

## EXPLORING GI LOCUM TENENS PRACTICE

*Gastroenterologists at all career stages are discovering the advantages—and occasional challenges—of the peripatetic life-style*

BY BONNIE DARVES

When Nina Nandy, MD, FACG, took her first locum tenens assignment in 2021, it wasn't part of some long-considered master plan. The Austin, Texas, based gastroenterologist, who completed her fellowship in 2017, was primarily curious—a colleague recommended she try it out, and she was intrigued.

That initial experience proved positive, and it planted a seed. "I had thought that I would practice academic medicine forever," Dr. Nandy said, "until I tried locums." Her CV—a litany of accomplishments starting with the American College of Gastroenterology's Young Physician Leadership program, an American Gastroenterological Association's Young Delegates award,

avid traveler and serious kayaker who speaks six languages and travels with her cat. "It's fun, because I get to go to towns that I've never visited and explore different geographies. Locums also enables me to spend time taking care of my parents and brother at home in between assignments."

These days, she works one or two weeks a month in a circuit that to date encompasses a handful of states. And that feels about right, for now. "I love gastroenterology, and I enjoy it even more now than I did when I was working full-time and feeling stressed out," said Dr. Nandy, whose professional interests include obesity medicine, Ayurvedic medicine, and women's health.

**"You're paid fairly, and you get to just show up and work. People are overwhelmingly grateful because they really need you. That's not something you hear every day in your regular job."**

- NEAL KAUSHAL, MD, MBA

and a longstanding stint cohosting the AGA's "Small Talks, Big Topics" podcast—suggested a beeline toward a top leadership role.

Five years after that first locums assignment, however, the nomadic life-style has in fact become her professional life and the ideal vehicle for accommodating her professional and personal objectives. "It's a great fit for me, and it has given me more time for my passions," said Dr. Nandy, an

For Neal Kaushal, MD, MBA, the foray into locums started "inadvertently," as he puts it. "It wasn't a goal, but I was in my first job and wanted a change because I felt I was outgrowing it," said Dr. Kaushal, who is division chief with INTEGRIS Health in Oklahoma and who operates a technology consulting company.

"Locums gave me a way to explore what's out there, and once I started working in the model, I discovered that I liked it," Dr. Kaushal said, who practices locums

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## LOCUM TENENS PRACTICE

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one week in six. “You’re paid fairly, and you get to just show up and work. People are overwhelmingly grateful because they really need you. That’s not something you hear every day in your regular job.”

Dr. Nandy concurs on the gratitude benefit of working locums. “People are mostly happy to see you because they have patients who have waited a long time for a procedure,” she said. She added that she has had very good support staff everywhere she has worked.

Besides the flexibility that locums offers, the diversity and volume of opportunities is highly appealing, both Dr. Kaushal and Dr. Nandy report. “You really can pick your assignment type—inpatient, outpatient, procedures, or a mix. And if you have a niche interest, you’ll find an opportunity for it,” Dr. Nandy said.

### UPSIDES AND DOWNSIDES

Of course, both Dr. Nandy and Dr. Kaushal acknowledge that locums practice isn’t always a bed of roses, even if the opportunities are plentiful and appealing. Travel is often arduous. Assignments occasionally get cancelled. Credentialing and licensure take time—up to several months depending on the state and the situation—and can cause start-date delays. Adapting to new systems and equipment can be challenging, and call duty can be extensive—and exhausting. “It won’t really matter that you’re in the middle of the wine country if you’re on call 24/7,” Dr. Kaushal said.

Despite the drawbacks, locum tenens gastroenterology practice in experiencing a major boom, largely for demographic and logistical reasons. The specialty is in a severe shortage state, and nearly half of U.S. gastroenterologists are approaching retirement age.

About 6% of gastroenterologists are currently practicing locums, but that figure is expected to increase to 10% in the next few years, per a recent report. Harish Gagneja, MD, who is vice-chair of the ACG’s Board of Governors, predicts that as hospitals struggle to

fill the coverage gaps resulting from community gastroenterology practices declining hospital duties and avoiding call, locums opportunities will increase in tandem. Dr. Gagneja doesn’t practice locums but is well versed in the model. He is currently working with a group of colleagues to help hospitals operate effective locums programs, and that group is also developing a forum for gastroenterologists to share experiences.

**“Right now, GI is one of the hottest specialties in the marketplace. Locum tenens used to be a stopgap—for people in between jobs or approaching retirement—but that’s no longer the case.”**

- RONALD WILSON, VISTA STAFFING

One driver in the growth of GI locums is the rapidly increasing demand for care as the population ages and cancer screening has been expanded to include younger patients. And even though the pandemic-induced procedure backlogs have long since been cleared, demand for procedures remains high—and shows no signs of abating.

This bad news is actually good news for gastroenterologists who want to explore locums, according to Ronald Wilson, director of operations for Vista Staffing, a national recruitment firm. “Right now, GI is one of the hottest specialties in the marketplace. Locum tenens used to be a stopgap—for people in between jobs or approaching retirement—but that’s no longer the case,” said Mr. Wilson. “It has become popular with physicians at all stages of their careers, for either part-time or full-time practice.”

Wendy Beesley, a national recruiter at CompHealth who specializes in gastroenterology, anesthesiology, and OB/GYN, reports that her company is encountering more younger gastroenterologists trying out locums than in the past—for a variety of reasons. “Fellows and newer gastroenterologists are

getting into locums now because it allows them to practice in different settings before they settle into their careers,” she said. Others are seeking better work-life balance—or just an opportunity to work less than full-time.

Younger gastroenterologists also appear to enjoy the travel opportunities, Ms. Beesley said, after their long years of training. One young gastroenterologist, she recalls, recently admitted that even though he had

seen a lot of the world, he had only been in four U.S. states. He chose locums practice so that he could explore his own country. Ms. Beesley noted that her company is now conducting a study to look at the career junctures at which gastroenterologists choose to practice locums.

Richard Heim, chief executive officer of LocumsPro, observes that many early-career gastroenterologists are getting into locums because it’s both highly flexible and potentially lucrative. “They understand that they can make pretty good part-time money working locums—and might earn 20% to 30% more than they would in traditional practice, without the hassles and the overhead,” he said. Older gastroenterologists closing in on retirement cite the same benefits, Mr. Heim said. “They still want to practice,” he said, but don’t want to deal with the attendant political, staffing, financial, and operational issues.

### WHAT TO KNOW BEFORE YOU GO

For gastroenterologists who want to try out locums practice—or even consider making a wholesale switch to the alternative model—there are numerous

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considerations to address before taking an assignment. The sources who participated in this article offered a range of guidance and tips.

**Figure out if it’s a good personality fit.** Locums is not for everyone, several sources acknowledged. Flexibility, self-assurance, and the ability to fit in to a wide range of environments are musts, for starters. “Being a locums isn’t always easy. You have to be able to walk into a new place, with new systems and new people, and be ready to work at more than 100%,” said Dr. Kaushal. “It can be a lot of pressure.”

Dr. Nandy reminds her colleagues that they’ll need to keep track of a considerable amount of paperwork as they move from one assignment to another—case logs, Medicare numbers, credentialing and licensure status, and CME requirement status in the states where they practice, to name a few. Mr. Nelson noted that many locums physicians who travel among several states hire a personal assistant to help them keep track of the details.

Because locums work is effectively self-employment, gastroenterologists must also be willing and able to handle the extensive paperwork and tax implications that self-employment entails. Gastroenterologists who plan on working locums extensively or in a full-time capacity should also determine whether it makes sense to establish their own business entity, such as an LLC, Dr. Gagneja said.

**Know what you’re getting into before accepting an assignment.** Understanding the compensation and assignment length (which can range from a week to several months) are important, of course. But it’s also advisable, sources said, to get a firm handle on the practice environment: the level of nursing or advanced



practice clinician (APC) support, call expectations, anesthesiology protocols, back-up procedures in place if things go haywire in the middle of the night, and of course, how liability is handled. Most locums companies or hiring entities provide malpractice, but coverage structures can vary.

Locums companies typically handle the lodging and travel details. But if gastroenterologists have specific needs or housing preferences, they should ensure that those are addressed before making a commitment.

Ideally, physicians exploring their locums options should insist on being connected to a colleague who is working at the hospital or practice, to gauge the situation and working environment. Gastroenterologists should consider making a call themselves if that connection isn’t readily offered.

**Have a legal professional review the contract.** Dr. Gagneja reminds

gastroenterologists that even if they’re considering a short-term assignment, they must understand their requirements as outlined in the contract and have an experienced attorney review the document. For example, physicians should know how many hours are included in the base daily compensation rate (a typical payment structure) before overtime begins, and what the hourly rate is for overtime if it’s needed.

In addition, gastroenterologists should clearly understand any post-assignment responsibilities and protocols, such as who reviews pathology results, who follows up with patients, and whether the locums physician will be paid for work that must be done after the assignment ends. It’s also important to know what happens if an assignment is cancelled on short notice or, conversely, if the physician either needs or wants to leave an assignment before the end date.

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

**“Fellows and newer gastroenterologists are getting into locums now because it allows them to practice in different settings before they settle into their careers.”**

- WENDY BEESLEY, COMPHEALTH

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BY BONNIE DARVES

Sometimes an innovation arises out of either an aha moment or a dawning realization. Other times, it emerges in response to a vexing problem in need of a solution. Sometimes, it's a mix of the two.

At Capital Digestive Care in Chevy Chase, Md., frustration with a restrictive and clunky reimbursement system that stymies patient care for a vulnerable population—patients with complex irritable bowel disease (IBD)—prompted Erica Cohen, MD, an IBD trained specialist, to research options for improvement. Her objective was twofold: She wanted to both reduce reliance on fee-for-service (FFS) billing based on the episodic office-visit structure and develop a care model that permits the continuity and accessibility that patients with chronic disease need—and deserve.

The solution that emerged, the Centers for Medicare & Medicaid's Chronic Care Management (CCM) program, was surprising on some levels. Most physicians don't expect to find a care-improvement model or a means of streamlining reimbursement in a government program. But that's what happened at Capital Digestive Care. CCM, which provides coverage for patients with two or more chronic conditions, enables practices to bill for the numerous non-face-to-face activities

that support continuous, supported, and multidisciplinary care. These activities include coordinating with other specialists, managing flare-ups in real time, dealing with the administrative burdens of the prior process, and helping patients address the life-style factors and emotional issues that attend chronic disease.

Today, the program, started in March 2023, includes 55 active patients and 100 patients who have gone through the program—and is scaled to readily expand to accommodate 100 additional patients as awareness increases. The broader Capital Digestive Care network includes more than 20 office locations and several outpatient surgery facilities and infusion centers in the mid-Atlantic region. The results have been dramatic: patients are both pleased and relieved to have ready access to a dedicated care team, outcomes are improving, and overall staff satisfaction has improved.

In addition, the team-based approach that underpins the CCM program has proved valuable as a mechanism for efficiently spreading the work among team members. And because of the program's largely virtual nature, the practice has decreased portal messaging time and freed up clinic space to accommodate

more patients in the clinic—largely through the more systematic processes that have improved access.

Gastroenterology Market Watch recently spoke with Dr. Cohen and the program's co-lead, Kristin Attiogbe, CRNP, about the IBD program's development and evolution, and its prospects for growth and replication.

## Q. HOW IS YOUR IBD PROGRAM STRUCTURED, AND HOW DOES IT ADDRESS PREVIOUSLY UNMET NEEDS?

**A.** Our multidisciplinary team includes a supervising gastroenterologist, a nurse practitioner, a nutritionist, and a social worker. The CCM model enables us to use CMS codes to bill for the considerable and usually unreimbursed time spent on care coordination and other activities—a frequent challenge for gastroenterologists when they provide non-procedure care. The FFS model disincentivizes this kind of care, yet it's essential to helping patients manage their complex disease.

Patients who are eligible for CCM typically include those with both IBD and other chronic conditions, and patients must have at least two chronic conditions to qualify. Examples include ulcerative colitis with iron-deficiency anemia, IBD with malnutrition, Crohn's with depression or anxiety, and IBD with steroid-induced complications like weight gain, high cholesterol, or fatty liver. Patients are eligible if their chronic conditions are expected to last one year or longer.

Our program essentially functions like a lower-cost concierge model with individualized care plans, because enrolled patients have 24/7 access to a care team member. Triage is conducted systematically, and Kristin coordinates care with the primary gastroenterologist and other specialists. We hold weekly multidisciplinary meetings to review patients' care and progress, and to identify issues that might require additional attention. Patient interactions

are documented in 20- to 30-minute increments, for billing purposes.

## Q. HOW LONG DOES IT TAKE TO SET UP A CCM PROGRAM, AND HOW WOULD YOU CHARACTERIZE THE RESULTS OF YOUR IBD PROGRAM SO FAR?

**A.** Practices should expect it to take about six months to set up the program and incorporate the other care providers. Practices could probably set up a program in three months, if they sought the expertise of a practice that has a CCM model in place. The key implementation components include EMR templates for proper documentation, a physician and nurse practitioner or advanced practice provider to champion the program and oversee the team, and dedicated billing oversight to manage the specialized codes. The coding can be cumbersome initially but gets easier over time. Practices also must establish their 24/7-access protocols.

Patients have consistently reported high satisfaction with the program. We heard from several new patients that they previously felt that their care was inadequate or haphazard, and that they're relieved to find a practice that recognizes and addresses the many debilitating issues that they face with their condition. What we've seen is that early enrollment of newly diagnosed patients can be particularly life changing, helping them to manage the disease therapeutically, emotionally, and nutritionally before complications develop.

On the operational level, our program streamlines billing for enrolled patients—CMS pays the practice and we, in turn, pay the affiliated providers. It's important to note that not all carriers cover the program—some commercial payers and some federal plans don't participate—but most practices likely have a sufficient

number of IBD patients to make CCM viable economically.

On the clinical side, the CCM program is also beneficial and gratifying for APPs. It gives them a practice niche and a career path with leadership potential, and a way to get involved on a national basis within their professional organizations to share their expertise.

Once APPs become comfortable with the system, they can manage approximately 150 patients at a time. Patients who achieve healing or complete the program cycle can “graduate” out of the program and still remain patients in the practice.

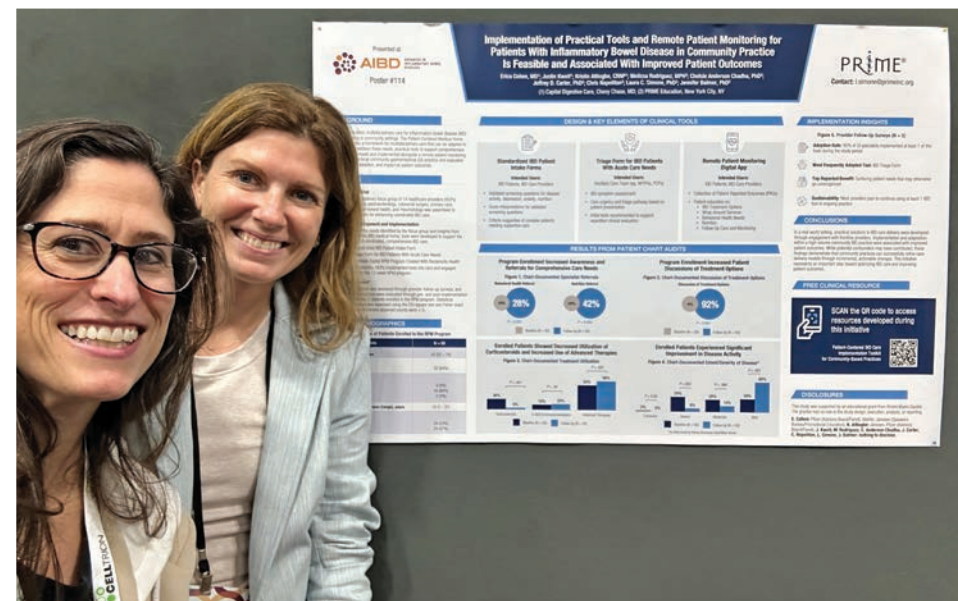
## Q. WHERE DO YOU SEE THIS CCM MODEL GOING IN THE FUTURE—FOR YOUR PRACTICE AND OTHERS THAT DECIDE TO REPLICATE IT?

**A.** Our program has already expanded to a second location in Rockville, Md., and we're currently working on marketing initiatives to increase patient referrals from other sources. Even though there are outside companies providing CCM services, it's beneficial, in our view, to maintain the system in-house. This helps build patient trust and also boosts practice branding.

Because of our program's success, we are now collaborating with the American Gastroenterology Association to study the financial feasibility, clinical outcomes, and qualitative benefits for providers and patients.

Based on our experience, this model could work well with many diagnoses both within and outside gastroenterology, where complex chronic conditions coexist.

Bonnie Darves is a Florida-based healthcare writer and editor.



Erica Cohen, MD, and Kristin Attiogbe, NP, co-lead Capital Digestive Care's successful IBD program.

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- › Manhattan, New York
- › Walla Walla, Washington
- › Napa, California
- › Tarboro, North Carolina
- › Newark, New Jersey
- › Rio Rancho, New Mexico
- › Orange County/ Fullerton, California
- › Baltimore, Maryland
- › Greenville, North Carolina
- › Albuquerque, New Mexico
- › Saginaw, Michigan
- › Nags Head, North Carolina
- › Fredericksburg, Virginia
- › Houston, Texas
- › Baltimore, Maryland (Pediatric)
- › Santa Fe, New Mexico
- › Houston, Texas (Advanced)
- › Tampa, Florida
- › Spokane, Washington
- › Eureka, California
- › Farmington, New Mexico
- › Clearwater, Florida
- › Allentown, Pennsylvania
- › Amarillo, Texas
- › Geneva, New York
- › Conway, South Carolina
- › Tampa, Florida
- › 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](mailto:katie.cole@harlequinna.com) or call 303-949-4020.

## MEDICARE PAYMENT SHIFTS SHAKE UP GI REIMBURSEMENT

Depending on how to look at it, and how your gastroenterology practice's volumes and patient mix break down, the changes in how Medicare reimburses GI services will surely cause confusion at the least and possible revenue losses for gastroenterologists this year. Starting in 2026, physicians will see a positive update to the Medicare Conversion Factor (CF), from \$32.3465 in 2025 to \$33.4009 this year 2026—a 3.26% increase.

While that's good news, that benefit could be offset by the other change the Centers for Medicare and Medicaid implemented this year: a 2.5% cut to work relative value units (wRVUs) for endoscopy and other non-time-based codes. The rationale for the cuts—that physicians have gotten more efficient over time and that the current RVU codes don't reflect that—is underinformed and misguided, according to the American College of Gastroenterology (ACG), and

has been roundly criticized by medical professional associations.

The only silver lining is that the 2.5% pay cut doesn't apply to evaluation and management (E/M) services—which account for an estimated 20% Medicare Part B allowed charges. As such, practices with a substantial focus on chronic-care management will be less affected by the reduction, according to the ACG.

## GI BURNOUT—NEARLY HALF OF GASTROENTEROLOGISTS AFFLICTED

A systematic review of burnout in gastroenterology and endoscopy published by the United European Gastroenterology Journal last year reported a burnout rate of 45% among GI physicians and an emotional exhaustion prevalence of 31%. The meta-analysis of 22 studies, some as recent as 2024, included 8,124 participants. The study also reported that 25% of GIs claimed a low sense of personal

accomplishment, and that fully 23% reported feelings of depersonalization.

The analysis found that female gastroenterologists and endoscopists are 60% more likely to experience and report burnout than their male colleagues, a finding borne out in numerous specialties characterized by intense time demands and high procedural workloads. Study

authors Mohamed Shiha et al concluded that the high prevalence of burnout noted that despite the heightened anxiety gastroenterologists experienced during the COVID-19 pandemic burnout prevalence did not increase in tandem. That suggests, according to the authors, that burnout likely stems from deeper systemic causes such as sustained workload pressures and lack of organizational support.

## MEDSCAPE: GI PRACTICES WEATHER CHALLENGING TIME

Reimbursement woes, administrative hassles, paperwork burdens, and short staffing are all causing GI practices headaches as they try to stay ahead of what feels like a nonstop influx of new patients during a period of rising operational costs, according to the Medscape 2025 Gastroenterology Practice Issues Report. Issued last December, the report found that 46% of gastroenterologists surveyed cited declining reimbursement as having “considerable financial impact” on their finances, and 38% reported rising staffing costs as significantly affecting their finances. The latter issue is somewhat

of a double whammy, as about a third of GIs report persisting challenges finding and hiring enough medical assistants and nurses to expand patient volumes.

In terms of GIs' workload, eight in 10 survey participants cited increased administrative work for physicians over the past three years and 43% cited “significant increases.” Some respondents spend two or more hours a day outside of clinic answering nurses' and patients' questions or pushing back on insurers denying diagnostic testing—a chief source of professional dissatisfaction. About 60% of total respondents practice

in office-based solo, single-specialty, or multispecialty groups, and nearly 80% practice in urban or suburban areas.

The Medscape report wasn't all bad news. While most respondents aren't expecting AI to become a magic bullet that streamlines operations and eradicates administrative inefficiencies, some have begun implementing AI with modest results. Ambient AI to the rescue? Not quite, but 31% of GI practices surveyed reported that ambient AI has “somewhat” or “substantially” increased efficiency and productivity by reducing documentation fatigue.

## WHY USING A SCREENING DIAGNOSIS IS IMPORTANT

BY ANGIE WHITTEN



When a patient comes in for a colonoscopy, you, the physician, have to determine if it is a routine screening, a surveillance procedure because of an identified risk, or part of a workup to ascertain whether the patient has a medical problem. Recently, I encountered a group of physicians who were not always using a screening diagnosis code (Z12.11) for high-risk Medicare patients. This results in incorrect payments for the colonoscopy procedure and may result in patients encountering higher out-of-pocket costs.

In my research, I discovered, by reviewing a broad range of sources, how important it is to code screening and surveillance colonoscopies using Z12.11 as the primary diagnosis. The main reason to do so is not to ensure that the claim will get paid, but instead to make sure that the claim will be processed as a screening.

According to the Centers for Medicare and Medicaid (CMS), positive Cologuard tests are considered to be an extension of a screening colonoscopy; therefore, when a patient has a positive Cologuard test that leads to the patient undergoing

a colonoscopy, both are covered as screenings, even if the colonoscopy turns diagnostic. Also, when a patient has a history of colon polyps or colon cancer and comes in for a surveillance or follow-up screening colonoscopy, both of these should be covered as screening colonoscopies, but only if the primary diagnosis is Z12.11 Screening colonoscopy.

would be little to no out-of-pocket expense for the patient.

Of course, if the patient has a colonoscopy because of symptoms they are experiencing, a screening code would not be appropriate. In this case, you would code signs and symptoms, or a definitive diagnosis if proven by the colonoscopy or pathology. In my research, I could not find anything that

**“In my research, I discovered, by reviewing many different sources, how important it is to code screening and surveillance colonoscopies using Z12.11 as the primary diagnosis.”**

According to CMS, a surveillance procedure is considered the same as a screening; therefore, a primary diagnosis of Z12.11 should be reported along with any other personal history of colon polyps, a family history of colon polyps, or a history of colon cancer. If a Z12.11 Screening colonoscopy is not used as the primary diagnosis, the claim would not be processed as a screening, in which case the patient might be required to pay more out of pocket. If the claim was instead processed as a screening, there

stated that Z12.11 Screening colonoscopy was not needed or warranted if a patient had a high risk for colon cancer.

Following are the key codes that gastroenterologists should consider when a patient will undergo a colonoscopy:

- ▶ Z12.11 Screening colonoscopy
- ▶ Z86.0101 Personal history of adenomatous polyps
- ▶ Z80.0 Family history of colon cancer
- ▶ Z85.0 Personal history of colon cancer

Resources:

[aapc.com/codes/coding-newsletters/my-general-surgery-coding-alert/medicare-coverage-correctly-file-screening-colonoscopy-claims-with-these-tips-171553-article](https://aapc.com/codes/coding-newsletters/my-general-surgery-coding-alert/medicare-coverage-correctly-file-screening-colonoscopy-claims-with-these-tips-171553-article)

[cms.gov/files/document/r12299cp.pdf](https://cms.gov/files/document/r12299cp.pdf)

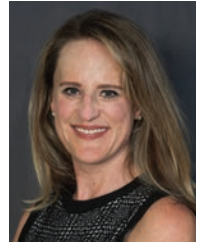
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# HOW IMPORTANT ARE PHYSICIAN REVIEWS IN YOUR JOB SEARCH?

BY KATIE COLE



Gastroenterologists understand the power of physician reviews in attracting patients. Medical Economics reports that 84% of patients check online reviews before scheduling an appointment. But how important are physician reviews in the context of a job search?

Potential employers almost always conduct Google searches on candidates before the first interview is scheduled. In my nearly 20 years of experience working with hospitals, academic departments, and private GI practices, reviews focusing on bedside manner and communication carry the most weight. A negative review regarding bedside manner can disqualify a candidate before the interview even begins.

Conversely, positive feedback highlighting a physician's patience and thoroughness can leave a strong impression—essentially serving as the first step of an interview that you aren't even present for.

Potential employers generally can discern biased or unwarranted physician reviews. Usually, the physicians or administrators who screen candidates will spend some time on the process of sifting through reviews that appear online. Those who read reviews carefully—beyond just star ratings—look for consistency in the wording and context. Reviews that seem influenced by office staff or appear biased based on race, ethnicity, or gender are usually discounted. What matters most are consistent reviews reflecting how patients were treated by the gastroenterologist, regardless of whether the feedback is positive or negative.

**“Usually, the physicians or administrators who screen candidates will spend some time on the process of sifting through reviews that appear online.”**

A potential employer seeks to hire a gastroenterologist who will continue building the facility's reputation—someone they would trust with their own care or that of their family. If you want patients to leave positive reviews, a few simple, intentional steps can create a positive patient experience and increase the likelihood of a favorable review after the visit.

The AIDET® model (first presented by the Studer Group and widely used in Cleveland Clinic and Kaiser Permanente training) offers a framework for a quick (three-minute) model to move toward a positive patient experience. AIDET is essentially a communication structure that enables physicians and other healthcare professionals to engage patients in a way that demonstrates empathy, helps improve clinical outcomes, and reduces burnout caused by miscommunication.

- ▶ **A**cknowledge – Use patient's name, and make eye contact
- ▶ **I**ntroduce – Describe your role and experience briefly
- ▶ **D**uration – Set expectations for visit length/tests
- ▶ **E**xplanation – Explain each step of their visit, answer questions, and let the patient know how to contact you
- ▶ **T**hank you – Appreciate the patient's time/trust

This consistent approach with each patient alone can raise survey scores 10% to 20% and generate reviews that reflect your bedside manner—not factors like staff interactions, office logistics, or other variables outside your direct clinical care and control. Research shows that the top drivers of positive reviews are eye contact, sitting instead of standing,



not interrupting in the first 30 seconds, clearly summarizing the plan, and writing and delivering instructions, ideally at the time of the visit. Patients assume clinical brilliance before meeting with you. Your kindness is remembered during and after the appointment.

Another quick, effective way to earn positive reviews is to engage in post-visit follow-up. While it reflects on the visit itself, the follow-up communication can be performed by you or an office staff member. The gesture of “checking in” post visit makes patients feel valued and reinforces a positive experience. Reach out—even if there's no new clinical update—via a quick call, message, or the patient portal.

A brief note saying it was good to see them and asking if questions came up after they got home is often appreciated and improves long-term satisfaction. Most patient portals are configured to readily accommodate such a note. You can also consider sending a short, reputable primer on the patient's condition discussed during the visit. Just ensure that the document comes from a highly regarded source—your specialty organization or a leading healthcare institution.

Positive patient reviews matter when potential employers are evaluating you as a candidate, and this review can occur before or after your initial interview. It's important to keep in mind that even physicians who are not actively seeking new opportunities are affected by the

## PHYSICIAN REVIEWS IN YOUR JOB SEARCH

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quality of patient reviews. In addition, reviews often factor into quality metrics tied to compensation, bonuses, and promotions. Roughly half of medical groups incorporate quality metrics into their compensation plans, making online feedback relevant beyond recruitment.

In short, reviews are a crucial consideration before starting your job search. They represent the first impression potential employers form before meeting you in person. Positive

reviews showcase your patient care skills and professionalism, while negative reviews—particularly those related to bedside manner—should be prepared for and addressed during interviews.

Sources:

[Patients turn to AI, social media when choosing doctors, survey finds | Medical Economics](#)

[Considerations of Bias and Reliability in Publicly Reported Physician Ratings - PMC](#)

[Half of medical groups tie physician compensation to quality measures in 2024](#)

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

## U.S. GASTROENTEROLOGY EVENTS

**20th Annual Advanced Liver Disease and Liver Transplantation Update**

▶ April 25 | Grosse Pointe Shores MI

**TSGE GI Women's Committee Meeting**

▶ April 29 | Virtual

**Obesity and Nutrition Summit**

▶ April 29 | Scranton PA

**DDW 2026**

▶ May 2-5 | Chicago IL

**Gastrointestinal, Liver, and Pancreatic Pathology**

▶ May 6-8 | Boston MA

**Gastroenterology Summit USA**

▶ May 28 | Nashville TN

**ACG Summer School Series**

▶ June 5-7 | Washington DC

**Gastroenterology 2026**

▶ June 8-11 | Boston MA

**AANP National Conference**

▶ June 23-27 | Las Vegas NV

**International Conference on Gastroenterology and Endoscopic Techniques**

▶ June 26 | Las Vegas NV

**International Conference on Liver Transplantation and Gastroenterology**

▶ July 2 | Las Vegas NV

**Cutting Edge Critical Care in Liver Failure: From Physiology to Transplantation**

▶ July 6-7 | Hollywood FL

**PancreasFest 2026**

▶ July 22-24 | Minneapolis MN

**ACG Annual Scientific Meeting**

▶ October 9-14 | Nashville TN

## INTERNATIONAL GASTROENTEROLOGY EVENTS

**2nd Congress of Internal Medicine, Hepatology and Gastrointestinal Surgery – Mayo Clinic and National Institute of Medical Sciences**

▶ April 17-18 | Ciudad de México, Mexico

**European Association for the Study of the Liver (EASL) Congress 2026**

▶ May 27-30 | Barcelona, Spain

**Ninth JCA-AACR Special Joint Conference on Novel Therapies and Diagnostics in Upper Digestive and Head and Neck Cancers**

▶ June 27-29 | Kyoto, Japan

**5th International Conference on Gastroenterology and Liver**

▶ June 29-30 | Paris, France

**International Conference on Digestive and Metabolic Diseases**

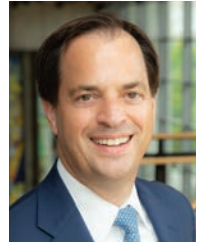
▶ July 6-7 | Amsterdam, Netherlands

**19th Annual Conference of the Dakahlia Hepato-Gastroenterology Association**

▶ July 30 | Mansoura, Egypt

To submit gastroenterology events to Gastroenterology Market Watch, please send details to Katie Cole at [katie.cole@harlequinna.com](mailto:katie.cole@harlequinna.com).

BY MICHAEL S. BYRD



Private equity (“PE”) firms have been increasingly drawn to the healthcare sector as a profitable investment opportunity. Private equity is a type of investment that involves pooling funds from investors in order to acquire companies with a goal of improving their financial performance to then sell them for a profit.

Gastroenterology has emerged as a recent area of interest for PE firms. Private equity firms are attracted to the specialty because of the steady demand for gastrointestinal (GI) services, which patients of all ages and demographics require. Additionally, the complexity of GI treatments and procedures creates a high barrier to entry for competitors, making it an attractive area for investors seeking long-term growth potential.

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## WHY IS PRIVATE EQUITY INTERESTED IN GI?

Private equity is interested in gastroenterology due to several factors that make it an attractive investment opportunity. These include:

- ▶ **Steady demand:** GI disorders affect a large portion of the population, and demand for GI services remains steady regardless of economic conditions or market volatility.
- ▶ **High barriers to entry:** The complexity of GI treatments and procedures creates a high barrier to entry for potential competitors, thus making it an appealing sector for investors who seek to maximize potential for long-term growth.

- ▶ **Growth potential:** The aging population, increasing rates of GI disorders, and advances in medical technology and treatments are expected to drive growth in the GI market in the coming years.

- ▶ **Favorable reimbursement environment:** The reimbursement rates for GI procedures and services are relatively stable, providing a steady revenue stream for investors.

- ▶ **Fragmented market:** The gastroenterology market is highly fragmented, with many small practices and clinics, thus presenting opportunities for consolidation and operational efficiency improvements through mergers and acquisitions.

## HOW DOES A PRIVATE EQUITY FIRM BECOME INVOLVED IN GI?

PE firms can get involved with the GI sector in several ways, including:

- ▶ **Acquiring existing GI practices:** PE firms can acquire existing GI practices to consolidate and create larger entities. This allows for economies of scale and operational improvements, resulting in improved financial performance.
- ▶ **Investing in GI-related services:** PE firms can invest in companies that provide services related to GI care, such as diagnostic services, medical devices, and pharmaceuticals.
- ▶ **Partnering with GI physicians:** PE firms can partner with GI physicians to create new practices or to expand existing practices. This structure can involve providing capital for expansion or partnering with physicians to acquire other practices.

“The key is for the physicians and the PE firm to have a shared vision for the future of the practice and to work together to balance the interests of all stakeholders, including patients, physicians, and investors.”

## LEGAL CORNER

In each of these cases, the PE firm typically provides the capital necessary to fund the investment and then works with the management team to improve operations and financial performance.

## PROS AND CONS OF PRIVATE EQUITY INVESTMENT IN GI

There are several potential advantages and disadvantages to PE firm involvement in a GI practice.

### Pros of private equity investment in GI:

- ▶ **Access to capital:** PE firms can provide the capital needed to fund growth and expansion of the GI practice, which in turn may enable the practice to invest in new technology, open new locations, or offer new services.
- ▶ **Operational improvements:** PE firms often have significant experience in improving operational efficiency and can bring expertise to the GI practice to improve profitability and patient care.
- ▶ **Consolidation:** PE firms can help consolidate smaller GI practices to create larger entities with greater scale and operational efficiencies.
- ▶ **Increased valuations:** The involvement of a PE firm can increase the valuation of the GI practice, potentially leading to a higher sale price in the future.

### Cons of private equity investment in GI:

- ▶ **Short-term focus:** PE firms often have a short-term focus on generating returns (usually four to seven years), which can create pressure to prioritize profitability over patient care.
- ▶ **Potential conflicts of interest:** The involvement of a PE firm can create conflicts of interest between the PE firm and the physicians in the practice, particularly if the PE firm has a different vision for the future of the practice.
- ▶ **Increased debt:** PE firms often use debt financing to fund investments, which can increase the debt burden on the GI practice.

## THE 123S OF PRIVATE EQUITY

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- ▶ **Loss of autonomy:** The involvement of a PE firm can result in a loss of autonomy for the physicians in the practice, particularly if the PE firm takes a more active role in the practice’s management.

- ▶ **Reimbursement pressure:** PE firms may put pressure on the GI practice to increase profitability, which can lead to an increased focus on high-reimbursement procedures rather than on patient care.

The involvement of a PE firm in a GI practice can bring both benefits and challenges. The key is for the physicians and the PE firm to have a shared vision for the future of the practice and to work together to balance the interests of all stakeholders, including patients, physicians, and investors.

## NON-LEGAL CONSIDERATIONS

There are both legal and non-legal considerations that practice owners should take into account when deciding whether or not to partner with PE. Among the non-legal considerations are:

- ▶ **Cultural fit:** It’s important to consider whether the values and culture of the PE firm align with those of the GI practice. A strong cultural fit can lead to a more successful partnership and better patient care.
- ▶ **Management expertise:** It’s important to assess the management expertise of the PE firm and to determine whether it has a proven track record in successfully managing healthcare practices and sufficient knowledge of the specialty.
- ▶ **Reputation:** The reputation of the PE firm should be evaluated to ensure that it has a history of ethical business practices and a positive reputation in the healthcare industry.
- ▶ **Impact on employees:** The impact of the partnership on employees should be considered, including the potential



for changes in compensation, benefits, and job duties.

## LEGAL CONSIDERATIONS

Legal considerations that practice owners should consider include:

- ▶ **Governance structure:** The governance structure of the partnership should be carefully considered to ensure that the interests of all parties are aligned and that the physicians maintain control over **clinical decision-making**.
- ▶ **Exit strategy:** It’s important to consider the exit strategy for the partnership, including the length of the partnership and the options for buyout or sale.
- ▶ **Regulatory compliance:** The GI practice should ensure that the partnership complies with all applicable regulatory requirements, including those related to patient privacy, fraud and abuse, and **anti-kickback laws**.
- ▶ **Legal and financial due diligence:** The GI practice should conduct thorough legal and financial due diligence on the PE firm to ensure that the partnership is financially viable and legally sound.

Partnering with a private equity firm can bring significant benefits, but it’s important for practice owners to carefully consider all the potential advantages and challenges before making a decision.

## IMPORTANCE OF OUTSIDE LEGAL COUNSEL

Partnering with a private equity firm can be a complex and high-stakes process, and having outside legal counsel can provide expertise and guidance throughout the process. Legal counsel can conduct due diligence and help the practice understand any potential risks associated with the partnership. An experienced healthcare attorney can also help negotiate favorable terms and protect the interests of the GI practice. This includes ensuring that the partnership agreement reflects the goals and priorities of the practice, and that the agreement includes appropriate protections for the physicians and patients.

Additionally, having outside legal counsel can help with regulatory compliance by ensuring the partnership complies with relevant laws and regulations. A partnership with private equity can offer meaningful opportunities, but only when approached with careful planning and guidance. By understanding both the strategic implications and the legal risks, GI practices can position themselves for long term success.

Michael S. Byrd is the CEO of Dallas-based ByrdAdatto, a national business law firm serving medical practices. As a leader in the healthcare industry, Michael helps physicians safeguard their practice and provides strategic direction to support their long term success.

## HARLEQUIN RECRUITING

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## HOUSTON HOSPITAL-BASED OPPORTUNITY

## FEATURED OPPORTUNITY

A large hospital in Houston is seeking a BE/BC gastroenterologist to join its existing group located in northern Houston. The position is open due to program expansion. The hospital-based group is a very busy practice and the community it serves has experienced exploding population growth in recent years.

The department, which is seeking a general gastroenterologist, currently has three gastroenterologists (two general and

one advanced) and two advanced practice providers (APPs). Office hours are 8 a.m. to 5 p.m. Monday to Friday, and the hours can be flexible based on patient volume. Call duties are shared with the other gastroenterologists in the practice, and call can be paid on top of salary.

The incoming gastroenterologist will have a mix of inpatient and outpatient practice with designated procedure and clinic time. The department is looking

for a candidate who has at least three years of experience.

This is a hospital-employed position, and the facility will offer a competitive salary and excellent benefits package, including a Defined Contribution Plan, 403(b) investments with match, as well as medical and dental coverage for the candidate and family. Texas has no state income tax.

