brand isn't about becoming an influencer or abandoning clinical medicine. It's about making sure that your expertise gets the recognition that it deserves and the reach that it could have.

## The practical reality

Your clinical skills got you to where you are now. But in today's healthcare environment, clinical skills alone aren't enough to build the practice you want or access the opportunities you deserve.

Whether you're interested in growing your patient base, attracting better referrals, speaking at conferences, consulting with industry, or just having more control over your professional trajectory, it all starts with the same foundation. People need to know who you are and what you do exceptionally well.

> **"Building a personal brand doesn't require you to become someone you're not or spend hours creating content that you don't care about. It requires you to be intentional about sharing the expertise you already have."**

This is especially true in gastroenterology. Your specialty naturally lends itself to patient education, research discussion, and industry collaboration. You treat conditions that patients actively learn about. You perform procedures that require explanation, and you manage diseases that benefit from ongoing communication.

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# Personal brand

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## Start where you are

Building a personal brand doesn't require you to become someone you're not or spend hours creating content that you don't care about. It requires you to be intentional about sharing the expertise you already have.

Maybe you're particularly skilled with inflammatory bowel disease management or you've mastered advanced endoscopic techniques. Perhaps you're the physician other doctors call when they have complicated cases.

Whatever your strength is, there are patients who need to know about it, colleagues who could learn from it, and organizations that could benefit from it.

The physicians who are thriving in gastroenterology today aren't waiting for the healthcare system to fix itself. They're not hoping reimbursements will improve or administrative burdens will lighten. They're building their own platforms and creating their own opportunities.

Your expertise is valuable. The question is whether you're going to make sure the right people know about it. In my articles, I'll help you develop your platform and get where you deserve to be.

*Olivia Morris is co-founder and chair of Verity Barrington, an international healthcare consulting firm, and creator of the Physician Branding Program. With more than 20 years of experience in business, she has personally guided hundreds of physicians through career transitions, brand development, and business growth, helping them move from being invisible experts to recognized authorities in their fields.*

*Through her Physician Branding Program, Olivia has helped physicians secure competitive consulting opportunities, speaking engagements, and industry partnerships. She has helped physicians build practices that patients actively seek out. Her clients regularly report increased referrals, enhanced professional opportunities, and greater control over their career trajectories.*

*Olivia offers personalized branding and career strategy sessions. Connect with her at olivia@veritybarrington.com or learn more about the Physician Branding Program at https://www.veritybarrington.com/physicianbranding*

## GASTROENTEROLOGY JOBS

Walla Walla, WA

Napa, California

Tarboro, North Carolina

Rio Rancho, New Mexico

Fullerton, California

Baltimore, Maryland

Greenville, North Carolina

Albuquerque, New Mexico

Saginaw, Michigan

Nags Head, North Carolina

Houston, Texas

Baltimore, Maryland *(Pediatric)*

Santa Fe, New Mexico

Houston, Texas *(Advanced)*

Tampa, Florida

Spokane, Washington

Eureka, California

Farmington, New Mexico

Allentown, Pennsylvania

Amarillo, Texas

Geneva, New York

Conway, South Carolina

Midland, Michigan

Albuquerque, New Mexico *(Pediatric)*

Roanoke Rapids, North Carolina

▶ For more information on these positions, or if you are interested in hiring a gastroenterologist for a permanent position, please contact katie.cole@harlequinna.com or call 303-949-4020.

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PO Box 396
Severna Park MD 21146

# FEATURED OPPORTUNITY

## Queen of the Valley Medical Center in Napa, California

Queen of the Valley Medical Center in Napa, California, a Level III trauma center, is seeking a BE/BC gastroenterologist to join their team. The department will consider both experienced GIs as well as graduating fellows. ERCP is preferred.

The incoming Gastroenterologist will have a mix of outpatient and inpatient practice. Call duties are shared within the department, and amount to seven to 10 days of call per month. Clinic hours are Monday to Wednesday 8 a.m.-4 p.m., and the OR schedule is Thursday and Friday from 8 a.m.-4 p.m. The practice has full APP support.

The facility will provide a generous compensation package including salary (the range is $614,000-$679,000), and five to six weeks annually of time away from practice for vacation/holiday/CME time. A shareholder-track opportunity is available starting in year three, with additional perks and annual bonuses worth more than $1 million over the course of a full career.

The facility will provide a generous, multiyear sign-on bonus and relocation assistance package, and a residency/fellowship stipend and robust student loan repayment program is available for qualifying candidates. The residency/fellowship stipend is up to $2,000 per month, and a robust student loan repayment program may provide up to $120,000 for qualifying candidates. In addition, Providence Medical Group providers are eligible for the federal Public Service Loan Forgiveness (PSLF) program.