WINTER 2024

Rumblings

PENNSYLVANIA SOCIETY OF GASTROENTEROLOGY / NEWSLETTER

President's Message / Karen Krok, MD, FAASLD, FACG

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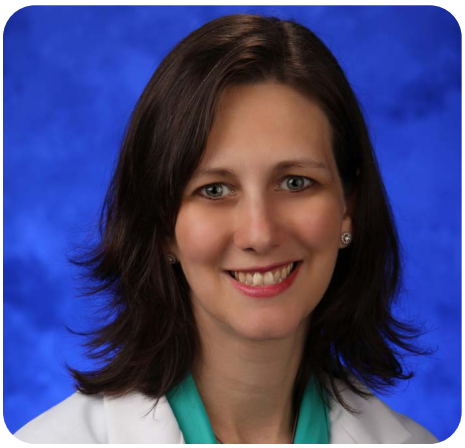

@Klkrok

LIFELONG LEARNING. We know in medicine that our colleagues – or maybe even you - will discover new and better ways to treat something. That there will be new guidelines that we should learn and incorporate into our practice. That new medications will become available, and you may be asked to treat a disease you hadn't thought you would be treating – I never thought as a hepatologist that I would be prescribing weight loss medications, but as this one of the best treatments for MASLD, then it should be something we consider doing!

We recently held our annual Pennsylvania Society of Gastroenterology Scientific Meeting. This meeting brought together more than 100 physicians and APPs throughout the states of Pennsylvania and West Virginia. I would like to thank Dr. Shailendra Singh, Associate Professor of Medicine at West Virginia University, for his role as Program Chair. He brought a lot of energy to the meeting. Assisting him on the Program Committee was also Dr. Harshit Khara (Geisinger), Dr. Hadie Razjouyan (Penn State Hershey), Dr. Matthew Kraft (WVU), Dr. Shyam Thakkar (WVU), Dr. Zubair Malik (Virtua Health), Dr. Areeb Alikhan (Fellow at Temple) and myself. Together we put together a dynamic conference. None of this could have been done, though, without the excellent organizational skills of Jessica Winger - she has been the program coordinator for more than 12 years now and brings with her years of experience and expertise - and Dawn Swartz, the Association Executive of the PSG.

The Saturday morning session started with topics concerning the liver and pancreas. New nomenclature and treatment options for MASLD were reviewed, we learned about treatments of autoimmune liver diseases as well as the emerging field of endohepatology. During a talk on the management of acute pancreatitis, I was struck by how Dr. David Loren referenced a poster that was presented by one of the trainees at this very meeting. This is learning and teaching at its best – we have an expert in the field who is at a meeting and as a lifetime learner and researcher is also discussing a poster that is being presented at the meeting!

In the General Gastroenterology section, we learned about being a gastroenterologist in the era of new weight loss medications. This is something that perhaps more of us should consider prescribing. You have a patient with bad GERD and you know if they lose weight this will help them – should you

continued on page 2

PSG/SOCIAL: @PAGastroSoc

INSIDE

President's Message

continued from page 1

consider this treatment in addition to the PPI? And of course it is a marvelous treatment for MASLD. And this was followed up with talks on pelvic floor dyssynergia and IBS-C and IBS-D. I appreciated the algorithmic approach that each of these speakers brought to their presentations.

Next up was Movies at PSG – and this is where we watched amazing videos of some of the great work that our therapeutic endoscopists can do. As a hepatologist and general endoscopist, I prefer to stay inside of the lumen, but it is good to know that there are some out there with skills that extend beyond the lumen and can assist us if we ever also find ourselves outside of the lumen!

Our keynote speaker was Dr. Austin Chiang of Jefferson Health and CMO of Medtronics, and he spoke on the "Future of AI in GI". Always an engaging speaker, Dr. Chiang enlightened us on the concepts of AI in endoscopy and in clinic. Many of you may already be using these tools, and it seems clear that more and more utilization of this will occur over the next few years. Will it make our lives easier? Will it make our lives better? Who knows? We were told the EMR would make things easier for us, but in many ways, it has only added to the burden for the physicians and care teams.

On Sunday morning, we had two excellent talks on new and emerging therapies for IBD as well as management of severe acute UC. As someone who doesn't treat IBD, I am amazed at the explosion of treatment options – look how far we have come in just 20 years and it is conferences like this that we continue to learn about the growing options for treatments. We heard about microscopic and indeterminant colitis and diverticular disease (something that is so common and rarely gets talked about). We had an expert discussing updates on billing and coding for GI providers. This session taught me a lot as well and is not something we learn anything about in training. I feel as if we should be giving this talk to the primary care physicians who order the procedures and have on the order "screening for colon cancer" and "chronic diarrhea". We can't bill for both and it leaves us in a challenging situation when we see the patient!

The PSG is very proud of our investment and commitment to the trainees! We have a poster competition every year and anyone who submits a poster gets the conference for free and $750 towards expenses (hotel room, etc). This year we had 20 posters for review and our judges selected the following as the winners (with monetary prizes):

First Place

The Impact of Statin Use on Trajectory of Liver Transplant Rejection: A Large Retrospective Database Analysis

Nino Gudushauri, MD
Jefferson Einstein Hospital

Second Place

GLP-1 Agonists Can Prevent Progression of Liver Disease in Patients with Metabolic and Alcohol-Associated Liver Disease (MetALD)

Seyedbabak Mirminachi, MD
UPMC Harrisburg

Third Place

Management and Outcomes of Antithrombotic Therapy in Endoscopic Ultrasound-Guided Gallbladder Drainage

Michael Makar, MD
Geisinger Medical Center

One of the sessions this year was a panel discussion about different career opportunities for the fellows from private practice, academic medicine, to being part of a larger group. This was the first year that we did this and PSG board member Dr. Fraser Stokes is spinning this off to having sessions for fellows throughout the year to answer some of their questions about different career opportunities.

And then there is the GI Jeopardy in which teams of 2 people vie for the coveted PSG trophy! Dr. Harshit Khara served as moderator, and this year's winner was West Virginia University! A great time was had by all in the audience!

We ended the conference with a hands-on session where we could practice stenting, using hemostatic spray, performing EMR and defect closure, and cannulation of the bile duct and the participants were taught by experts in the field from around the Commonwealth.

I enjoyed walking around and speaking with the residents and fellows who are interested in GI. I welcome you to encourage your trainees to attend this annual meeting as it is a great way to learn from local experts and make connections! It was at a meeting like this that I met a fellow looking for a job and she became a colleague of mine for many years!

We are all lifelong learners. This is a wonderful conference to connect with local experts and colleagues and I enjoy seeing some people that I may only see once a year!

Next year we will be in Philadelphia on September 20th and 21st, 2025! Again, we promise to have an exciting conference full of clinically relevant pearls and topics as well as time to gather and meet up with colleagues! Thank you to all who came this past year and I look forward to seeing you next September!

PSG Research Grants and Awards: Request for Proposals (RFP)

The Pennsylvania Society of Gastroenterology is a private, non-profit organization established to support the practice of gastroenterology in the Commonwealth of Pennsylvania and the State of West Virginia. The PSG was founded in 1982.

For 2025, we are looking for research proposals in the following areas:

(1) Increasing access and utilization of colorectal cancer screening

(2) Improving value in endoscopic care delivery

(3) Improving access to gastroenterology and hepatology care delivery –

Each grant award will be up to $12,500.

2025 Research Grant Submissions Are Due **January 31, 2025.**

Submission: Please submit using this link: https://form.jotform.com/242405531753048.

Or you can go to https://www.pasg.org/25grant.

Grant Applicant Criteria:

- Applicant Criteria: Must be a PSG member. Be a physician, physician in training (letter of support), or hold an advanced degree (MD, DO, PhD or an international equivalent).
- Must be held in the field within gastrointestinal disease that impacts the regional patient populations of Pennsylvania or West Virginia.
- Investigators may be in any stage of their career.
- Mentor program: Through the PSG grant process, a physician applying for a grant may request and be provided with a mentor through the PSG.
- Grant research proposals should not exceed 3 pages. They should include a Specific Aims, Background and Significance, Preliminary Data, Proposed Studies, and Methods.
- Literature cited should be provided separately.
- Budget Justification: Not more than one page. Justification for salary support and supplies and equipment listed in the budget page should be detailed.
- All grant applicants are encouraged to attend the annual meeting of the calendar year where the recipient will be announced.
- All recipients are expected to present their research at the Annual PSG meeting 1 year following the award and are expected to provide a short description of their research for the PSG newsletter (Rumblings).
- Recipients are expected to reference the PSG award for any publications that result from the grant.

Other Grant details:

- Grant awardees will receive 50% of funds at the start of the grant and the remaining 50% after a 6-month single page progress report is received and reviewed by the research task force for appropriate progress.
- All grants are for 1 year

Selection Criteria and Notice of Award:

- All proposals received and accepted for review will be reviewed by the Grant Review Council. The members of this committee are all physicians/researchers with special interests in the field of gastroenterology and hepatology. They will review the proposals and make recommendations for funding based on the merit of the proposed research. The committee will make a report to the Board of Directors. Notice of award to be sent by email Spring 2025.

Questions? Please contact Dawn Swartz at info@pasg.org

"Dear First Year Fellow"

Brittney Shupp
PGY-5 Gastroenterology Fellow

I would like to welcome you to the world of gastroenterology. There are few things more exciting in our medical careers than the three years of GI fellowship. After all, it has taken years of hard work and dedication to make it to this point. It is often hard to believe that those long years of medicine residency and long nights doing research projects to build your resume and earn a spot in a program, have all culminated in this moment. For many of us, this still feels unreal. As a second-year fellow, I still frequently have those "pinch me" moments where I must remind myself that this is no longer an elective rotation, but "the real deal". I am now training to do something that I will be doing for the remainder of my medical career. However, do not be mistaken, those same surreal, "pinch me" moments can be associated with a huge wave of fear of failure and self-doubt. Medical training can be difficult and mentally taxing. This is why "Imposter Syndrome," or the inability to acknowledge one's own talents and success, is so commonly encountered in physician trainees, including GI fellows.

Entering into GI fellowship, I was so excited to finally get my hands on a real scope, not the colonoscopy simulator, and dive into procedures. However, I quickly realized that the art of endoscopy was not something that I was going to master quickly or even in my first year of fellowship. As someone who considers herself a "Type Triple-A Perfectionist," I found scoping to be extremely frustrating in my first year of fellowship. Many days I felt like a failure despite my attendings unwavering support and constant, positive feedback that I was exactly where I was supposed to be. Every time I felt like I was making some progress, I would encounter an impossible sigmoid on a petite, older lady or tough bleeder in the duodenal sweep that would force me to relinquish the scope. Every time the attending would need to take over, I would again doubt my abilities and failed to recognize the incredible progress I had made. It was also difficult to not compare myself to my second and third year co-fellows. I was in awe at their scoping abilities, mistakenly thinking things came so easily for them, and hoping to be at their level over the next one to two years. I also found it challenging being the one to find and diagnose a horrible GI malignancy, often during my first encounter with a patient, yet not have the ability to address and treat it myself. Although I often struggled in my first year, these moments helped me to realize the importance of self-reflection and the amount of uplifting strength that one can receive from the relationships you build with your co-fellows and attendings who have shared similar experiences. And also, from patients whom you choose to positively impact not only by your hands but by your words and compassion.

I would like the first year fellows to know that you are not alone. Scoping and seeing all those new consults on a busy service, does become easier (although polyps are still my enemies for the time being). Now as a second-year fellow, scoping has grown to become my favorite part of my job. Also, I am no longer the "new kid on the block". Although I still look to my co-fellows and attendings, I now also look at the first year fellows with so much hope. But more importantly, I look to them with such excitement and enthusiasm knowing their future to come and hope to instill in them a sense of positivity and optimism during those moments of frustration. Those feelings of fear, failure, and self-doubt can be overcome by perseverance, dedication, and the desire to succeed. If GI fellowship and scoping was meant to be easy, it would certainly not be a three-year fellowship which is why we have been lucky enough to have been given this precious time to learn this incredible art and have fun while doing so. So, remember: do not ever forget that you are not alone, you are more than capable, and you got this!

Rooting for you,
Brittney Shupp, PGY-5
Gastroenterology Fellow

How Old Is Too Old for a Colonoscopy?

Carolyn Crist

Colonoscopy remains the gold standard method for detecting colorectal cancer (CRC) and removing precancerous polyps.

The recommended age for CRC screening in the United States spans 45-75 years, with the benefits of colonoscopy diminishing considerably after this point.

Older adults are much more likely to experience complications before, during, and after a colonoscopy. Bowel preps can cause dehydration or electrolyte problems in some, while bleeding and bowel perforation can occur perioperatively, and pulmonary or cardiovascular complications may arise postoperatively.

These risks often outweigh the benefits of catching a precancerous lesion or early-stage cancer, especially given the low rates of advanced neoplasia and CRC detected from screening and surveillance after age 75. Yet the research overall suggests that more than half of older individuals continue to receive screening and surveillance colonoscopies outside the recommended screening window [1].

So is there a point in time when a person is too old to receive a colonoscopy? The answer is not always clear-cut, but life expectancy should be a key consideration.

"Taking the most extreme example, if you have 6 months to live, finding early-stage cancer is not going to help you," says Michael Rothberg, MD, of Medical Institute and director of the Center for Value-Based Care Research, Cleveland Clinic, Cleveland.

For those with more time, the benefits of continued screening and surveillance may outweigh the risks, but when that balance shifts from helpful to not helpful remains inexact, Rothberg noted.

What's Recommended?

In May 2021, the US Preventive Services Task Force (USPSTF) lowered the CRC screening threshold to age 45, recommending all adults aged between 45 and 75 years receive screening [2].

For those aged between 76 and 85 years, the USPSTF upheld its 2016 recommendation of selective screening, noting that the "net benefit of screening all persons in this age group is small" and should be determined on an individual basis. The USPSTF, however, did not provide recommendations on surveillance colonoscopies among those with previously identified polyps.

In November 2023, the American Gastroenterological Association (AGA) issued a clinical practice update that provided advice on risk stratification for CRC screening and post-polypectomy surveillance [3]. For adults older than 75 years specifically, the AGA recommended that the decision to continue CRC screening or perform post-polypectomy surveillance be based on risks, benefits, comorbidities, and screening history and decided on a case-by-case basis.

For instance, previously unscreened patients without comorbidities could benefit from screening beyond age 75 — up to age 80 for men and 90 for women — while those who have had regular colonoscopies, per recommended guidelines, but severe comorbidities that may limit life expectancy could stop sooner, even by age 65.

Although an individualized approach leaves room for variation, it's essential to consider life expectancy and the time it takes for a polyp to progress to CRC, as well as the risks associated with the procedure itself. Certain older adults are "less likely to live long enough to benefit from surveillance colonoscopy, due to competing, non-CRC mortality risks," and clinicians should discuss these risks with their patients, the experts explained.

When to Stop Screening Colonoscopies

Research shows that screening colonoscopies continue well after the recommended stop age.

A 2023 JAMA Internal Medicine study found, for instance, that a large proportion of screening colonoscopies occurred among the 7067 patients who were 75 years and older with a life expectancy < 10 years [4]. Overall, 30% of patients aged between 76 and 80 years with a limited life expectancy had a colonoscopy. That percentage increased to 71% for those aged 81-85 years and to 100% for those older than 85 years.

But the benefits of screening were minimal. Overall, colonoscopies detected advanced neoplasia in 5.4% of patients aged 76-80 years, 6.2% of those aged 81-85 years, and 9.5% of those older than 85 years. Only 15 patients (0.2%) had CRC detected via colonoscopy, five of whom underwent cancer treatment. Of those five, four had a life expectancy ≥ 10 years, and one had a life expectancy < 10 years. At the same time, adverse events requiring hospitalization were

common 10 days post-colonoscopy (13.58 per 1000), and the risk for hospitalization increased with age.

"For all kinds of screening, we're not that comfortable in America with the idea that people are eventually going to die, but as you get older, the potential benefits for screening decrease," said study author Rothberg.

In general, life expectancy provides a good predictor of whether people should continue screening or receive treatment following a CRC diagnosis.

Patients aged 76-80 years in good health, for instance, could benefit from screening and, potentially, treatment, Rothberg said. And "if doctors don't feel comfortable or confident about predicting life expectancy, taking comorbid illnesses into account can be helpful, especially for that age range."

Weighing Surveillance Benefits

Surveillance colonoscopy is often recommended post-polypectomy to reduce the risk for CRC. But even in this higher-risk population, those older than 75 years may not benefit.

Recent evidence [3] indicates that those with a history of one or two adenomas less than 1 cm in size have only a slightly (1.3-fold) increased risk for incident CRC — and no significant increased risk for fatal CRC.

Another recent study [5] found that detecting CRC at surveillance colonoscopy was rare among older adults. In surveillance colonoscopies performed among 9601 individuals aged 70-85 years with prior adenomas, 12% had advanced neoplasia detected, and only 0.3% had CRC detected.

Similar rates of advanced polyps (7.8%) or CRC (0.2%) were reported [6] in another recent analysis of more than 9800 adults older than 65 years receiving surveillance colonoscopies. Despite the low rates of polyp and CRC detection, nearly 90% of patients with recommendation information available received advice to return for a future colonoscopy. Even among patients with no polyps or small ones, almost 60% who had life expectancy of less than 5 years were told to return.

Although someone with prior adenomas has a higher risk for CRC, that doesn't tell the whole story for an individual patient, concludes Samir Gupta, MD, professor of gastroenterology at the University of California San Diego, and co-lead of the Cancer Control Program at Moores Cancer Center. For older adults, it's vital to consider the competing risks and how much time it might take for CRC to develop. At Digestive Disease Week in May, Dr. Gupta presented new research that looked at cumulative risk among patients aged 75 years and older with prior precancerous polyps vs prior normal colonoscopies. Although those with prior adenomas had a higher risk for CRC overall, their cumulative CRC risk was low — about 0.3% at 5 years and 0.8% at 10 years. Cumulative CRC deaths were even lower — 0.2% at 5 years and 0.7% at 10 years — while the risk of dying from something other than CRC was 20% at 5 years and 40% at 10 years.

"What this means to me is that patients who are 75 and older should think really carefully about whether they want to do surveillance," said Gupta, who co-authored the AGA's clinical practice update [3]. "Someone who is very healthy and doesn't have obvious medical problems can look at that risk for developing colon cancer and the risk of dying and make a decision about whether there's enough concern to go ahead with surveillance."

Those with competing health priorities, on other hand, should likely concentrate on those instead, he said, and feel reassured that even if they choose not to do surveillance, they're probably not doing themselves any harm.

"The bottom line is that referring older adults or frail adults for surveillance colonoscopy shouldn't be a rubber stamp or check-the-box action," Dr. Gupta said. "We need to think about it carefully and give ourselves — as clinicians and patients — the room to decide that it may not need to take high priority."

What to Tell Patients

Overall, older adults who have had prior colonoscopies, no or low-risk polyps, and low CRC risk will likely face greater risks from the procedure than benefits.

"The more invasive the screening the test, the more dangerous it could be," Rothberg noted.

Many patients, however, are open to stopping and often trust their primary care provider in the decision-making process, said Audrey Calderwood, MD, director of the Comprehensive Gastroenterology Center at Dartmouth Hitchcock Medical Center. "But the systems we have in place don't optimally support that decision-making at the time it matters most."

For example, at a prior colonoscopy, a gastroenterologist may recommend surveillance again in 5-7 years. But in the interim, the patient could have new medications or develop comorbidities and other health issues. Rather than defer to the gastroenterologist's recommendations from years ago, clinicians and patients can reassess the pros and cons of screening or surveillance based on current circumstances, Dr. Calderwood said. "There should be lines of communication and systems of support to allow primary care providers to decide whether it is still needed," she said.

While some may be ready to stop, other patients are going to continue to want and ask about CRC screening or surveillance, Dr. Rothberg said. In these instances, communication style matters.

"You don't want to tell a patient that they're not going to be screened because they're not going to live long enough to benefit," Rothberg said. However, steering people toward less invasive tests or telling them it's important to give other health problems priority may be more sensitive ways to communicate that it's time to ramp down or halt screening.

"Sometimes when you say you're going to stop cancer screening, older adults misperceive that you're giving up on them," Dr. Gupta said. "We spend 30-40 years driving home the message that prevention and screening are important, and then it feels like we're taking it away, so we need to find the best way to discuss it and make the choice that's comfortable for them."

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Written by:

Carolyn Crist is an independent health and medical journalist, living in Georgia. This article appeared on Medscape Gastroenterology on August 26, 2024 and has been reprinted with permission [https://www.medscape.com/viewarticle/how-old-too-old-colonoscopy-2024a1000fkn].

Carolyn has been published in: Business Insider, Daily Mail, Fox News, MSN (US), Reuters, The Washington Post, WebMD, Yahoo Canada, Yahoo News, AOL, @webmd and @medscape. crist.carolyn@gmail.com.

SAVE THE DATE

Geisinger-PSG Capsule Endoscopy Course 2025 & Fellows Networking Event

Pennsylvania Society of Gastroenterology

Date: August 15, 2025

Time: 12 noon to 5 pm

- **Location:** Heron Cove Pavilion A, Chilisuagi Trail, Montour Preserve, 374 Preserve Rd, Danville, PA 17821
- **Networking Activity:** Kayaking and Boating on Lake Chillisquaque after the course from 5pm-7pm (optional and complimentary)
- **Fees:** This course is being offered free of cost to all attendees, supported by an education grant obtained by Geisinger Foundation from Medtronic, and championed by the Training Committee with the Pennsylvania Society of Gastroenterology.
- **Lodging:** A complimentary one night stay will be offered to all attendees traveling from out of town at Pine Barn Inn in Danville, PA on Friday 8/15/25
- **Meals:** Lunch, Snacks, and Dinner (for overnight guests) will be provided as part of the course

Registration will open in late spring.

GI Career Tracks: The Hospital-employed Model

R. Fraser Stokes, MD, FACG
PSG Practice Management Committee Chairman

Practice opportunities for gastroenterologists are evolving rapidly.

A major trend in healthcare economics now is the consolidation of the physician workforce. A report from the Physicians Advocacy Institute and Avalere Health in 2023 found that 58.5 % of U.S. practices are either owned by health systems or corporations. Additionally, 78% of physicians are now employed by hospitals, health systems, or other corporate entities. Between 2019 and 2021, it's estimated that 108,700 physicians left traditional private practice for employment.

In recent issues of Rumblings, I have written articles about "supergroup" private practice opportunities and locum tenens options in gastroenterology. Now I focus on the hospital-employed practice model. A great number of GI physicians are now working as employees of a hospital, either in an academic or non-academic setting. Some are choosing this option straight out of fellowship and others become hospital employed after their private practice has been purchased by a hospital system. As a side note, when purchasing practices, hospitals commonly cannot offer as substantial of a monetary buy-out as can private equity backed supergroups, due to anti-kickback regulations for hospitals and their requirement to offer "fair market value." Hospital buy-outs mainly involve paying for office furniture, supplies, equipment, charts, etc. However, hospitals do offer competitive salaries and benefits to GI doctors, especially for the first contract.

There are many advantages to working for a hospital system in comparison to working in traditional private practice. Some of these advantages pertain also to physicians that work as equity owners in a supergroup. A major advantage of hospital employment is the reduction in administrative responsibilities compared to traditional private practice. It has become quite complex to run a private practice, over the past 10 to 20 years. Practice administration can be time consuming and stressful, especially to a physician who is busy doing clinical work. Particularly difficult areas to manage include regulatory compliance, recruiting, revenue cycle management, human resources, negotiating insurance contracts, property management, equipment and supplies, information technology, marketing, and provider scheduling.

A second advantage of hospital system employment is reducing financial risk. Private GI practices are susceptible to items outside of their control that can significantly curtail their income. Examples include COVID, insurers dropping reimbursement rates, inflationary increases in labor and supply costs, and facility and EMR problems that necessitate temporary office slow-downs or closures. Another advantage of the hospital-employed model is more frequent opportunities for academic pursuits, such as research and teaching. Greater mobility is also an advantage of hospital employment, as physicians can leave a hospital practice and relocate to another area much more easily than if they were equity owners of an independent practice. Minimizing debt to a young physician is yet another advantage to the hospital-employed model. Gi private practices usually require a buy-in for partnership and often a second buy-in to an ambulatory surgery center. In certain markets, an advantage for the hospital employment model is having a built-in solid patient base. As hospitals become more vertically integrated, many patients are directly or indirectly restricted from seeing physicians that aren't employed directly by the local hospital system. Hospital network referral systems sometimes favor sending patients to hospital-employed providers.

There are some disadvantages of working for a hospital system, too. The most commonly cited issue is the lack of provider autonomy, whereby physicians feel they have a reduced level of control of their schedule and of the administration of their various activities. For example a hospital may be unwilling to purchase a new technology that a physician feels is important to have for their practice. Non-physician administrators are often the bosses, and can control how doctors deliver health care. These managers may lack a fundamental knowledge of GI-specific practice management strategies, and could tend to use the same administrative approaches that they use for primary care or other specialty practices. At times physicians feel a lack of job security when working for a hospital system, as hospitals may terminate a physician or decide to not renew a physician's contract. Some gastroenterologists complain of excess time spent in committee meetings that they've been assigned to, but aren't particularly interested in. Some physicians are frustrated by

staff that are not directly employed by them and at times are not quite as responsive to their interests, perhaps related to physicians having minimal input in hiring or firing these employees. Physician practice owners are often able to establish a special office culture and positive work environment, yet this may not be as easy to do for hospital employed docs. Working for a hospital can also mean limited opportunities to generate additional income, such as adding new revenue streams, for example clinical research or in house pathology. Finally, I have observed disgruntled colleagues that are hospital-employed being asked to make significant financial and benefit concessions when negotiating second and subsequent contracts.

Choosing the right GI career path is a complicated process and one that deserves careful consideration. Gi physicians each have different career priorities, and determining the path that best fits a person's needs is paramount. No option is perfect for everyone. Personality may determine which path would be best. Those that are risk-averse and value structure may be best suited to hospital employment, and those that are more risk tolerant and entrepreneurial may be happier as business owners. Those gastroenterologists with strong academic career goals are usually best suited to working for a large hospital system. Finally, for some gastroenterologists, working in one practice environment during an early or middle part of their career may be optimal, while switching to another opportunity type may work best later on.

The PSG practice management committee is establishing an outreach program to GI fellows to educate them on career options. This will involve Zoom meetings between committee members and fellows whereby a presentation will be made to fellows, followed by an extensive question and answer session. The goal of this PSG project is to provide an unbiased and experienced educational resource for those exploring future career options. If your training program has interest in participating in one of these online meetings, please email me at fraserstokes@mac.com.

2025

PSG Annual Scientific Meeting

September 19-21, 2025

LOEWS HOTEL, PHILADELPHIA, PA

PSG Pennsylvania Society of Gastroenterology

LEGAL CORNER

Artificial Intelligence and Legal Risks in Gastroenterology

Richard E. Moses, D.O, J.D.
@therealgidoc

Introduction

The Artificial Intelligence (AI) revolution is here and all around us. Terminator jokes and analogies to Skynet as well as the Matrix abound. Be that as it may, AI is rapidly moving forward to transform diagnosis, screening, treatment, and research in medicine including in the field of gastroenterology (GI). The goal of medical applications of AI is to aid clinicians to improve patient outcomes, reduce costs and enhance efficiency. It is certain that eventually, AI will change our professional lives. It is not uncommon for technology to be ahead of legal and social issues. We saw this in the 1990s as the Internet matured. Despite the potential benefits and opportunities of AI, its use also entails significant legal risks and implications for medical practitioners, including malpractice, privacy issues, data security, consent, and ethics. Some of these medical-legal issues with AI are already occurring and others are rapidly developing. My goal is to provide an overview of the legal issues involved with the roll out of AI in GI.

Current and Future Uses of AI

AI is already being widely applied to pathology, radiology, and genetics. Current use of AI in endoscopy mainly pertains to polyp detection. Further applications are being developed to classify, and characterize colon polyps but these are not currently approved for use. Research for applications for endoscopic assistance in gastroscopy and capsule endoscopy is ongoing. AI can assist in the assessment of disease activity, severity, and potentially prognosis of inflammatory bowel disease, celiac disease, and gastric cancer, among other diseases. The goal is for AI to provide real-time feedback, guidance and recommendations to endoscopists. AI is also being studied in the medical genetics, helping to analyze and interpret complex genomic data that is relevant to IBD as well as hepatocellular and colorectal cancers. It may also be able to assist in identifying novel genes, variants, and cytokine pathways that are involved in disease pathogenesis, susceptibility, and progression.

No field is more advanced in the use of AI than radiology. AI applications can be used to pre-screen imaging studies, pointing out areas on scans that might need closer attention by the radiologist. Uses in pathology are also a growth area, and will be an important part of diagnosis. Incorporation of data regarding gene mutations, protein expressions, and microbiome profiles can potentially help AI make more accurate diagnoses and suggest therapies, particularly for malignancies. For preventative medicine, AI may allow us to spot high-risk individuals and populations for GI diseases based on the analysis of the risk factors, biomarkers, and screening tests. In turn, it will suggest appropriate interventions, including lifestyle modification, chemoprevention, and surveillance.

Legal Risks and Implications

The use of AI poses a number of potential significant legal risks.

Risk of Malpractice

Malpractice occurs when a medical professional fails to meet the standard of care and causes harm to a patient. AI may injure patients if there is misdiagnosis, delayed diagnosis, inappropriate treatment, an adverse event, or error in data processing, analysis, or interpretation. This is not foolproof technology, and the developer is not necessarily ultimately responsible. If the AI system provides an incorrect diagnosis or recommendation, and the clinician relies on it without verification, negligence may result. Clinicians must never allow AI to be a substitute for their own clinical judgment. AI should be designed, developed, tested, and used with the highest standards of quality, safety, and reliability. The potential harm, damages, and errors that can occur in different scenarios must be recognized and handled appropriately.

Privacy and Consent

AI collects, stores, processes, and shares large and sensitive personal data including health data, biometric data, genetic data, and behavioral data. Individuals have the right to control the use of their own personal information. AI can violate privacy regulations if it collects, analyzes, or shares sensitive health data without appropriate consent. Similarly, it the system leaks confidential date or if phishing or malware is involved, a privacy breach occurs. Clinicians

must always get informed consent from their patients before using AI. AI should respect, protect, and enhance the privacy of the personal data that is collected. AI systems should comply with the current statutes, including the Health Insurance Portability and Accountability Act (HIPAA).
The type of consent for AI-related actions depends on the nature, purpose, and consequence of the actions or decisions, but it should always be clear, comprehensive, accurate, voluntary, informed and specific, and must be capable of being revoked or modified if necessary. Patients, clinicians and third parties should obtain consent to actions or decisions that could affect their rights, interests, and expectations. AI must respect the autonomy, dignity, and justice of the people affected.

Data Security

Failure to protect data from unauthorized or malicious use, modification and destruction results in a data breach, which is another related legal risk when using AI in any medical field. Data security can be compromised when it is capable of being hacked, tampered with or manipulated, since the AI system could produce inaccurate or harmful outputs, or even expose potentially personal and sensitive data to unauthorized parties. To avoid these problems, clinicians must use appropriate and secure AI systems that include mechanisms to detect and prevent attacks and errors. Safeguards to prevent unauthorized access and data breaches must be implemented to ensure data security.

Regulation

AI is subject to national and international laws, rules, and standards, and professional guidelines that are relevant to gastroenterology, such as the Food and Drug Administration (FDA) in the United States. The regulation of AI can be based on the risk, benefit, or innovation of the AI system, whether the AI is low-risk, high-risk, or novel, and whether its purpose is diagnostic, therapeutic, or research.

Ethics

AI raises numerous moral, social, and cultural issues and dilemmas. The trustworthiness of the AI system is significant, and whether the system is aligned with human values, norms, or expectations is relevant. The ethics is guided by various legal frameworks and can be influenced by the involvement of many stakeholders, including patients, clinicians, researchers, developers, manufacturers, and regulators. There needs to be a continuing dialogue regarding moral, social, and cultural dilemmas of the AI system so that the ethical issues are always at the forefront of consideration.

Current Healthcare AI Issues

There is a paucity of direct litigation against physicians using AI currently although that is likely to change. The Department of Justice (DOJ) settled criminal and Anti-Kickback cases in 2020 against Purdue Pharma and Practice Fusion over their collusion to design automated pop-up alerts pushing physicians to prescribe addictive analgesics. The DOJ is now specifically starting to scrutinize the use of AI embedded in patient records. Federal prosecutors have been subpoenaing specific pharmaceutical companies because health care record vendors have allegedly been using AI to match patients with certain drugs and devices. The DOJ is questioning what algorithms are being built into EMR systems to help determine whether the prompts are resulting in more care than is medically necessary. In the same vein, certain insurance companies are facing class actions from consumers (and their estates, for deceased patients) relating to the use of AI in denying claims which were medically necessary. The Department of Health and Human Services is now required to set up a safety program to consider unsafe healthcare practices involving AI. A wave of lawsuits relating to AI usage is expected to continue to spread over the various aspects of healthcare in the near future. Experts are predicting AI litigation will become a regular occurrence by 2027.

AI is a powerful and promising tool that can revolutionize diagnosis, screening, treatment, and research of GI disease. However, AI also poses significant legal risks and challenges including liability, privacy, consent, regulation, and ethics that need to be addressed and resolved as this technology works its way into clinical practice. Will failure to use AI in medical practice fall below the standard of care? Will medical practices be forced to purchase every AI technology to "keep up" and defend against a bad outcome?

I have tried to review the main legal issues and implications, and have offered possible solutions and recommendations. AI is in its early stage in GI, and a rapid growth curve ahead is expected. The applications are many and currently ahead of the law that will develop as AI matures and becomes more widely adopted in clinical practice. Hopefully, "I'll be baaaaack" to explore this further in the future; if not my AI hologram likely will.

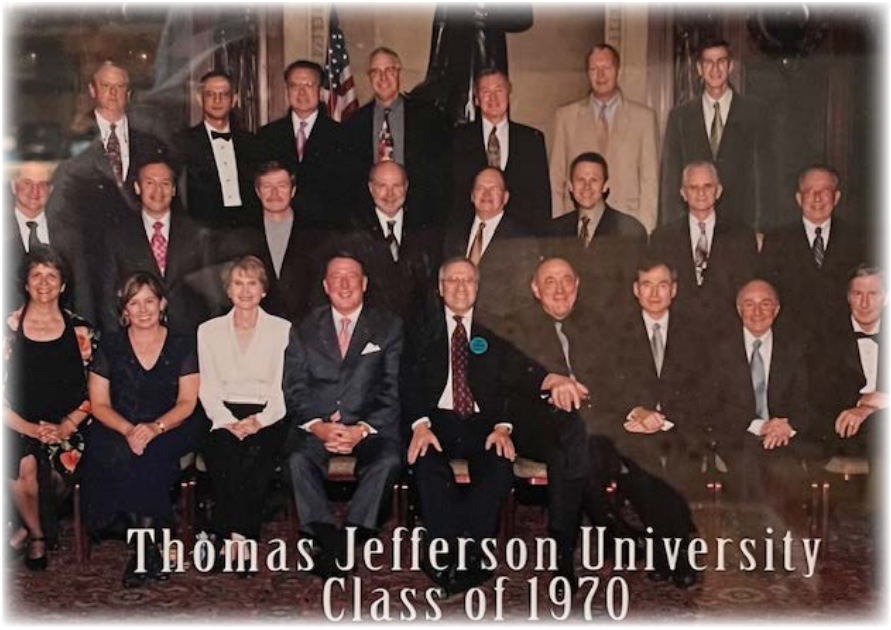
Celebrating the life and work of Dr. Harvey Lefton (1944 - 2024)

It is with profound sadness, that we announce the passing of Dr. Harvey Lefton of Huntingdon Valley, PA and Margate, NJ on Tuesday, November 5, 2024. He was a beloved son, brother, husband, father and grandfather and highly respected gastroenterologist. Dr. Lefton was a revered physician whose career spanned over 55 years, dedicating his life to the care and well-being of others. Born on May 17, 1944 in Cleveland, Ohio, he was the son of Nat and Edith Lefton and brother of Saundra, all of whom preceded him in death. He completed his undergraduate degree at the University of Pittsburgh. He graduated from Jefferson Medical College, going on to complete his residency and fellowship in gastroenterology at the Cleveland Clinic. After his medical training he served in the United States Air Force as a Major at Scott Air Force Medical Center in Belleville, Illinois.

He then moved to Philadelphia where he built the largest GI practice in Northeast Philadelphia and he served as Chief of Gastroenterology at Jefferson North East Hospitals. He was a Fellow of multiple societies, including American College of Physicians (ACP), American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and American Society of Gastrointestinal Endoscopy (ASGE). He served as the 151st President of the Philadelphia County Medical Society and was honored to have been President of the Pennsylvania Society of Gastroenterology. He was known not only for his expertise but also for his unwavering dedication to his patients and colleagues alike.

Beyond his professional accomplishments, he was a beloved husband of 56 years to Paulette. He was a cherished father to Allison and Daniel, father-in-law to Dr. David Sass and Laura Lefton, and adored 'Papa' to Lauren and Aaron Sass, and Jake, Emily, and Brandon Lefton.

Dr. Lefton's legacy is carried forward by his family, friends, and the countless lives he touched.



...beloved son, brother, husband, father and grandfather and highly respected gastroenterologist.

2024 Annual Scientific Meeting—Photo Gallery

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