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GI HOSPITALIST MODEL MAKING INROADS—IF SLOWLY

BY BONNIE DARVES

The hospitalist model, long entrenched in internal medicine, has been slow to arrive in gastroenterology—until the COVID-19 pandemic became the push that came to, if not shove, at least nudge the specialty toward establishing viable inpatient-only focused programs. Michelle Hughes, MD, a GI hospitalist at Yale School of Medicine who helped establish the American Society for Gastrointestinal Endoscopy (ASGE) Hospitalist Special Interest Group and has been pivotal in the GI hospitalist (GIH) consortium, said that the model has been steadily gaining ground in the recent years.

"We saw early attempts at GI hospitalist program in the late 1990s and early 2000s, but some of those failed to gain traction due to low volume and insufficient financial benefits," said Dr. Hughes, as well as an unfavorable healthcare landscape at the time. "We've seen significant growth over the last five years—with that growth particularly driven by the COVID-19 pandemic."

The consortium has evolved from a small, informal networking group to 75 members, who now meet regularly over video sessions and at formal gatherings at national specialty meetings. The consortium also operates a collaborative research arm and has begun providing support to members who seek to establish GIH programs. "We plan to establish a more visible structure in the in the coming months," Dr. Hughes said.

Although it's difficult to ascertain just how many GIH programs exist nationally because of a lack of data, a 2023 survey found that 23% of academic institutions have GIH models in place, and the consortium's growth suggests that many more are likely in formation in both academic and community practice settings.

The recent GIH program growth is likely spurred by economic and logistical factors, Dr. Hughes observes, as well as practice-style preferences. "GI hospitalists and locums providers are becoming more common as practices pulls out of service agreements with hospitals, creating service gaps that need to be filled," she said. In private practice and employed models, the perennial quest for better work/life balance, for all gastroenterologists, is also likely driving GIH implementation.

In addition, as the acuity of hospitalized patients increases, so does their management, which creates challenges for GIs who attempt to straddle their practice between outpatient clinics and inpatient settings. Many GIs struggle to deliver high-quality inpatient care without disrupting increasingly busy outpatient clinic and procedure schedules.

"We've seen significant growth over the last five years—with that growth particularly driven by the COVID-19 pandemic."

– MICHELLE HUGHES, MD, YALE UNIVERSITY

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PUBLISHER
Katie Cole
303.949.4020 | katie.cole@harlequinna.com

EDITOR
Bonnie Darves
503.680.8791 | bonnie@darves.net

ART DIRECTOR
Annie Harmon, Harmony Design
720.580.3555 | annie@harmonyd.com

GI HOSPITALIST MODEL

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Although GIH adoption—and the structure and size of programs—varies considerably, one thing is certain: As word gets around, interest among GI fellows and gastroenterologists already in practice in taking dedicated GHI positions is increasing, Dr. Hughes has observed. In her 2020 article in Gastroenterology & Hepatology on the nascent GI hospitalist movement, she noted that although published data is scant on the extent to which dedicated GI hospitalist services have altered the financial landscape, improvements are occurring. Some practices have reported increased volumes ranging from 31% to 100%, increased inpatient procedure volumes, and significantly increased office revenue.

WHAT GIH PROGRAMS LOOK LIKE

The Yale GIH service, which is staffed by three hospitalists, is structured so that two hospitalists are on service at any given time. One focuses on consults and the other on performing endoscopies. The service also oversees a team of three fellows, of Yale's total 18 GI fellows. The Yale program operates as a consult-only service from Monday through Friday, from 8 a.m. to 5 p.m., and nights and weekends are covered by the general call pool that includes hospitalists.

Although the economics and operational aspects of Yale's service haven't been formally studied and reported, the program has demonstrated improvements in both procedural productivity and adherence to standard-of-care guidelines, Dr. Hughes noted. Impacts on patient length-of-stay, long a Holy Grail in the hospital-operations sector, "have been difficult to measure," she said, because of multiple factors. The patients GI hospitalists care for tend to be acutely or even critically ill, and many have multiple comorbidities, for example, making it difficult to isolate particular metrics.

While Yale's program grew largely out of a need to better structure inpatient coverage and, later, to manage pandemic-era system stressors, the GI hospitalist program at Stanford University was established in 2022 to address faculty members' overwhelming workload and an increasingly complex patient population. David Goldenberg, MD, director of the Stanford GI hospitalist program, said that the service, which operates within a larger faculty of 71 gastroenterologists, is staffed with three or four hospitalists who specialize solely on gastroenterology patients. The GI hospitalists work one week at a time, enabling the faculty to focus on complex clinical cases and teaching.

"The number of weeks the hospitalists work depends on staffing levels and hospitalists' individual goals," Dr. Goldenberg said. "When faculty are on service, they close their outpatient clinics so that they can focus entirely on their hospital duties and avoid becoming overwhelmed." The Stanford GI division operates separate hepatology, general GI consult, and advanced endoscopy services.

Some of the hospitalists on the service are career internal medicine hospitalists, Dr. Goldenberg explained, while others are hospitalists preparing for GI fellowship. This unusual structure enables the latter cohort of hospitalists to expand their clinical skills and still devote substantial time to scholarly work, thus bolstering their fellowship applications. Stanford's GI hospitalist service, in a recent restructuring to streamline hospitalist services, is now part of the division of hospital medicine.

The Stanford hospitalist program has been successful in several categories, Dr. Goldenberg noted. Faculty, fellows, hospitalists, and advance practice providers all report improved professional and work/life satisfaction, as well as improved communication within the hospital. Patient coordination, care efficiency, and care continuity have also improved, as well as discharge coordination—particularly for IBD and hepatology patients. Despite these gains, Dr. Goldenberg stressed that Stanford's GIH program is not focused on improving metrics. "We implemented this program for patient care and mentorship reasons rather than for financial motivations, so that hospitalists interested in GI fellowship have more protected time for scholarly work," he said.

> **"This model helps build social capital, and the hospitals appreciate that our hospitalists are onsite and available to take emergency cases."**
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> – ANDY TAU, MD
> AUSTIN GASTROENTEROLOGY

Saad Saffo, MD, an assistant professor at Northwestern's Feinberg School of Medicine, who practices as a GIH on the hepatology service, noted that there is likely significant variability in both programs' schedules and implementation. Many organizations, like Northwestern, operate hybrid models—with GIs moving between hospitalist and outpatient roles. "The overall landscape of this emerging field is still very scattered," Dr. Saffo wrote, so drawing had conclusions about what is occurring is challenging.

At the same time, although there are numerous reports of improved productivity and utilization with GIH models, "there isn't enough published high-quality data,"

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Dr. Saffo observed, to draw conclusions about the model's benefits. Most of us feel that the system, in theory, will improve care and other associated metrics, but [only] time will tell."

VasiliKalas,MD,PhD,agastroenterologist and hepatologist at Northwestern who has written frequently about GI hospitalist practice, reported in an April 2026 Gastroenterology & Hepatology article that, despite the relatively limited data on the GIH model's benefits, success stories are accruing and the practice is attracting gastroenterologists at all stages of their careers. "What began as a pragmatic staffing solution has evolved into a distinct and rewarding career track—one that enriches fellowship training, alleviates key pain points for outpatient colleagues, and enhances institutional performance across both academic and community settings," Dr. Kalas wrote.

COMMUNITY GIH MODELS EMERGING

GI hospitalist programs, while becoming more common in academic institutions, are also on the rise in community-based private practices. One with an interesting history is Austin Gastroenterology in Texas, a 37-physician practice dating to 1980 that now commands an 80% share of the local market and provides hospitalist services at three hospitals. The genesis of the GIH program, established in 2011, is based on a group policy: incoming gastroenterologists are required to spend the majority of their first two years providing inpatient care.

"Our associates are required to cut their teeth in the hospital to earn their dues," said Andy Tau, MD, a partner with the practice, before they move into outpatient care. "They're almost like ER doctors—we want them to be able to handle the more acute situations."

In Dr. Tau's case, those two years became seven because he found he enjoyed the high acuity. "I got bitten by the bug—hospitalist practice is hard work, but it's meaningful," he said. The GIH program is staffed by two permanent hospitalists, with support from a GI who focuses solely on advanced cases such as ECRP, EUS, and stenting and the services of a dedicated advanced practice provider. The current service model evolved for both logistical and financial reasons: it enables gastroenterologists who aren't on hospitalist duty to focus on the highest-producing activities, an extremely busy clinic practice and outpatient endoscopy.

"We don't want our physicians taking a break during the day to go to the hospital," Dr. Tau said. The hospitalists, who work Monday through Friday, provide continuity of care for the inpatients and also a reliable point of contact for both hospital colleagues and referring physicians in the community. "This model helps build social capital, and the hospitals appreciate that our hospitalists are onsite and available to take emergency cases," he said. "It also builds trust between the internists and our GIs."

Because Austin Gastroenterology commits to 24/7 hospital coverage, partners and associates take call to cover nights and weekends, in what amounts to a hybrid practice for the physicians. For the hospitals, a key benefit is that it enables them to refrain from hiring locum tenens gastroenterologists. "Locums avoidance is a big motivator," Dr. Tau said. He added that practices considering setting up GIH program must ensure that they have a financially viable professional services agreement in place with the hospital before committing. "You really have to make sure that you're getting fair market value for your services," he said.

SCHEDULES, STRUCTURES VARY AMONG GIH PROGRAMS

Dr. Hughes, who has researched and followed the GI hospitalist sector's evolution, reports that hospitalists' schedules vary. While some work regular Monday through Friday schedules, others, like internal medicine hospitalists, work one to two weeks at a time (block models), interspersed with weeks when they are off service. Other models staff their hospitalist services intentionally to reduce their GIs' call time, given that inpatient practice is typically accompanied by a higher level of intensity and stress than inpatient practice.

For organizations planning to establish a GIH model, Dr. Kalas suggests that they ensure that hospitalists are given protected inpatient time, that schedules are predictable, and that groups set clear expectations regarding workflows, consult scope, and required endoscopic skills.

As gastroenterology groups—both academic and private—decide to explore implementing a hospitalist service, they may find it helpful to access the resources offered through the ASGE's GI Hospitalist Special Interest Group, Dr. Hughes noted. (See Resources.) "As leading experts of inpatient gastroenterology and endoscopic emergencies, we've started offering more content at national conferences—and have even organized our first master class this fall," Dr. Hughes said. "It's very exciting."

Resources:

American Society for Gastrointestinal Endoscopy GI Hospitalist Special Interest Group. Accessible at **asge.org/home/join-us/asge-special-interest-groups**

Master class: **ASGE | On the Bleeding Edge: Mastering GI Emergencies and Inpatient GI Consultation**. The class will be a blend of didactics and hands-on from leading experts and promises to be a high-yield course for attendees.

Michelle Hughes, MD, Yale GIH, who researches the hospitalist model and counsels organizations interested in establishing programs, can be reached at michelle.hughes@yale.edu.

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

NEW FRONTIERS IN GASTROENTEROLOGY

Jennifer Phan, MD, shares her view from the cutting edge

PRACTICE PROFILE

BY BONNIE DARVES

Recent advances in gastroenterology have occurred across the board—in procedures and therapies, devices, new technologies, and of course, the emergence of AI and robotics. Gastroenterology Market Watch recently spoke with Jennifer Phan, MD, a renowned researcher and clinical leader whose work focuses on the absolute forefront of developments in endoscopy, about the key advances changing daily practice today and what gastroenterologists can expect in the years ahead.

Dr. Phan's professional life in Southern California is almost dizzyingly diverse: She is the medical director of the Hoag Irvine Advanced Endoscopy Center, director of bariatric endoscopy, director of the advanced endoscopy fellowship program at Hoag, and plays an active role in the American Gastroenterological Association Center for GI Innovation and Technology. She completed medical school, residency, and fellowship at UCLA Geffen School of Medicine.

Q. Gastrointestinal endoscopy has undergone enormous expansion in recent years, in both technological improvements and its usage in both advanced diagnosis and new treatment options. What are the three most important advances, in your view, that progressive GI practices might be able to incorporate in their clinical offerings in the coming years?

A. One of the most important developments is how AI applications are transforming clinical practice, particularly in colon polyp detection—moving beyond identification to include risk assessment and resection recommendations—and how it will continue changing practice over the next five to 10 years. Another promising area is advanced endoscopy procedures like endoscopic ultrasound (EUS) for better pancreatic cancer assessment and safer therapeutic procedures.

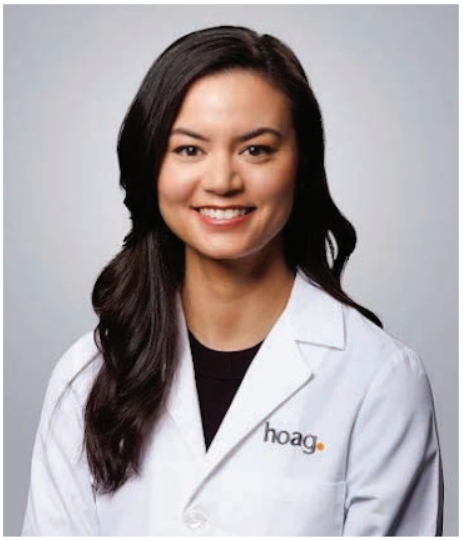
Endoscopic submucosoal dissection (ESD) is also expanding the minimally invasive treatment options for patients with early-stage colon cancer or polyps with negative margins—which would have required surgical partial colectomy a decade ago. Of course, surgery maintains a permanent role in the treatment spectrum, for more advanced cancers, but ESD is quickly expanding our treatment capabilities.

As for developments in the clinical pipeline, I'm excited about developments in an AI platform that is enabling international collaboration across South America, Europe, and the US. With AI, there are concerns being cited about the potential "de-skilling" of gastroenterologists, but I think that the focus should instead be on using AI to help with mental fatigue, and to improve efficacy and patient safety.

Q. You mention endoscopic robotics as one of the most exciting advances that's in the pipeline. Where does that stand now, in terms of a potential treatment option?

A. It's definitely in development, in the R&D phase and with limited testing at academic centers and at well-established priva-demic institutions like Hoag, which has committed significant C-suite level resources to technological innovation. But commercial availability is still two to five years away. And when it arrives, it will be limited initially to select centers that can afford the technology. Once those commercial platforms are established, we'll see formal training programs emerge.

With all these developments, we will be able to do much more for patients than we were able to do in the past.



Jennifer Phan, MD

Q. In recent years, management of obesity has been very much in the limelight with the advent and ensuing exponential uptake of the GLP-1s. Other developments—such as your own pioneering work in endoscopic management of obesity and metabolic disorders—have been quieter but are very promising in changing the practice landscape. What are you especially excited about?

A. Bariatric endoscopy using endoscopic sleeve gastroplasty is an important minimally invasive option available now, for both initial treatment and revisional treatment when it's needed for patients who regain weight following bariatric surgery. It's important to have options beyond GLP-1s because we know that 30% to 40% of patients stop the drugs within

> **"With AI, there are concerns being cited about the potential 'de-skilling' of gastroenterologists, but I think that the focus should instead be on using AI to help with mental fatigue, and to improve efficacy and patient safety."**

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two to three years, and that up to 70% those who discontinue GLP-1s see their weight and their comorbidities return. So, we need to have a transition plan—and interventions available to manage and support these patients because obesity is a treatable disease and is finally being reframed as such.

The ideal, I think, is to establish a collaborative multidisciplinary approach among primary care physicians, bariatric endoscopists, and surgeons, to ensure that patients are treated and supported and educated about their options.

Q. The recently announced advances for treating pancreatic cancer have gotten a lot of attention because the disease can be so devastating, so quickly. What development in this realm do you think gastroenterologists should be paying attention to, in the relative near term?

A. EUS-guided targeted therapy that delivers treatment directly to the primary pancreatic tumor is the potential for an abscopal effect for body-wide immune response are important advances that will become more widespread soon. That's because the device is commercially available now, and the protocols are being shared. It's not the "heavy lift" for adoption that robotic systems are, and although the formal trials are being conducted at select main hospital sites, there are options for community hospitals to adopt the technique outside of formal trial enrollment.

In addition, with this and other emerging technologies, we're seeing considerable collaboration among larger centers and private practices, which enable private-practice patients to access cutting-edge procedures at places like Hoag. Private GI physicians really serve as a gateway, and we know that we couldn't do what we do without them. We have shared patient pools, and their patients are our patients.

Q. Do you have any parting thoughts for your younger colleagues about the importance of these innovations for their future clinical practice?

A. The advances in our field have been huge in the last 10 years, and they will continue in the years ahead. It's truly an excellent time for young gastroenterologists to come out of training.

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

GI JOBS

- **Walla Walla, Washington**
- **Dubois, Pennsylvania**
- **Geneva, New York**
- **Napa, California**
- **Tarboro, North Carolina**
- **Newark, New Jersey**
- **Rio Rancho, New Mexico**
- **Orange County/ Fullerton, California**
- **Baltimore, Maryland**
- **Albuquerque, New Mexico**
- **Saginaw, Michigan**
- **Hartford, Connecticut**
- **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**
- **Roanoke Rapids, North Carolina**
- **Geneva, New York**
- **Conway, South Carolina**
- **Tampa, Florida**
- **Midland, Michigan**
- **Albuquerque, New Mexico** *(Pediatric)*

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.

DEVELOPMENTS IN AI INTEGRATION

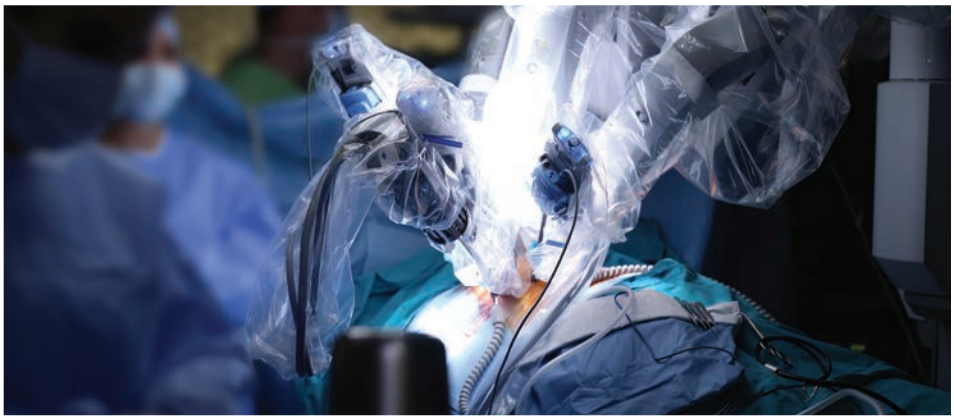
Robotics changing the endoscopy landscape

From the standpoint of innovation in the device and associated procedures market, gastroenterology is one hot specialty right now. Some of the key drivers are illustrated by precisely what GIs are experiencing in their daily practice lives: an aging population seeking more care, changes in cancer screening recommendations prompting younger patients to opt for baseline diagnostics, and technology-driven awareness of and demand for minimally invasive treatment of GI disorders.

In its recent publications, iData Research, a Canadian global medtech and healthcare market research and consulting firm, identifies several market trends, drivers, and key players in the fast-evolving device market. Technology advances that are reshaping procedure include HD/HD+ imaging and magnification, improved maneuverability, and slimmer, smaller instruments that promise to significantly expand the range of therapeutic options.

On the financial side, iData points to the emergence of group purchasing organizations (GPOs) that may expand technology availability by leveraging collective buying power for hospitals and health systems—thus potentially making devices more affordable for entities large enough to take advantage of GPO structures.

iData's 2026 report, U.S. Single-Use and Reusable Endoscope Market, noted that procedure-volume growth is boosting demand for both single-use and reusable endoscopy products, and that manufacturers are competing for purchasers through one of two avenues: imaging, handling, and platform integration capabilities, or a combination of economic value and workflow benefits. The total market for single-use and reusable devices totaled $3.16 billion in 2025 and is expected to experience a continued annual growth rate (CAGR) of approximately 6% in the coming years.



Following are highlights from recent iData reports:

AI INTEGRATION IN GI ENDOSCOPY

Academic, priva-demic, and a handful of large GI centers are moving incrementally toward integrating AI in endoscopy to boost polyp detection and, in the process and in real time, improve diagnostic consistency and accuracy. The systems being developed and continuously improved by leveraging large data sets and cloud infrastructure are increasing adenoma detection rates and diagnostic precision, and these innovations promise to boost workflow efficiency for gastroenterologists—ultimately improving clinical outcomes.

iData cites the Medtronic GI Genius, the Olympus OLYSENSE/CADDIE, and the AnX Robotica NaviCam ProScan as forerunners in this arena.

CAPSULE ENDOSCOPY INNOVATION

Developments in this fast-evolving technology are expanding capsule capabilities to not only improve imaging but also incorporate new capabilities such as sensor-based detection and magnetic capsule control. These advances promise to help fine-tune diagnosis in a range of conditions that gastroenterologists frequently encounter: bleeding disorders including upper GI presentation, Crohn's disease, and tumors.

iData points to the Cook Medical PillSense™ and the AnX Robotica's NaviCam products as leaders.

ROBOTIC ENDOSCOPY ADVANCES

Although developments in this sector are nascent, there's a groundswell of research and large-scale trials occurring that will likely move the devices into the mainstream over the next five years. The big promise in this emerging AI- and technology-assisted area purport to boost gastroenterologists' workflow and potentially reduce procedure-associated fatigue by allowing for greater physical maneuverability, improved diagnostic accuracy, and enhanced precision.

The upshot, product developers report, will be better navigation, lesion detection in real time, and, by extension, potentially earlier cancer diagnosis. (See the profile of Jennifer Phan, MD, in this issue of Gastroenterology Market Watch for more details about clinical and adoption developments in this area.) iData identifies the EndoQuest PARADIGM trial, the Olympus/SwanSurgical partnership, and Virtual Incision's compact platforms as examples of sector-leading players in this arena.

Editor's note: *In this 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.*

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

NAVIGATING GLP-1S

How GI practices can support patients' journeys

BY JESSICA KABALA, DNP, ARNP

The rapid growth of GLP-1 receptor agonists has transformed the healthcare landscape. While these medications are often associated with weight management and diabetes care, their impact is increasingly being felt within gastroenterology practices—specifically with the use of these meds for fatty liver.

The conversation around GLP-1 therapies often focuses on efficacy and emerging indications. While these discussions are important, they may overlook another critical factor: how we support patients once treatment begins.

Patients often arrive with questions that extend far beyond the prescription itself. They want to know what they should eat, how much protein they need, whether certain symptoms are expected, when to seek medical attention, and what happens if they can no longer access the medication. Many are receiving care from multiple providers and are trying to piece together information from different sources.

This is where important gaps begin to emerge.

GI physicians and providers are increasingly caring for patients who are taking GLP-1 therapies regardless of where the prescription originated. Whether patients present with gastrointestinal symptoms, concerns about tolerability, or questions about treatment, these encounters often reveal opportunities to strengthen education and care coordination.

In many cases, the most valuable intervention is not another medication. It is helping patients understand what to expect and ensuring that they have access to the support needed to navigate treatment successfully.

One practical opportunity for GI practices is to strengthen patient education. Standardized educational materials, clear expectations regarding nutrition, hydration and physical activity, and structured follow-up processes can help address common concerns before they become barriers to treatment success.

Another opportunity is improving continuity of care. Patients receiving GLP-1 therapies frequently move between primary care, endocrinology, obesity medicine, hepatology, and gastroenterology. While each specialty contributes with valuable expertise, fragmented care can sometimes result in inconsistent messaging and missed opportunities for support. Strong communication between providers can help create a more cohesive patient experience.

"Building collaborative relationships with dietitians, behavioral health professionals, primary care providers, and obesity medicine specialists can help GI practices better support patients throughout their treatment journey."

The growing use of GLP-1 therapies also highlights the value of multidisciplinary care. Obesity and metabolic disease are complex chronic conditions that rarely fit neatly within a single specialty. Long-term success often depends on medical treatment, nutrition support, behavioral interventions, physical activity, and ongoing follow-up. Building collaborative relationships with dietitians, behavioral health professionals, primary care providers, and obesity medicine specialists can help GI practices better support patients throughout their treatment journey.

Finally, GI providers should consider discussing an exit strategy at the beginning of therapy, not just when a problem arises.

While GLP-1 therapies may be intended for long-term use, the reality of clinical practice is often different. Patients discontinue treatment for a variety of reasons, including insurance changes, cost, medication shortages, side effects, pregnancy planning, or personal preference.

When conversations about discontinuation occur only after access to treatment has been lost, patients are often left feeling unprepared. Discussing a maintenance strategy from the outset helps set realistic expectations and reinforces the message that medication is one component of a broader treatment plan. Patients should leave the initial conversation understanding not only how to start therapy, but also how they will be supported if treatment changes in the future.

GLP-1 therapies have changed what is possible for many patients. The next challenge is ensuring that our care models evolve alongside them.

The practices that will be best positioned to support patients are not necessarily those that prescribe the most GLP-1 medications. They are the practices that recognize the gaps patients experience after treatment begins and proactively work to close them through education, continuity of care, multidisciplinary collaboration, and thoughtful long-term planning.

In the GLP-1 era, success depends not only on helping patients start treatment, but on helping them navigate everything that comes with and after the treatment.

Jessica Kabala, DNP, ARNP, is a Gastroenterology Nurse Practitioner and co-founder of AFYA CARE PLLC, where she focuses on obesity management, metabolic health, and sustainable behavior change.

QUESTIONS EVERY GASTROENTEROLOGIST SHOULD ASK BEFORE ACCEPTING A JOB

BY KATIE COLE

For many gastroenterologists beginning their first job search after fellowship, it's easy to develop tunnel vision. The focus naturally gravitates toward the obvious factors: location, compensation, and employment model. While these are important factors to consider, they are only part of the equation. Alone, they rarely determine whether you'll still be happy in that position five years later.

For newly trained gastroenterologists, it can be difficult to know which questions to ask to properly evaluate not only the opportunity, but also the lifestyle that comes with it. In my experience, the questions gastroenterologists don't ask during the interview process are often the same ones they raise when they begin looking for their next position.

Today's gastroenterologists are practicing in a very different environment than physicians who entered the workforce even a decade ago. Administrative responsibilities continue to grow. Private equity has reshaped many practice models. AI is beginning to influence workflows, and its impact in the future is unclear. In addition, reimbursement continues to evolve, and documentation requirements change frequently and increase every year.

These changes affect not only how gastroenterologists practice medicine, but also how much autonomy they have and how they spend their work time. Before accepting an offer, it's important to try to understand what your professional life will actually look like—and that means asking questions you might not have considered before the interview process.

Some of the most common sources of physician dissatisfaction, which might later prompt a decision to leave a job, include:

- Excessive administrative responsibilities that reduce time spent with patients.
- Productivity expectations that clearly prioritize volume over quality and might be very difficult to meet.
- Limited autonomy in clinical decision making, to the point of being either intrusive or problematic from a care-standard standpoint.
- Insufficient staffing or support resources, with no concrete plan to address them.
- Little physician input into operational decisions that directly affect patient care.

Many of these issues won't surface during the interview process unless you ask about them directly. While every practice is different, posing the following questions can provide a much clearer picture of what it's actually like to work in the practice.

WHAT DOES A TYPICAL WEEK ACTUALLY LOOK LIKE FOR THE OTHER GASTROENTEROLOGISTS IN THE PRACTICE?

Rather than asking about the schedule, ask what physicians are actually doing each week. How many clinic sessions, procedure days, hospital responsibilities, and administrative hours do they typically have? This often provides a much more accurate picture than a written job description and can reveal how closely the day-to-day reality matches what was discussed during the interview.

HOW MUCH FLEXIBILITY WILL I HAVE OVER MY SCHEDULE AND PATIENT VOLUME?

Practices vary considerably in how much autonomy physicians have. Some physicians can gradually shape their schedules over time, while others have little control over clinic templates, procedure blocks, or patient volumes. Understanding those expectations early can help determine whether the practice is a good medium- to long-term fit.

WHAT ADVANCED PRACTICE PROVIDER (APP) SUPPORT IS AVAILABLE TODAY?

This is a very highly misperceived topic. Many organizations discuss plans to expand APP support, but it's important to distinguish future plans from what is actually available when you start. It's common for additional support to be promised during recruitment, only for that timeline to change after a physician joins the practice. Ask what resources are already in place, what responsibilities APPs currently handle, and how they are integrated into the workflow. If there isn't APP support in place, be specific as to what the timeline or projections for APP support are and how long in the future.

HOW DOES THE COMPENSATION MODEL WORK?

If compensation includes RVU production, ask where and when productivity thresholds begin, how those benchmarks were established, and whether current the current GIs consistently achieve them. And ask for documentation on those numbers. Also ask how long it typically takes new GIs to reach those benchmarks. Understanding these expectations before signing is far better than discovering them several months into the job.

ARE QUALITY METRICS TIED TO COMPENSATION?

Many organizations incorporate quality measures into physician compensation. Ask which metrics are used, how they're measured, and whether the physicians currently in the practice feel those expectations are realistic and meaningful.

WHAT ADMINISTRATIVE SUPPORT IS AVAILABLE?

The strength of your support staff has a significant impact on your daily practice. Ask about prior authorization support, medical assistants, nursing staff, scheduling resources, scribes, and other personnel who can help physicians spend more time caring for patients and less time managing administrative tasks.

HOW ARE CLINICAL AND OPERATIONAL DECISIONS MADE?

Every practice has a different governance structure. Understanding who makes

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QUESTIONS EVERY GASTROENTEROLOGIST SHOULD ASK

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decisions regarding scheduling, staffing, equipment purchases, workflow changes, and clinical protocols tells you a great deal about the practice culture and the extent to which physician input is encouraged.

WHAT DO GASTROENTEROLOGISTS WHO HAVE BEEN HERE FOR SEVERAL YEARS SAY ABOUT THE PRACTICE?

The physicians who have been with the practice the longest often provide the clearest perspective on its culture. If possible, speak privately with someone who joined several years ago. Ask what has met their expectations, what has changed since they started, and what they wish they had known before accepting the position. Those conversations often provide insights that won't be contained in a contract or discussed during a formal interview.

No practice is perfect, and every position involves trade-offs. The goal isn't to find a flawless opportunity, but to find one that aligns with your professional goals, your preferred style of practicing medicine, and the life you want to build outside of work. Asking the important questions during the interview process can help you determine if this opportunity could be a good, long-term fit.

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 Update in Liver & Gastrointestinal Diseases
- July 31- August 1 | Clearwater FL

American Neurogastroenterology and Motility Society (ANMS) Annual Meeting 2026 and Clinical Course
- August 7-9 | Denver CO

Cleveland Clinic Multidisciplinary Metabolic Dysfunction-Associated Steatohepatitis (MASH) Conference: Advancing Multidisciplinary Care Across Disease Spectrum
- August 14-15 | Cleveland OH

Florida Live Endoscopy 2026
- August 20-22 | Orlando FL

Physician Medical Weight Loss Training Workshop
- August 23 | New York NY

ACG Annual Scientific Meeting
- October 9-14 | Nashville TN

ACG Women's Initiative for Success & Empowerment (WISE GI) Leadership Course
- October 23 | Las Vegas NV

Advances in Cancer Immunotherapy™ (ACI): A Focus on Gastrointestinal Cancers
- September 9 | Milwaukee WI

NY-LIve – 2026
- September 10-12 | Stonybrook NY

Annual Obesity Symposium 2026
- September 11 | Plymouth MI

8th Annual Global GI AI Summit & Workshop
- Sept 18-19 | National Harbor MD

The Liver Meeting (AASLD)
- November 5-9 | Denver CO

Global Gastroenterology, Liver Diseases & Hepatology Conference & Industry Expo
- November 19-20 | San Fransico CA

INTERNATIONAL GASTROENTEROLOGY EVENTS

19th Annual Conference of the Dakahlia Hepato-Gastroenterology Association
- July 30 | Mansoura, Egypt

XXIX International Federation for the Surgery and Other Therapies for Obesity (IFSO) World Congress
- September 1-4 | Toronto Cananda

48th ESPEN Congress on Clinical Nutrition & Metabolism
- September 5-8 | Berlin, Germany

World Congress of Gastroenterology
- September 30-October 3 | New Dehli, India

The 14th International Conference on Health and Hepatitis in Substance Users (INHSU 2026)
- October 6-9 | Prague, Czech Republic

16th World Gastroenterology, IBD, Hepatology Conference & Exhibition
- Dec. 10-11 | Kuala Lumpur, Malaysia

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

EMPLOYMENT-AGREEMENT ISSUES

8 employment-agreement issues gastroenterologists should understand

LEGAL CORNER

BY MICHAEL F. SCHAFF, ESQ., LUKE R. HORNBLOWER, ESQ., AND ALEXANDRA M. SHAPIRO, ESQ.

Gastroenterology employment agreements often include complex compensation models, restrictive covenants, and operational expectations, with risk-shifting provisions on malpractice, compliance, and termination. A focused review of the following eight topics can help align expectations and mitigate avoidable risk when entering into an employment agreement.

1. COMPENSATION STRUCTURE

Gastroenterologists should understand how their compensation is structured, as many employment agreements combine a base salary with productivity-based incentives that can materially affect overall earnings. Review the proposed base salary, any guarantee period during which the salary cannot be reduced, and whether any additional pay is offered for weekend or on-call coverage. Some agreements also offer potential ownership opportunities in an ambulatory surgery center or endoscopy center, as well as the potential to buy into other ancillary investments in which the practice's owners may have an interest, which may include practice-related real estate or a management service organization.

Review the terms of any signing, retention, or relocation bonus, including any repayment obligations, prior to signing. Where compensation is formula-based, the formula should be clearly explained and illustrated.

Many agreements allow gastroenterologists to increase their compensation based on individual production, based on collections or work relative value units (wRVUs). Clarify any applicable productivity thresholds and how services are valued. For wRVU based compensation models, confirm the conversion rate paid per wRVU. Agreements should also address whether compensation may be reduced for missed targets and allow an opportunity to remedy shortfalls before any reduction takes effect. For collection based compensation models, confirm the right to receive post termination collections and negotiate a defined payment period.

2. RESTRICTIVE COVENANT

Gastroenterologists should understand any restrictive covenant provisions, as they can limit (i) the ability to engage in outside business or professional activities during the term and (ii) the post-termination practice opportunities. Restrictive covenants may restrict the ability to practice within a specified geographic area for a defined period of time (also known as a "non-compete"), which, to be enforceable, must be reasonable in scope and duration. What constitutes "reasonable" can vary significantly depending on the relevant market. Some non-competes also restrict post-termination work within a certain number of miles from multiple employer practice locations, even if the physician did not provide significant services at all those locations. Non-solicitation provisions should be reviewed carefully, as they may extend beyond a physician's own patients to referral sources and employees, or in some cases, to broader networks regardless of direct contact.

3. DUTIES AND CLINICAL EXPECTATIONS

Typically, gastroenterologist employment agreements include provisions that set out your duties, which are usually drafted from the perspective of the practice. These provisions will often grant the employer broad discretion over a gastroenterologist's day-to-day responsibilities. Where possible, physicians should seek specificity, as excessive administrative work can result in decreased productivity, and in turn, decreased compensation.

Employment agreements should define expected work hours (including minimum clinical hours), days of the week, on call responsibilities, paid time off, and holidays. They should also describe the scope of administrative responsibilities. For call coverage, physicians should understand whether call is hospital or practice based, whether additional compensation is provided, and whether the obligations are defined or left ambiguous. If call obligations are "equitably split," physicians should review how rotation is handled as participants join or leave. New hires sometimes face disproportionate call requirements.

Agreements should identify required practice and hospital sites and any travel expectations. Commuting to distant locations can reduce patient facing time, affect productivity and compensation, and potentially implicate post termination restrictions. Where possible, physicians should limit the locations where they could be required to provide services. Note that some practices may expect full discretion to require physicians to work at any location where the practice currently (or in the future) provides services. Physicians should also assess whether minimum productivity expectations are imposed and whether the practice will provide the resources necessary to meet them, such as adequate endoscopy suite access, sufficient block time, and administrative support.

4. TERM AND TERMINATION

Term and termination provisions shape position stability and exit flexibility. Physicians should consider the initial term, any auto renewal provisions, and the notice required to prevent renewal. Note that if an agreement permits the practice to terminate the physician without cause with 90 days' notice, even a multi-year term may functionally operate as a short term 90-day arrangement. Without-cause termination rights should be mutual. For-cause termination triggers should be clearly defined with cure opportunities (ways to resolve issues) where appropriate and should include a provision that the physician can terminate if the practice breaches. Physicians should be aware of any repayment obligations that may apply

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to retention or relocation bonuses in the event of a termination of employment. They should also understand any circumstances that will trigger that obligation. Agreements should also address the timing of payment for any earned productivity or incentive compensation following termination.

5. MALPRACTICE INSURANCE

Review malpractice insurance provisions carefully. Claims made policies are generally less expensive at the outset but do not cover claims filed after employment ends unless tail coverage is purchased and in place. Occurrence insurance includes coverage for claims made post termination. Physicians should confirm the type of coverage provided and who is responsible for paying for tail, including whether that obligation changes depending on the reason for termination.

Agreements should also address the allocation of payment responsibility for tail coverage upon termination of employment if the malpractice insurance policy is converted from occurrence based to claims made. Physicians with an existing tail obligation when leaving one practice and joining another, should consider negotiating with the new employer to cover that cost.

6. BENEFITS AND PROFESSIONAL SUPPORT

Employers typically provide that core benefits such as health insurance and retirement plans can be modified, reduced, or even eliminated in the future with limited or no participant input. Make sure that any language permitting reductions to core benefits provide that they will only apply if uniformly applicable to all physicians, and require at least 90 days' advance written notice of any change. Physicians should negotiate upfront individualized fringe benefits such as enhanced paid time off (PTO), holidays, continuing medical education (CME) leave, and CME budgets (including travel and lodging, if applicable).

7. COMPLIANCE AND REGULATORY PROVISIONS

Employment agreements often include broad representations and warranties, including those related to regulatory compliance, which, paired with a broad indemnification provision, can create significant liability for the physician if any of those provisions are incorrect. Make sure that those are all accurate, before agreeing to them. The breadth of the indemnification obligations resulting from such a breach may come as an unpleasant surprise to the physician and can be expected to encompass all costs and expenses related to such breach. Physicians should seek to narrow overly broad representations and warranties and, where possible, limit indemnification obligations through qualifications or exceptions. At a minimum, the provision should exclude losses covered by insurance.

8. OWNERSHIP

Gastroenterologists should discuss any interest in immediate or future ownership opportunities where appropriate. These opportunities might include equity in the practice, practice-related real estate, a management service organization, or an ambulatory surgery center. Candidates who are not in a position to negotiate definitive arrangements should understand that outlining the material terms of potential arrangements—such as buy-in cost, valuation, and timing—can be helpful. Keep in mind that even non-binding terms may create momentum and increase the likelihood that ownership opportunities are ultimately honored.

In all cases, clarity is essential. Physicians should also be aware that practices may offer quasi- or phantom-equity arrangements that function primarily as retention or incentive tools. Physicians interested in equity participation should communicate that interest explicitly.

CONCLUSION

These eight topics highlight some major areas of concern when reviewing your employment agreement. This article does not delve deeply into the options available, and it doesn't capture every issue that may materially affect your employment arrangement. Additional issues may be relevant depending on the facts, as well as your goals and career stage. Prior to entering into negotiations, we strongly recommend that you retain counsel with experience in representing gastroenterologists in negotiating employment agreements so that a thorough review is performed.

Michael F. Schaff, Luke R. Hornblower, and Alexandra M. Shapiro are health law attorneys at Wilentz, Goldman & Spitzer, P.A.

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GI OPPORTUNITY IN SOUTHERN CALIFORNIA

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Providence St. Jude Heritage Medical Group is seeking a BE/BC Gastroenterologist to join their well-established team in Orange County, California. The department will consider both graduating fellows as well as experienced gastroenterologists.

The incoming GI will have a dual practice between locations in Fullerton and Orange, CA. The schedule is 4.5 days, Monday-Friday, with a 1:7 call schedule during weekdays and weekends. Call will only be out of a single hospital. ERCP training preferred but not required.

The role serves a diverse patient population across southern California. Compensation is between $450,000-700k+ (including bonuses). St. Jude Heritage Medical Group is a multispecialty medical practice fully integrated with St. Jude Medical Center.

The facility has over 150 skilled physicians in virtually every specialty, St. Jude Heritage's medical services range from primary care to leading-edge surgical procedures. The facility will provide a full compensation package including base salary, full comprehensive benefit program, CME, malpractice, and relocation.