Northern California Society for Clinical Gastroenterology

NEWSLETTER

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UPDATE (July 2020)

Unfortunately due to COVID-19, the NCSCG GI Symposium will not be hosted as a live event.

We are excited to announce that the NCSCG GI Symposium will be held virtually using the same outstanding faculty and agenda.

If you have already registered for the live event, no further action is required on your end.

More details will be available within the next two weeks.

For More Information as it Becomes Available Click Here

NEW!
NCSCG APP COMMITTEE

The Northern California Society for Clinical Gastroenterology (NCSCG) is pleased to announce a new subcommittee, the Advanced Practice Providers (APPs).

This subcommittee is chaired by Sandip Suprai, DNP, NP-BC a nurse practitioner/ APP Lead at Stanford Healthcare with the Gastroenterology/Liver and Renal team.

The APP subcommittee is formed of APPs from all over Northern California from various institutions collaborating together to help increase APP attendance in the future GI and Liver Symposia that NCSCG hosts twice a year.

This new APP subcommittee is excited to be part of the NCSCG to help increase networking opportunities, education in the realm of gastroenterology/hepatology issues and research for the APPs. This subcommittee hopes to increase APP attendance at the GI and Liver symposia and to create a network for APPs to engage and share knowledge pertaining to GI/Liver topics. So come one, come all and enjoy this great opportunity to connect with Northern California's APPs at the next GI Symposium in October, with plans for a social happy hour/break out session worked into the virtual format.

GHAPP Gastroenterology & Hepatology Advanced Practice Providers

For More information on the GHAPP Third Annual Conference on September 10-12, 2020 and to register, click the GHAPP logo.

NCSCG MEMBERSHIP SPOTLIGHT

Suraj Gupta, MD

Advanced Endoscopy
Department of Gastroenterology
Kaiser Permanente San Francisco

Where are you originally from or any personal background you want to share:

I grew up on Long Island, New York, and I'm an avid New York sports fan, sticking with my childhood teams even though they always seem to lose. A glutton for punishment, I did my medical training in the cold weather climates of Boston and Michigan, and managed to find an even colder environment for my advanced endoscopy fellowship in Portland, Maine. In 2015, I was fortunate enough to secure a position at Kaiser Permanente in San Francisco, and become a member of an amazing GI team.

Clinical and/or research interests:

I love working in the rapidly evolving field of advanced endoscopy, and trying to devise endoscopic treatment plans for complex conditions. I am also the GI lead for quality improvement in San Francisco, and hope to pursue quality improvement at a regional level in the future. Finally, I'm very excited to work with the fellows in our new GI fellowship, and trying to improve as a medical educator.

Your involvement with NCSCG (e.g. how long, what activities, etc.):

This is my third year with NCSCG. Being new to the Bay Area, it's a great opportunity to meet and collaborate with colleagues at the other prestigious institutions in the area. I am helping to organize our first two-day NCSCG meeting, and the COVID pandemic has certainly made things more challenging.

What most excites you about GI/hepatology in 2020/2021:

From an advanced endoscopy perspective, I am always excited about the constant evolution of novel techniques and endoscopic management of what was once surgical disease. From a wider perspective, I am excited to see how GI and medicine in general evolves during the pandemic, and how this may affect the way we practice in the future.

Interesting Facts:

In case you were wondering, I am a fan of the Mets, Knicks and NY Giants. I was also at the University of Michigan for the 3 worst years of their 100+ year football history (2008-2011)

Where are you originally from or any personal background you want to share:

Born and raised in the Bay Area, I have spent pretty much my entire life in the Bay Area with the exception of a one year research stint at the NIH between college and medical school.

Clinical and/or research interests:

My clinical and research interests involve better understanding disparities in epidemiology, outcomes, and quality of care among patients with chronic liver diseases with a specific focus on ethnic minority and vulnerable populations. I particularly enjoy research that incorporates large databases such as NHANES, SEER, UNOS/OPTN.

Your involvement with NCSCG (e.g. how long, what activities, etc.):

I've been involved with NCSCG since 2019 and help coordinate the trainee and education committee as well as our recently launched quarterly newsletter. I'm passionate about education and mentorship to engage various levels of trainees into opportunities to get more involved with research or educational initiatives.

Robert Wong, MD, MS

Staff Physician,
Gastroenterology and Hepatology, Veterans Affairs Palo Alto Healthcare System

Division of Gastroenterology and Hepatology, Stanford University School of Medicine

Why did you join NCSCG:

NCSCG is our local GI and hepatology society and it offers a unique opportunity for us to engage GI and hepatology providers across different practice settings in our region. I joined NCSCG because I was interested to help with this initiative to expand our footprint in the Bay Area and to better understand how our society can serve the needs for all providers and trainees who care for patients with GI and liver diseases.

What most excites you about GI/hepatology in 2020/2021:

Given my focus on liver diseases, I'm most excited about the ongoing research related to new therapeutics in the field of HBV and NASH. I'm also excited to see a movement towards developing quality measures to improve our management of patients with chronic liver disease and cirrhosis.

Interesting fact you want to share about yourself:

I love traveling to explore the culture and traditions of different world regions via culinary adventures!

REFLECTIONS ON COVID-19

Pre-Covid I was a self-proclaimed worrier. I would worry about my patients and their ability to pay for medication. I would agonize over their ability to access stable housing. I would worry about their families and their children. I was constantly troubled by those who would call me, fighting back tears, and ask if they were going to be ok.

The tables have turned.

Now, my patients worry about me. They worry about my safety. They worry that I'm not eating enough and not getting enough sleep. They worry about the health of my family. They worry that I don't have proper PPE. They worry they might expose me to disease, or worse.

I never thought it was possible that my patients would one day worry about me in the same way I have worried about them. In some strange way, in the era of social distancing, my patients have become closer to me than ever before. They have shown me a genuine concern for my health and well-being that I had mistakenly not previously understood.

Undoubtedly, the domain of Covid will end someday. However, it has demonstrated an often hidden, although amazingly beautiful side of the provider-patient relationship. While the limited clinic time is generally one-sided, my patients have taken the opportunity to show me that they love me the way that I love them, and I am eternally grateful.

Devon Kiker is a nurse practitioner in the division of gastroenterology and hepatology at UCSF Fresno. She earned her NP degree from Georgetown University. Her interests include alcoholic liver disease, autoimmune hepatitis, and transplant hepatology. She has recently been selected for the 2020 NP/PA Clinical Hepatology Fellowship by the AASLD.

GI Reconditioning in the Time of Covid

The outbreak of Covid-19 has confounded every modern domain, stimulating significant anxiety therein.

That anxiety stems from changes in boundaries between what an individual can and cannot control. In education, the formats for learning have altered. To continue patient care, keep practices afloat, and prepare for its anticipated permanent role after the pandemic subsides, faculty and fellows have adopted telemedicine albeit with lurching progress involving a heterogeneous set of video platforms. Little distress has been expressed that the physical exam, long lamented as fading from prominence, may further decline. The ostensible virtue of improved access may apply to mainly the young and relatively healthy while older, frailer patients may not participate due to lack of familiarity, sometimes generated by physical and economic constraints, with unclear consequences if telemedicine replaces large bulks of in-person visits. Video conferencing has enabled continued teaching, a boon in amplifying the cognitive aspect of GI. While helping to grant time to obey faculty exhortations to read more, the halt to elective procedures has diminished opportunities to do advanced and conventional endoscopies at a point in which new fellows were eager to solidify their skills and graduating fellows to refine them before joining new jobs.

Indeed, worry and speculation have grown about the future for common job models. With smaller hospital censi and suspended procedures, rumors emerged that hospital employed practitioners might struggle to reach production benchmarks. Such factors have even penetrated academia and eroded the security employment typically provides. Physicians have been asked to take pay cuts or furloughs sometimes while still being requested to take call. The economic impact matters insofar as to the degree practice location influences practice viability particularly in California with its high cost of living and, previously for now, punishing commutes.

Autonomy in private practice offers little solace as Covid, in necessitating uniform GI societal recommendations, has taken it away although arguably in some places it was already blunted, seemingly subject, without large capital reserves as buffer, to John Stuart Mills' "the oppression of custom" from surrounding monolithic institutions, again highlighting the role of location as states have reopened at different rates with concomitant changes on practice websites from Alabama and Texas to Washington and Idaho. And it may stay away if private equity finds the environment riper for buyouts even if the financial relief for these medical small businesses is welcomed.

Many, if not most, graduating fellows had committed to jobs by the time the pandemic erupted, and turnover remains high and therefore expected. But to what extent can they assess accurately their fit during the first years of practice as the impact of Covid and sheltering measures limits the applicability of precedent to guide their analysis?

Overall, the response to the pandemic has compelled the development of new skills but obscured the future health of settings in which they will be used, a variable outside individual control. The actual reconditioning may consist of learning to live with a greater degree of uncertainty than before.

Patrick McCabe MD, MEd is a 2020 graduate of the California Pacific Medical Center gastroenterology fellowship program. His research has focused on the impact of frailty assessed subjectively on liver transplant waitlist patients and graft recipients. In his free time, he enjoyed attending live sporting events and trying new restaurants.

Awakening During the Pandemic

The novel coronavirus has wrought havoc across the globe, but it has also highlighted the importance of community in our lives. People have been able to reconnect as they check in, commiserate, and sympathize. Sheltering in place has allowed some people to see their family more, since many adults are now working from home or unable to work, and kids are no longer being shuttled to and from school and activities. The bonds of community are reinforced by our common experience of the pandemic. The Bay Area community has done a fantastic job supporting healthcare workers by acting early and effectively to flatten the curve.

Communities need leadership, particularly during difficult times. We look to our leaders to make good decisions about new protocols and recommendations for our wellbeing. Here in the Bay Area, our leaders have been organized and strategic about policies to mitigate the crisis. COVID-19 has prompted me to ask if I am the leader I want to be for my trainees. Am I calm, fair, and appreciative? Leadership skills do not come naturally for most people, but fortunately, leadership training is available through GI societies (AGA, ASGE, etc.) and elsewhere (Coro, Coursera, MIT Sloan School of Management).[1]

COVID-19 has stirred the pot of human emotions. As healthcare providers, we may feel a range of emotions, from guilt to fear to exhaustion and frustration. With all the talk of heroes on the front line, the impostor phenomenon may come up. As gastroenterologists, we must remind ourselves that we are highly trained and doing our part. Like many, I have experienced anxiety related to the changes and uncertainty of the pandemic. It has affected my sleep and the resulting fatigue has heightened my emotions. Leaning on my community has certainly helped. Other tips for emotional wellness include finding some routine, getting regular exercise, focusing on gratitude, and generally developing your self-care toolkit.

Self-care has always been important, but it is necessary during a pandemic more than ever. Whether taking a mindful moment or practicing "radical self-acceptance," now is the time to be kind to yourself. If you can find peace within yourself, its effects will expand exponentially as you share that light with the people around you. Together, we will navigate the trial of COVID-19 and emerge transformed on the other side.

[1]https://www.inc.com/larry-kim/9-places-to-learn-leadership-skills-for-free.html

Michele M. Tana, MD, MHS is an Associate Clinical Professor at UCSF, based at Zuckerberg San Francisco General Hospital & Trauma Center. Her research focuses on health disparities in autoimmune hepatitis, and she is an Associate Program Director for the UCSF GI Fellowship Program. In her free time, she enjoys learning Spanish and keeping in touch with her GI colleagues around the Bay Area.

I am a lifelong clinician, mostly in Gastroenterology . I retired but then returned to do as needed work at a public hospital. I have, of course, found the situation we are all in with this pandemic remarkable. On one hand, it increased the demand for work in the Emergency Departments and ICU's but on the other, at least for a time, completely eliminated routine outpatient procedures and in person clinic visits. I have never seen such a radical change in health care occur so rapidly. Clinics have been converted to telemedicine with remarkable speed. These actions will likely change outpatient clinical services forever. The steps the AGA and other professional associations are putting in place to assure the safety of patients and providers in returning to outpatient procedures and in person clinics has been unprecedented and historic.

Although the current pandemic is certainly unique, it has not been the only viral epidemic I have experienced in my work in health care over the past almost forty years. Of course, none of the previous ones have changed the way medical care is delivered to the extent SARS-CoV-2 has. Nonetheless, they do share some similarities. One is the reaction of fear from both patients and providers. When HIV started we did not know the mode of transmission. We did not know if treating infected patients would result in health provider infections. We found out later, to everyone's relief that the virus was not easily spread in the health care environment. HIV, along with hepatitis B and hepatitis C virus infections, lead to refinement of blood born precautions. The same fears arose as SARS, MERS, and Ebola became threats to our patient population but fortunately these epidemics were successfully contained before they caused the large scale damage the current pandemic has delivered. Similarly, in these previous epidemics we increased use of personal protective equipment (PPE) and contagion precautions in the health care setting and provided information to our patients and the public on how to avoid infection. Even the yearly influenza epidemics bring similar notes of caution. I was infected with a severe influenza after performing UGI Endoscopy on a patient who we found out later had influenza. There was no influenza vaccine at that time. Now I have the vaccination yearly! Certainly, COVID-19 will be a milestone in all our careers. I suspect we will see a very different health care system when it is all over.

Thomas M. Cuff, MD, MPH was a Gastroenterologist at Kaiser Permanente for over 25 years and is now retired. For much of that time he was also an Assistant Clinical Professor of Medicine for UCSF. He has been working as needed as a Gastroenterologist at Alameda Health System. Other interests include developing a small acreage in Sonoma County on which he has goats and chickens.

NORTHERN CALIFORNIA GI PROGRAM HIGHLIGHTS

The Northern California GI Program Highlights section will be a regular section in our NCSCG newsletter that highlights different centers of excellence and expertise in our northern California GI community. On a rotating basis, each newsletter will highlight two programs from two institutions in northern California. In addition to highlighting the diverse wealth of expertise in our region, this will also provide helpful information for providers interested in referring their patients to these programs.

UCSF DeLIVER Care

UCSF DeLIVER Care is doing just that, delivering hepatitis C care directly to their patients. Under the direction of Dr. Jennifer Price, this converted shuttle launched as a mobile HCV testing unit for the San Francisco community in January 2019. In the first phase of operations, services included rapid HCV antibody testing, confirmatory HCV RNA blood draws, a FibroScan for fibrosis staging, and HCV counseling and linkage to HCV care. Screening shifts were held at several locations throughout San Francisco with an emphasis on reaching patients who currently inject drugs or have a history of injection drug use and are marginally housed or experiencing homelessness. Initially, the team partnered with local community based organizations (CBOs) with established relationships in this community. This facilitated a smooth integration into community-based testing, allowing the team to shadow CBOs to learn unique cultural competency skills and begin establishing a reputation as dependable service providers in the community. Within a few months of DeLIVER Care's launch, the team realized demand was high not only for HCV screening and fibrosis staging but also for a more accessible treatment option. Therefore, in their second phase of operations, they expanded services to provide on-site low threshold HCV treatment. Dr. Price, Jeff Mckinney, NP, and Lisa Catalli, NP, offer HCV direct-acting antiviral (DAA) treatment to DeLIVER Care patients via telehealth visits, which are set up on the van by the DeLIVER Care team. Patients have pre-treatment and on-treatment labs drawn on site and their medications delivered in a schedule that works for them. This allows flexibility for patients with competing priorities and for clinicians who balance a full clinic schedule simultaneously. On the van, the team's unique approach to HCV treatment allows the group to meet patients where they are and support them in getting cured. Several patients previously labeled 'difficult to treat' have successfully completed a full treatment course and have achieved sustained virologic response (SVR12). The team plan is now bringing their experience to new partnerships, expanding the scope of services offered by UCSF Street Nurses and local CBOs who want to offer HCV treatment on site. It is their hope that the telehealth model used on the van can be adapted in these additional partnerships to offer patient-centered quality HCV care in a location both convenient and comfortable for the patient.

For more information:
UCSF DeLIVER Care
513 Parnassus Ave. S357, San Francisco, CA 94143-0538
Phone: 415-502-4254
Email: delivercare@ucsf.edu
Website: https://delivercare.ucsf.edu/

The Esophagus Program at Stanford University

The Stanford Esophageal Multidisciplinary Program in Innovative Research Excellence provides clinical care for patients with esophageal disease in tandem with education and research initiatives. Gastroenterologists John Clarke, Nielsen Fernandez-Becker, Patty Garcia, Houssam Halawi, Afrin Kamal, Linda Nguyen, Irene Sonu, George Triadafilopoulos and Tom Zikos provide consultation across a range of esophageal disorders, including achalasia, Barrett's esophagus, dysphagia, eosinophilic esophagitis, gastroesophageal reflux disease and non-cardiac chest pain. State of the art diagnostic procedures including high-resolution esophageal manometry, impedance, wireless pH testing, EndoFlip and advanced Barrett's imaging techniques are available to help guide therapy. Radiofrequency ablation, cryotherapy, EMR, ESD and per-oral endoscopic myotomy are performed by Drs. Shai Friedland and Joo Ha Hwang as needed. The group prides itself on close collaboration with partners including surgery, otolaryngology, nutrition, pain management and neurology. The gastroenterology & surgery groups perform clinic in tandem and have a joint weekly conference to discuss challenging cases to ensure a true multidisciplinary approach tailored to the individual needs of the patient. Patients have the opportunity to receive all available standard clinical care as well as access to novel clinical trials evaluating new therapies for Barrett's esophagus, eosinophilic esophagitis and gastroesophageal reflux.

With regards to education, the esophageal group holds an annual educational CME event each year in April. The first program was held in 2017. Unfortunately, the 2020 program was cancelled due to the Covid epidemic, but is planned to resume in 2021. The group is also a pilot center for the OESO Society (World Organization for Specialized Studies on Diseases of the Esophagus), with international virtual educational events sponsored in conjunction with OESO on a monthly basis. The esophageal program also sponsors a virtual multicenter esophageal conference held monthly including gastroenterologists and surgeons from many of the top programs in the country including UCSF, Washington University, Northwestern University, Johns Hopkins, Harvard and the Mayo Clinic.

From a research standpoint, the group has individually authored over 500 papers, including over 25 in the last year alone. Clinical trials are currently evaluating the role of diagnostic studies including EndoFlip, potential automation of motility interpretation, optimization of motility testing protocols, and novel diagnostics and therapies for Barrett's esophagus, eosinophilic esophagitis and reflux.

For more information:
https://stanfordhealthcare.org/medical-clinics/esophagus-center.html
Esophagus Program
Stanford University
430 Broadway Street, Pavilion C, 3rd Floor
Redwood City, CA 94063
Appointments: 650-736-5555

How Do I Approach the Updated Guidelines from the Multi-Society Task Force on Colorectal Cancer Surveillance?

Joseph Marsano, MD
University of California Davis

In March 2020, the US Multi-Society Task Force on Colorectal Cancer comprised of members of the American Gastroenterological Association, American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy presented updated clinical practice guidelines for follow up intervals after colonoscopy and endoscopic removal techniques for colorectal lesions.

Highlights: Follow Up Intervals after Polypectomy

- For patients with 1-2 tubular adenomas < 10 mm in size, surveillance interval can be extended to 7-10 years after index colonoscopy. This was based on meta-analyses which showed small differences in advanced adenoma risk for patients with low-risk adenomas versus no adenomas at baseline colonoscopy. As would be expected, the risk of advanced adenoma at subsequent examination was much higher for patients who had an advanced lesion at baseline colonoscopy.
- For patients with 3-4 tubular adenomas < 10 mm in size, the MSTF favors a 5-year interval. This is based on similar risk of advanced neoplasia in these patients when compared to those with 1-2 adenomas < 10 mm in size. It is suggested that this similarity in risk may be due to greater attention of colonoscopy quality metrics and high definition colonoscopes. A definitive recommendation of 5 years will require further study, but for now, the MSTF recommends an expanded interval of 3-5 years for patients with 3-4 low-risk tubular adenomas.
- Patients with 5-10 adenomas < 10 mm can be offered interval colonoscopy at 3 years.
- Patients with 1-2 sessile serrated polyps < 10 mm can be offered colonoscopy between 5-10 years.

Highlights: Endoscopic Removal Techniques for Colorectal Lesions

- For diminutive lesions (< 5mm) and small polyps (6-9 mm), cold snare should be employed to ensure complete resection of the lesion.
- Forceps can still be considered for polyps < 2 mm provided that complete removal of the lesion can be achieved.
- Flat or non-pedunculated lesions between 10-19 mm can be removed with either cold snare or hot snare polypectomy. Sub-mucosal injection can be considered in these lesions.
- Endoscopic mucosal resection should be employed for lesions > 20 mm. Indigo carmine, methylene blue or viscous solutions such as Eleview should be used to lift the lesions.
- Hot snare polypectomy should be performed for pedunculated lesions > 10 mm

- Prior to removal, detachable loops or hemoclip placement should be placed on the stalk of pedunculated polyps when the head of the lesion is > 20 mm or the stalk is > 5 mm.

The post-polypectomy surveillance guidelines are a reflection of the advances in colonoscope technology and quality metrics over the past several years. Better adenoma detection with higher quality exams has refined the post-polypectomy guidelines by permitting longer surveillance intervals in certain cases. It is important that we continue to improve quality metrics in our practices by ensuring that we use the most up-to-date high definition colonoscopes, bowel preparation protocols to detect lesions < 6 mm, adherence to and commitment to higher adenoma detection rates. Adenoma detection rate is the measure at which we define quality, but total detection of adenomas and serrated lesions is equally as important since higher number of adenomas or synchronous adenomatous and serrated lesions confers greater risk of advanced lesions at follow up. Though the current guidelines lay out an excellent framework for how we should now approach average-risk patients after polypectomy, there are still questions pertaining to follow up intervals for high risk groups or risk factors such as obesity, younger age or location of adenomas (proximal vs distal), for which further study is needed.

I know in my practice, as well as many of you, the guidelines with respect to endoscopic removal may be an affirmation of what is already part of your practice. However, the use of cold snare, especially in diminutive lesions, underscores the importance of complete resection and how this factors into a high-quality examination for which the updated surveillance guidelines are predicated.

In the coming years, these guidelines may be further refined or confirmed as we continue to improve adenoma detection, removal of lesions, increased knowledge of higher risk groups and their long-term impact on reducing colorectal cancer.

Joseph Marsano, MD is Health Sciences Assistant Professor at UC Davis. His clinical and research interests include familial polyposis and non-polyposis syndromes, study of devices to increase adenoma detection, and colorectal cancer. He enjoys spending time with family, cooking and hockey (when the rinks aren't shut down).

In The Times of COVID-19 for the APP's

Boom! And just like that the world was on lockdown! March 2020 changed everything, from businesses, restaurants closing, sports being canceled, schools closing, children learning virtually to even how hospitals operated. Who would have thought this would ever occur, especially in times where technology and health care is so much more advanced. Unfortunately, some situations such as COVID-19 is beyond anyone's control, or perhaps not? I guess we really won't know!

But, what I do know is that the healthcare providers all came together to adapt to the new changes the hospitals faced. Administration worked hard alongside healthcare providers to come up with solutions to create protocols to ensure safety of patients and staff. Town hall meetings, daily updates, check in processes were created to help keep all staff informed of any changes occurring. Temperature checks, symptom checks, and wearing of masks of all providers was required.

From canceling elective procedures to creating outpatient virtual visits easily accessible to patients, we as hospital came together to be there for our patients and staff. A protocol was creating rapidly to help screen not only patients, but also staff members. Drive thru testing sites were started to help those who need to get tested. Staff members were allocated to different areas of need, and were utilized to help. So much went into the planning, preparing, and teaching and to do so in a timely, efficient manner.

COVID-19 proved to us Advance Care Providers (APP's) and other health care disciplinary members that we are stronger together and can adapt to the changing situations. The hospital hallways that once were filled with conversations, patients, families and staff members, looked like ghost towns. Staff who didn't need to be at the hospital got access to work remotely. Some got time off as census dropped, some got called to other units and teams to help out. There were many mixed emotions, some were anxious, many were fearful of what's to come and many stressed due to day care issues or afraid to bring home something to our elderly parents/family members. Patients expressed feeling lonely without family not being able to be at the bedsides. Providers stepped in to give extra emotional support to the patients.

With the current situation, no one really knows what to expect or how long this will last. But, what I do know is that if we stick together and work together and adapt the best we can, we will get through this. We all know that it won't be and it isn't easy, but we can do it if we all work together! One day at a time, small steps forward with caution and hope for all to go back to the new " normal" way of life.

Sandip Suprai, DNP, RN, FNP-BD, Lead Advanced Practice Provider, Stanford Health Care

Fellows' Corner: Gastroenterology Career Search Advice

Dr. Gavin Park and Dr. Patrick McCabe graduated from California Pacific Medical Center's GI Fellowship Program June 2020. Gavin will be joining Queen's Medical Center in Oahu, Hawaii as a gastroenterologist and Patrick will be joining GI Consultants in Reno, Nevada.

Here are a few things we learned, or wish we knew, on our own job search.

1. ***Location, Location, Location.***
   - Just like in real estate, location will likely be the most important factor when starting your job search. That is not to say that there is only one location you should hone in on, but the United States is large and you don't need to apply to every hospital like you did for fellowship. Practice setting will play a role in regions you decide to explore, but don't forget the other factors that come in to play such as family, personal interests, or even local tax laws and medical legislation.
   - To find openings, you can, often a year before graduation, speak with faculty and mentors and sign up for GI/Hepatology Society and other firms' job alerts to be linked to in-house and agency, i.e. externally hired, recruiters for practices and hospitals.
2. ***Practice Setting***
   - There are two major practice settings; employed or self-employed…complicated, right?
   - Employed model examples include working for an academic institution, the federal government, a managed care consortium (e.g. Kaiser Permanente), or a medical group associated with a county or private hospital. Major features of an employed model are a fixed salary, and benefits including health insurance, retirement contributions, and perhaps performance bonuses. In exchange for relative financial stability and peace of mind, you give up varying degrees of your autonomy. Also keep in mind that by definition, as an employee *you are paid less than what you generate in revenue*, otherwise you are not profitable and thus not worth employing.
   - Self-employment is touted as the American Dream. Being your own boss, captain of the ship, king (or queen) of the castle. Just remember the Shakespearean misquote, "heavy is the head that wears the crown"; maximum autonomy allows you to dictate your hours and practice as you see fit, but also requires you to develop a business plan. This business plan needs to include not only the obvious such as office space leasing and payroll, but things that you may not have thought much about, such as how one establishes an infrastructure for yourself and your employees that will comply with workplace health and safety (OSHA). You can be a single private practitioner, which is challenging but not impossible, especially if you plan on setting up shop in an area with a need for more gastroenterologists and you have an entrepreneurial mindset. Instead, you may join up with a small group of private practitioners, principally to aid in cost sharing of overhead associated with any medical business (i.e. support staff salary, EHR fees, medical billing processing, office lease, etc.). Many private practice groups will discuss having you sign a contract of employment for the first year or so. This contract serves several purposes, the most important among them are terms for a salary to help offset the initial low reimbursement/income when building a new practice to adequate patient volume and to set the terms of cost sharing, and possibly terms for becoming a partner in the practice. Additionally, there has been a rise in larger groups of gastroenterologist. These larger groups can further mitigate overhead, may help leverage hospital or insurance contract negotiations, or offer other investment opportunities. The most notable investment opportunity for the private practitioner is the endoscopy center.
   - The endoscopy center is probably the most enticing benefit of private practice and usually not available to hospital/foundation-employed physicians. Endoscopy is an integral part of our practice and akin to autonomy in your clinical practice. Outpatient endoscopy centers are generally known to be cost-saving compared to hospital-based endoscopy centers. Non-hospital based endoscopy centers also tend to run more efficiently for a number of reasons, but it boils down to the fact that time is money. So in summary, the option to invest in an endoscopy center seems to have positive financial, clinical, and workflow benefits.

- Buy-in to assets. Foremost is the endoscopy center. Buy-ins range from none at all to book value to multipliers of fair market value, each with their own merits and flaws. Other assets, which practices can have or lack in different combinations, that often require buy-in but then generate revenue for experienced clinicians are pathology labs, anesthesia, infusion centers, pharmacy, and for some multispecialty groups, labs and imaging. Some practices also require associates becoming partners to buy into the hard assets such as the equipment and clinic space, a figure usually divided by the number of partners. The buy-in process varies greatly from center to center. Ask lots of questions and discuss it with someone you trust, including the lawyer reviewing your contract.
- Locum tenens is another avenue of employment which I admittedly did not dive too deep into. Basically, you would be offered a short-term employment opportunity, sometimes mediated through a locum's organization, at a hospital requiring your services. Terms of employment are highly variable depending on the hospital needs. Anecdotally, the pay is at least competitive, if not better, than a more traditional employed position (at minimum it's because of lack of job security) and presumably with fewer benefits than would be seen in a longer term position. If you don't have particular ties or obligations, this seems to be a nice way to "try out" a location or practice setting without fully committing. Moreover, if the relationship is mutually beneficial, you could be offered a more permanent position! Locums organizations also tend to help with the credentialing hoops, which is a nice convenience.
- There are other employment opportunities such as going into the private sector as a consultant or researcher. Immediate entry into the field seems opaque, and some such jobs prefer candidates with some post-graduate clinical experience. If interested, you can consider contacting a mentor or company or rep directly including at national and local meetings. If starting early in your career, you may wish to ensure that the job budgets some time for locums work so you can maintain your endoscopic skills, particularly if you might return to clinical practice.
- You may see different combinations or spins on these models where the boundaries blur. Some private practices still get involved in academics, or are the sole consultants at local hospitals, or form statewide or national networks with some centralization such as for HR, or keep their own employed doctors, or have sold some of their asset stakes to other entities such as majority endoscopy center shares to surgical service companies. Most profoundly, some private practices and systems have been bought out partly or entirely or been approached for such by private equity or publicly traded companies which can affect how much autonomy and access to investments you may have now and in the future albeit with ostensibly more job security much like an employed position.

3. Professional skills

- Similar to fellowship programs, practice settings will have variations of what "special" patient services (e.g. esophageal manometry, capsule endoscopy, ERCP, endoFLIP) are offered. You have likely already figured out to some extent which specialized procedures you might be interested in using in your clinical practice. Keep in mind that the skills you tout will alter your referred patient population, for better or worse. ERCP +/- EUS is probably the most commonly sought after additional skill which will improve your marketability significantly. Joining a practice with the infrastructure to support your skill(s) is easiest; be careful if you are being hired to help establish a service as this will likely require some modicum of entrepreneurship. It is also perfectly ok to focus solely on general gastroenterology; just know that ever other fellowship graduate in theory has a similar skill set.

4. Contract Negotiation Hints

- This is by no means an exhaustive guide to contract negotiation. Hopefully you can find mentors to sit down with and discuss their experiences. It seemed that contract offers for employed positions tended to be "boiler plate", meaning it is a standard contract drafted by the organization's lawyers. This contract will be essentially what has been signed by your prospective colleagues. The implication is that there is low risk of any "funny business" hidden in the fine print. On the other hand, contract offers to join in to a private practice are more variable in the terms offered. You should have a lawyer review it for and with you to ensure fair terms regarding job duties, site coverage, pay, and conditions for termination and to negotiate for items you prioritize.
- Everything/anything is negotiable, within reason. Keep in mind that you will either be negotiating with a large organization with much more leverage than you, or with your future private practice partners whom you will be hopefully engaging in a long, healthy, and collegial professional relationship. An effective lawyer will act as a diplomatic intermediary.

- Non-compete clause. It basically prevents you from practicing within a certain radius from your practice location for a certain number of years after you leave. The specified radius can be quite large, so look carefully for this clause especially if you suspect that this won't be your last job in that area. Fortunately, this clause was present only in the minority of contracts I reviewed, and when present, was a negotiable term.
- Relative Value Units (RVUs) and Bonuses. You have likely heard your attendings mention RVUs, which are numerical increments assigned to procedures and clinical work independent of the mix of patients' insurances who may pay different rates for the same service. Hospital systems consolidate those discrepancies with the RVU, often assigned a dollar amount to each RVU generated. Suffice to say, this is one of the main, if not THE main, metric used to evaluate you. Contacts will have varying degrees of minimum RVU generation requirements or monetary bonuses for meeting RVU thresholds. It is worth contemplating, or asking on interview day, if the RVU goals set forth in the contract is reasonable and/or attainable or what are the consequences of not meeting the thresholds and how often practitioners have missed them.

5. ***Miscellaneous***
    - Disability insurance. Your intellect has gotten you this far, but you've entered a subspecialty where your hands, and posture, are more important than ever. You should strongly consider obtaining true own-occupation coverage, meaning that you will be paid if you cannot continue in gastroenterology although you could practice non-procedural medicine. Buying as a trainee may be cheaper than buying as a graduate although locations for both may significantly influence the different rates. Resources like the *White Coat Investor* explain options and vendors in greater detail.

Northern California Society for Clinical Gastroenterology

About the NCSCG

The Northern California Society for Clinical Gastroenterology ("NCSCG") is a 501(c)(3) non-profit organization devoted to the pursuit of clinical excellence in Gastroenterology and Hepatology, primarily through continuing medical education. By providing a forum for the exchange of ideas, the NCSCG aims to encourage professional growth, stimulate intellectual curiosity, and further patient outcomes by expanding access to up-to-date information of interest to practitioners.

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