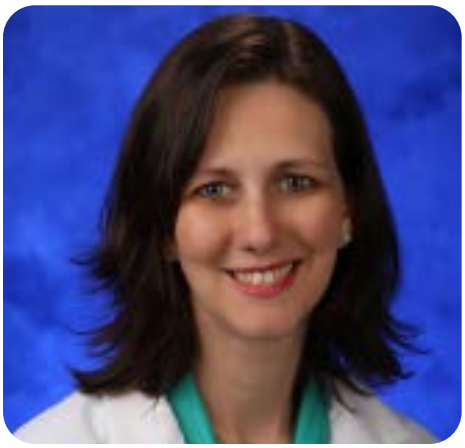
SUMMER 2024

Rumblings

PENNSYLVANIA SOCIETY OF GASTROENTEROLOGY / NEWSLETTER

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

www.pasg.org



@Klkrok

The summer is always a time for new beginnings in the world of Medicine – new residents and fellows are starting, medical students come to school for the first time or come back from summer break. It is a time that I look forward to every year as I have dedicated a lot of my career to mentoring fellows, residents and medical students. One of the jobs I have enjoyed the most in my career has been as an Associate Program Director for our GI Fellowship program and previously when I was the fellowship program director.

It always reminds me of why I went into medicine. What made me write a paper in 6th grade about my future career – and I chose DOCTOR? Although I wrote about being a pediatrician – which I am obviously not – my goal in life since I was a kid was to be a doctor. Why did you choose your path?

Mentors help you to choose your path. As a child I spent time as a patient at the Children's Hospital of Philadelphia requiring 4 surgeries on my bladder and kidneys. My connection to my surgeon – Dr. John Duckett, some of whom would describe as the Father of Pediatric Urology – was profound. I wanted to help others as he helped me and my family. He was always warm and kind when I went to visit him. He suggested a high school for me to attend – and I did. He offered me a summer and holiday break job working in his office – which I did. It wasn't a fancy job – I filed papers (yes – it was at a time when there were paper charts), answered the phone and other clerical tasks, but I was able to spend more time with my mentor. When I applied to medical school, he recommended that I look at The University of Pennsylvania. And on the day that I found out I was accepted to Penn, I learned that he passed away unexpectedly. He was my first mentor and I wonder to this day if I would have been a urologist to follow in his footsteps if he were alive to mentor me during medical school.

I enjoy being a mentor. I enjoy rounding with the medical students and teaching them – and of course learning from them. The questions that we get asked on rounds encourage us to be better doctors and to seek out the answers as to the WHY we do something; you can't just say to the student "we just do it this way" as you need to explain the pathophysiology behind hepatorenal syndrome or encephalopathy. I know many of you have mentors that have influenced you. I would encourage you to reach out to one of those mentors and thank them for

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PSG/SOCIAL: @PAGastroSoc

INSIDE

President's Message

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what they have done for you. I was able to speak at Dr. Duckett's funeral as a former patient and mentee and became friends with his wife. Recently when a medical student reached out to me to tell me what they were doing currently – it was such a pleasant surprise to hear from them and it brought me joy knowing that they were doing well!

You also choose your path because no one has put a barrier in front of you. I never had someone tell me that I couldn't be a doctor – well at least not at a young age (more to come about that story). I was the first person in my family to go to graduate school. My parents encouraged me to dream big and that I could accomplish anything. Be encouraging to those around you. I find myself frustrated by my medicine right now – so many administrative burdens when all we want to do is help people and now I feel that barriers are being placed in front of us – but I would never discourage anyone from pursuing a career in medicine. If that is their dream – then go for it. Remember back to when you started medical school and your excitement walking into the anatomy lab (or at least the smell of that first day) and weren't you thankful that no one discouraged you from achieving your dream. My organic 2 professor did say to me at one point "well, maybe being a doctor is not the right career for you". Luckily, I was old enough to not take that to heart and let that dissuade me from my path and instead used that as a challenge to prove him wrong! I don't know what path my kids will take in their lives but I want them to dream big and I will always encourage them in their passion – because if you have passion then hopefully you will also find joy, excitement and contentment in your future!

I went into medicine to help people; with the PSG we are working to improve care in the State of Pennsylvania for our patients. We have a goal to work with Medicaid to allow for endoscopies at ambulatory surgical centers. This will not be something we can accomplish overnight but it is something that we are starting to look into. This came for some of you all – some of the members of the PSG who brought this forward as an issue and we are looking to try and advocate for you and our patients.

As a mentor and a teacher, I also love to learn and I am very excited about the annual meeting that we will be having in Hershey on Sept. 13-15! There is a fantastic program planned – that includes a hands-on session, poster presentation from fellows in the state, and talks on weight loss medications, billing and coding, metabolic dysfunction associated steatotic liver disease, AI in GI, endohepatology, IBD medications and so much more. We hope that you will come and meet new people, learn something new and enjoy the weekend in Hershey! With Hershey Park so close we are offering discounted tickets and a picnic at the park on Saturday night!

Looking back, I am not sure what I would have done without my mentors encouraging me at so many important points in my life. Be that person for others. Be a mentor! Be a teacher! Be encouraging!

SAVE THE DATE!

ACG 2024

PSG Pennsylvania Society of Gastroenterology

JOIN US FOR THE PSG RECEPTION

Where: Maggiano's! Little Italy

When: Sunday, October 27, 2024

Digestive Disease National Coalition Update

Ralph D. McKibbin, MD, FACP, FACG, AGAF
PSG Representative to DDNC and DDNC Past President

The Digestive Disease National Coalition held its 34th Annual Public Policy Forum March 3rd and March 4th in Washington, DC. The DDNC is an advocacy organization comprised of the major national voluntary and professional societies concerned with digestive diseases. PSG is a longstanding member and provides ongoing physician leadership. Pennsylvania's Federal House and Senate offices are targeted to give physician and patient feedback about ongoing issues. The DDNC focuses on improving public policy and increasing public awareness with respect to diseases of the digestive system. The mission is to work cooperatively to improve access to and the quality of digestive disease health care to promote the best possible medical outcome and quality of life for current and future patients. This umbrella organization brings a strong consensus agenda when advocating to legislative members and regulatory groups. This election year creates caution so continued advocacy through the summer is needed. The DDNC legislative and policy priorities are as follows:

DDNC urges legislators and federal officials to pass legislation and implement policies that benefit patient access to care by strengthening the patient-provider decision-making relationship, limiting patient out-of-pocket spending, and curbing the ability of third-party payers to shift overly burdensome costs onto patients through utilization management tactics such as prior authorization, step therapy, co-pay accumulators, and non-medical switching.

Resource: DDNC Whitepaper on Cost Shifting
DDNC Copay Accumulators Patient

Safe Step Act (S 652/H.R. 2630) – This bipartisan bill would establish common sense guidelines for appealing step therapy protocols under ERISA health plans. DDNC urges legislators to pass the Safe Step Act in the 118th Congress.

Resource: Safe Step Act Fact Sheet and Summary.

Step therapy is one of many "utilization management" or "cost-shifting" tactics employed by third parties to shift costs away from themselves and to the patient, which delays appropriate treatment, increases patient out-of-pocket costs, and drives a wedge between a patient and their health care provider's decision-making.

HELP Copays Act (S. 1375/H.R. 830) – The bipartisan HELP Copays Act requires health plans to count the value of copay assistance toward patient cost-sharing requirements.

Treat and Reduce Obesity Act (S. 2407/H.R. 4818) – The bipartisan "TROA" allows coverage under Medicare's prescription drug benefit of drugs used for the treatment of obesity or for weight loss management for individuals who are overweight while improving access to behavioral therapy.

Medical Nutrition Therapy Act (S. 3297/H.R. 6892) – The bipartisan "MNTA" extends dietitian access and coverage to individuals with other diseases and conditions, including obesity, eating disorders, cancer, and HIV/AIDS; such services may also be referred by a physician assistant, nurse practitioner, clinical nurse specialist, or (for eating disorders) a clinical psychologist. Further information on coverage and access issues for the community can be found here.

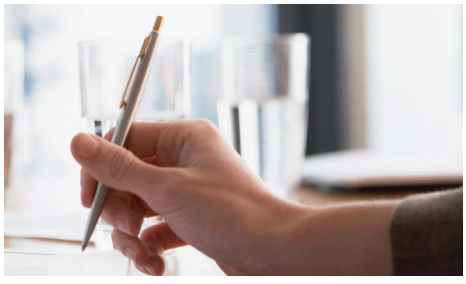
The Food Labeling Modernization Act (S 1289/H.R. 2901) and the Gluten in Medicine Disclosure Act (HR 2435, 117th Congress) - This legislation would strengthen requirements related to nutrient information on food labels, and require food allergens, such as gluten and medicines derived from gluten-based products, to be clearly labeled.

The Liver Illness Visibility, Education, and Research (LIVER) Act (S. 3041/H.R. 5675-117th Congress) – This bill would amend the Public Health Service Act to support liver illness visibility, education, and research. Additional investment in research will benefit individuals affected by advanced fibrosis and non-alcoholic steatohepatitis (NASH).

Ensure that Medicare, Medicaid, and private insurers provide proper coverage of prescribed ostomy prosthetic supplies such as fistula supplies and other medical supplies.

Enhance the GI physician and Wound Ostomy Continence nurse workforce. Resource: White Paper that validates WOC nurse specialty.

The DDNC priorities apply to everyone in the GI diseases community. As providers, business owners and decision makers we should make our voices heard.



LILLY FOR BETTER

Our founder, Colonel Lilly, said, "Take what you find here and make it better and better." Today, this commitment to making life better extends to every aspect of our business and the people we serve. Guided by these words, our commitment to humanity defines the spirit of our company.

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Lilly

My experience with The Visiting Inflammatory Bowel Disease Fellowship Program

Michelle Bernshteyn, MD—PSG FIT

I have had a growing interest in inflammatory bowel disease during my gastroenterology fellowship. I found out about the **Visiting Inflammatory Bowel Disease Fellowship Program**, which is sponsored by the Crohn's and Colitis Foundation (CCF). This program offers a unique opportunity for for gastroenterology fellows in their second or third year of fellowship training to do a clinical observership. It is a one-month rotation hosted at various IBD centers of excellence nationwide, and provides an invaluable opportunity to deepen ones understanding, regardless of their future sub-specialization or career path. This experience facilitates an immersive learning experience and is particularly beneficial for those lacking extensive IBD exposure at their home institutions.

Applying to the program involved answering specific questions about one's interest and objectives, along with submitting a letter of recommendation from the applicant's program director acknowledging full support. For this year, applications were accepted from January through March, with notification of selection status in April. Rotations are set up monthly from September through April of the following year.

There are eighteen hosting institutions, and applicants rank their top five choices and specify their preferred rotation month. For the 2023-2024 cycle, I was honored to be one of twenty-two fellows that were chosen to take part. I did my rotation at Massachusetts General Hospital in Boston in February of 2024.

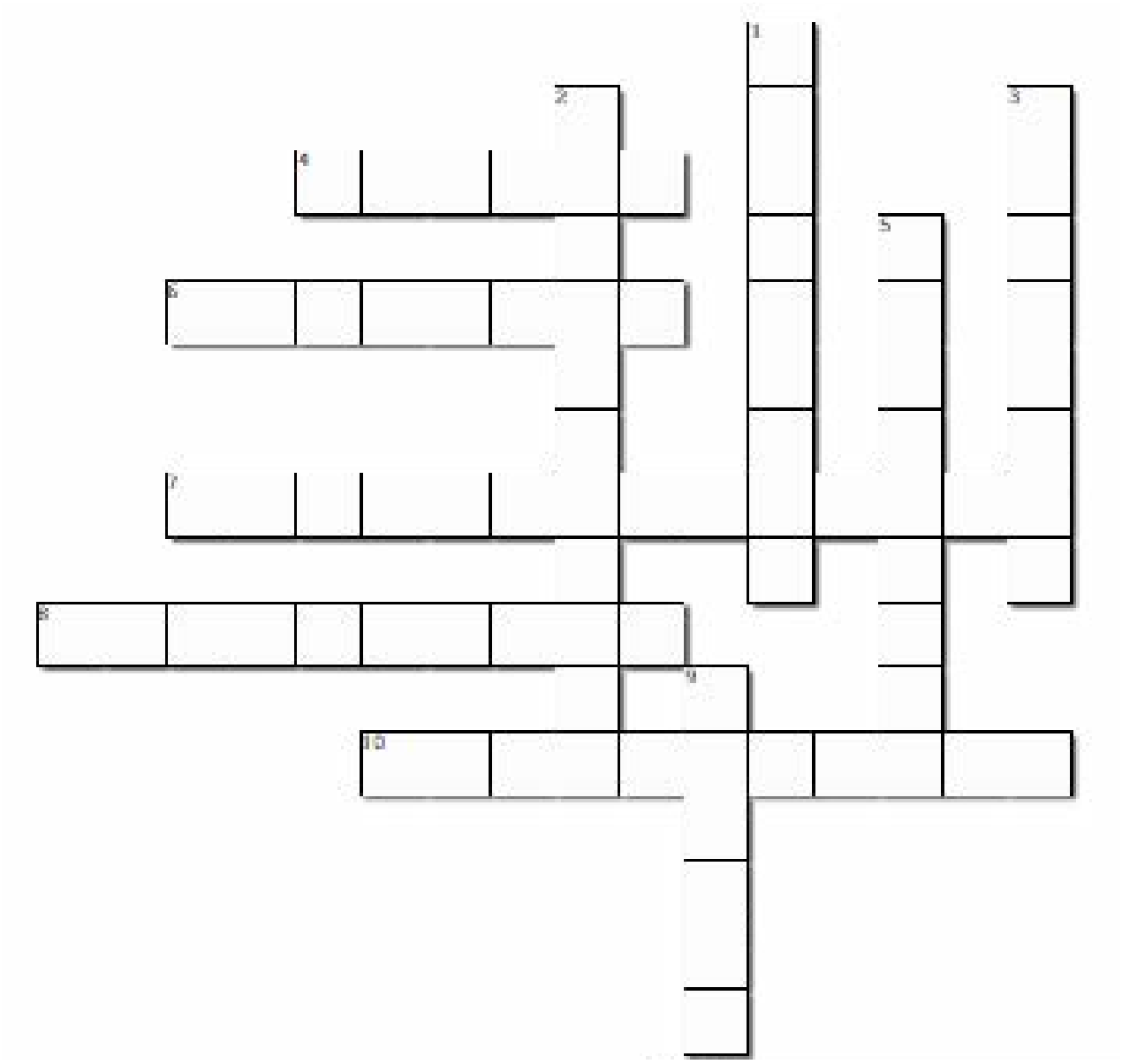
Participants receive a suggested reading list and must fulfill requirements such as submitting proof of medical licensure, background checks, vaccination records, as well as some additional documentation. This process was straightforward and manageable. The CCF generously assists with housing and travel expenses. Despite initial challenges in finding suitable accommodation within a reasonable distance from the hospital and within budget constraints, reaching out to my contact with the CCF facilitated swift solutions. I found that the Foundation was extremely receptive to my questions and provided ample assistance ensuring that the process was smooth. My stay in a nearby Airbnb allowed me to immerse myself in the charming Beacon Hill area. The streets are lined with brownstone buildings, inviting restaurants and coffee shops at each corner, as well as nearby attractions such as Quincy Market, the Boston Commons, and the Freedom Trail. Importantly, there was a Whole Foods Market nearby which was very convenient for grocery shopping or a quick lunch.

Throughout my observership, the program coordinator was an invaluable resource, providing a well-structured schedule that enabled me to work closely with each of the IBD specialists in the outpatient setting. I was also given the opportunity to work with the center's dietician and psychologist. This was an important part of the rotation as I was thoroughly able to understand what makes a dedicated IBD center so valuable. Moreover, I was able to understand the role of the IBD pharmacist and how this positively impacted patient care. Spending time in the endoscopy center also was rewarding, as I developed a better understanding about what an IBD specialist looks for while doing colonoscopy.

I was warmly welcomed by the faculty and staff, who generously shared their expertise and insights with me during clinics, grand rounds, and multidisciplinary discussions. Witnessing firsthand the high standard of care provided to patients with IBD left a lasting impression with me.

My experience with the Visiting Inflammatory Bowel Disease Fellowship Program at Massachusetts General Hospital was immensely rewarding. I wholeheartedly recommend this program to all second- and third-year gastroenterology fellows. I am eager to apply the knowledge gained to my future practice.

Crossword Puzzle Fun!



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1. FDA approved IBS medication that is a locally acting inhibitor of Na/H exchanger 3

2. Medication that has shown efficacy for the treatment of sinusoidal obstruction syndrome

3. This drug is a GABA-b receptor agonist and decreased transient LES relaxation

5. Criteria used to diagnose hereditary non polyposis colorectal cancer

9. Disease caused by mutation of ATP7B gene on chromosome 13

Locum Tenens in Gastroenterology

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

Gastroenterologists are becoming increasingly aware of locum tenens employment opportunities. We receive recruitment emails, texts, and even cold calls from locum agencies almost daily and frequently interact with locum physicians in our emergency departments, operating rooms, hospital wards, and clinics.

Locum tenens is Latin for "holding the place". Current statistics suggest that almost 50,000 doctors, or 7% of the U.S. physician workforce, work on temporary assignments. This is a 90% increase from 2015. According to Staff Care's 2020 Survey of Temporary Physician Staffing Trends, 85% of U.S. healthcare facility managers relied on locum tenens physicians in 2019. About 60% of these were medical specialists, and three quarters were 51 years or older. A 2019 survey by staffing agency CompHealth found that locum tenens was a 4 billion dollar industry, and likely even more today. Gastroenterolgy is one of the top 10 specialties for locum physician need.

Why do physicians choose to do locum work? Some use it to check out a new full-time job they are considering. Others choose to do locum work immediately after completing post graduate training while applying for permanent jobs elsewhere. Many docs do locums while transitioning from one full time job to another. Physicians in the final stage of their careers often do locums when they aren't quite ready for full retirement. Some physicians do locum shifts in their time off from full-time jobs to supplement their income to pay off debt, contribute to retirement savings, or allow for a special vacation.

Some physicians work full time in locums, going to multiple practice settings each year. With many GI's suffering from burn-out, limited locums work can free up distressed providers to do valuable wellness activities. Lastly, many physicians find locums attractive due to the absence of administrative responsibilities. It is not uncommon for a locus physician to bring a significant other with them to their locum city.

Last year, I wrote a piece in Rumblings describing a major shortage of gastroenterologists in our country. This is due to an inadequate number of newly trained digestive specialists as well as an aging GI physician work force with increasing retirement. In addition, there's increased demand for GI services in an older population needing more digestive healthcare. Inadequate GI coverage leaves a tremendous hole in services for a hospital or a practice. Not being able to properly care for esophageal foreign bodies, GI bleeds, acute liver and biliary disease, IBD flares, and more leaves a hospital in a serious bind. Thus, many facilities and practices seek out locum physicians to fill the void.

Some facilities hire locums directly. They establish a relationship with providers and reach out whenever they have a staffing need. In this model, 100% of the fee the facility pays for coverage services goes to the provider. In practice this does not happen often, as it's difficult to recruit a pool of available short-term physicians in the specific specialties. Instead, most facilities enlist the services of a locum agency to handle their temporary physician staffing needs. There are many such agencies in our country. When a facility hires a provider through an agency, the fee that they pay is split between the agency and the provider. However, in most cases hourly income to physicians is equal to or greater than the average pay that this provider would receive in a standard full time job in their specialty.

Working for a locum agency provides many advantages to physicians. They will have numerous job opportunities for a provider to consider, including some that are relatively close to one's home and others that are in desirable parts of the country or the world. They may also have opportunities in underserved areas where a provider can "make a difference." The agency typically pays for the physician's malpractice insurance (note: the physician should request "tail coverage" if at all possible). Travel expenses and lodging are commonly included in the contract. Locum agencies also typically assist with the cumbersome credentialling and licensing process required for working in a new facility or a different state.

The best locum agencies strive to make a good fit between the physician and the new practice opportunity. To optimize this, a recruiter needs to develop a close relationship with a locum candidate and learn exactly what a provider is looking for in terms of desired workloads and responsibilities. A recruiter also needs to know details of each temporary job opportunity.

There are also some downsides to locums. Working in an entirely new setting may entail learning a new

electronic records system, engaging with new staff, and struggling to find quality doctors for surgery or tertiary level consultation. A provider may be accustomed to having valuable help from a physician assistant or nurse practitioner and might find it difficult to work in a demanding position without assistance from a physician extender. Some work situiations may not come with anesthesia support for endoscopic procedures, meaning the GI physician will need to manage conscious sedation themselves during endoscopy. Some physicians may be uncomfortable living in a community that's completely unfamiliar to them. Others may experience frustration when they find a locum position that they are very comfortable with, but later learn that they are no longer needed there. Locum providers are independent contractors that receive 1099 tax forms. They are responsible for their own estimated tax payments, health/life/disability insurance, and retirement plans.

Here are some practical points to know if you are considering doing Gi locum work, according to CompHealth.

1. **Pay. Average GI locum pay runs about $2000-2500 per day. Advanced procedure work, such as ERCP and/or EUS, typically pays more. Working as a GI hospitalist is more lucrative than working in an outpatient clinic or ASC. Generally, the busier a provider is while working – the higher the pay. An outlier quote was for a very busy GI hospitalist opportunity in Ohio for 5 days of 24/7 call was offering over $5,000 per day. A locum GI hospitalist often traditionally gets paid a base rate for a set number of hours of work per day. Extra pay is given when working past those agreed upon hours. They often get paid a "beeper fee" to be available to return to the hospital after regular hours. They typically get paid extra for each time they return to the hospital to do extra work. The highest paying places for locums in 2023 were Washington DC (130% of the national median), West Virginia (128%), Mississippi, Colorado, Delaware, South Dakota, Missouri, Kansas, Vermont, and Montana. Predictably, jobs that pay more are in high demand, and these opportunities are competitive and fill quickly. Exact terms are usually somewhat negotiable.**

2. **Schedules: Typical for the outpatient setting is Monday through Friday 8 AM to 5 PM. For inpatient work a standard schedule is 7 days on / 7 days off. Most facilities are looking for a locum physician that can work one to two weeks per month for multiple months.**

3. **Advanced procedures: 15% of GI locum opportunities require competency in ERCP and other advanced procedures.**

4. **Location selection: Locum agencies have contracted opportunities in nearly every state but will reach out to facilities that are in an area a physician wants to work in, if the agency doesn't have a contracted job opening in that area.**

For the right physician at the right time in their life, locum positions may provide an excellent opportunity for professional satisfaction as well as enviable compensation. However, there are pros and cons to this type of work, so each GI doc who is considering doing locum coverage will need to weigh these before making a final decision. Fortunately, the locum companies have experienced staff that are an outstanding source of information that can be used to help decide. If you are considering this direction, seek out some GI docs that are already doing locum work for their perspective on the entire process.

Negotiating Key Employment Contract Terms

Karen E. Davidson[1]

Physician employment contracts encompass relationships between doctors and savvy hospitals/health systems, academic medical centers and private practices. These contracts have evolved into sophisticated instruments drafted principally for the benefit of the employer. They specify the duties and obligations of the physician (from clinical hours to on-call duties), outline compensation, address professional liability insurance coverage, and delineate termination rights. This article seeks to raise awareness of four key contract areas and highlight some related negotiation tips.[2]

1. Compensation.

While physician compensation historically was a set amount with annual increases, changes in reimbursement and the health care marketplace have vastly increased compensation complexity, often shifting risk to physicians. What exists now are elaborate compensation models that typically provide guaranteed base compensation for one or two years, after which the base and/or bonus is subject to incentives and productivity benchmarks. These include work relative value units (wRVUs) (a measure of physician work effort) or collections, quality measures and others that serve as targets to determine if a physician will retain, lose or garner certain compensation. Anticipated compensation should be analyzed based on a specialty's compensation survey data (available through subscription). Physicians should fully understand their compensation/incentive targets, ascertain if they are likely to achieve them and estimate the amount or range of compensation to which they ultimately will be entitled.

Negotiation Tip: Seek to negotiate compensation that is definitive for as long as possible through set compensation with specified bonus amounts including perhaps sign-on or retention bonuses, with set increases, whether established amounts or percentages. For variable portions of compensation (such as floating base or productivity bonuses) seek lower target thresholds for wRVUs or collections, and greater wRVU dollar values based on compensation survey data.

2. Professional Liability Insurance.

Most physician contracts specify that the employer will purchase professional liability insurance covering the physician for services rendered during the period of employment. They should also address which party is responsible for purchasing a post-termination extended reporting endorsement (i.e., tail coverage) if the underlying policy was written on a "claims made" basis. Absent an express obligation by an employer to purchase tail coverage, physicians are generally liable for the cost. It is critical that the contract clearly specifies the party responsible for tail coverage cost and the circumstances under which such party will assume tail responsibility. It has become increasingly important to ascertain if there is any limit on the extent of tail coverage. This is because some employers limit tail coverage to the applicable statute of limitation period, leaving the physician open to potential future liability.

Tail coverage is expensive, ranging from 100% to 200% of a physician's annual professional liability premium. The cost can be exorbitant for high risk specialties with costly annual premiums. For example, an OB/GYN physician's tail coverage could cost upwards of $80,000 during the first year of medical practice. Regardless of the tail arrangement, the physician should fully understand the extent of tail coverage liability he/she could be obligated to assume.

Negotiation Tip: Negotiating tail contract provisions can be tricky because who pays the tail may depend on the type of termination. Ascertain if the employer will assume the full cost of unlimited tail coverage upon termination regardless of the termination reason. If that is not possible, consider seeking to have the employer assume the full tail coverage cost if it terminates the contract "without cause" or if the physician terminates "for cause." Alternatively, it may make sense simply to seek a cap on the physician's tail obligation amount or propose that the parties share the cost equally.

3. Term/Termination.

Physicians are often told by prospective employers that they are being offered a multi-year contract. Yet, the contracts often allow the parties to terminate for any reason (i.e., without cause) at any time upon

relatively short notice (e.g., 60 or 90 days). Contracts also typically include "for cause" termination provisions allowing an employer to immediately terminate due to acute circumstances such as loss of licensure or professional liability coverage, or contract breach. These provisions can be based on subjective factors and drafted too broadly, so should be carefully reviewed.

When assessing the impact of termination provisions, physicians should ascertain what the fall-out will be under "without cause" and "for cause" circumstances. That is, under what termination circumstances might the physician be liable for tail coverage (discussed above), be obligated to repay a sign-on bonus, moving expenses, educational loan amounts or other items, or lose a productivity, quality or other bonus or compensation. Note that a physician may only be entitled to certain incentive compensation payments if he/she is employed at the time of payment, which is often many months after it is earned. Bottom line, physicians should try to limit such losses and repayments as much as possible.

Negotiation Tip: Ascertain if it makes sense to seek a "no cut" deal where neither party has the right to terminate the contract "without cause" for 1 or 2 years. Doing so may limit the need to repay certain items. Also, if a significant obligation (such as tail cost) is triggered by a "for cause" termination, try to negotiate objective, narrow "for cause" provisions. Physicians should also seek to reduce repayment obligations by negotiating burn-offs that gradually reduce repayment amounts over the course of one or two years.

4. Non-Compete Clauses.
Non-compete clauses typically limit physicians from practicing within certain geographic areas (often based on a mileage radius around a location or multiple sites) for a specified time-period following contract termination. Most states uphold non-compete restrictions that legitimately protect an employer from unfair competition and that are reasonable in geographic area and time. Time restrictions of one to two years are usually upheld as reasonable. Reasonableness of mileage restrictions may depend on whether the employer is in an urban, suburban or rural area. For example, a 10-mile non-compete may be reasonable in a suburban locale, but unreasonable in the heart of a city. Note that a Spring 2024 Federal Trade Commission vote is anticipated on its proposed rule banning non-competes; however, such a ban is not expected to apply to non-profit entities/organizations.

In the meantime, physicians should carefully analyze noncompete restrictions and ascertain all locations from which a mileage restriction applies. Online distance calculator tools can facilitate examination of an anticipated restricted area. If a restricted area is extensive and applies to several of an employer's sites or locations, the physician should ascertain if he/she will have to relocate upon termination of employment.

Physicians need to understand the extent of the noncompete restriction(s) and determine where they could work if subject to the noncompete. Some contracts contain remedies for noncompete violations including liquidated damages which can be a multiple of the physician's annual compensation. For physicians leaving a position which is subject to a non-compete restriction, care must be taken to ensure that any new position will not be violative. Ultimately, physicians should not sign a non-compete with which they do not intend to comply.

Negotiation Tip: Seek to limit a non-compete to locations where the physician renders services for the employer. This may entail a further limitation if the physician covers multiple locations, perhaps limited to the location where the physician primarily renders services but delineated with as much specificity as possible. If there are realistic future employment opportunities within certain geographic areas, try to reduce the mileage or negotiate zip-code or institution carve-outs where the physician might seek employment after termination.

Summary
Physician employment contracts are sophisticated instruments with potential for significant adverse impact on physicians. They should be carefully analyzed and negotiated to limit physicians' exposure to financial loss and other liability.

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1 About the Author: Karen E. Davidson, Esq., managing member of Law offices of Karen E. Davidson, LLC, is a veteran attorney focused on representing health care professionals. She has over 30 years' experience serving the legal needs of her clients in business, regulatory and reimbursement matters. Ms. Davidson is a graduate of Temple University – James E. Beasley School of Law, licensed to practice law in the Commonwealth of Pennsylvania, State of Maine and the District of Columbia (inactive), and a member of the Bar Associations in those jurisdictions. She is also a member of the American Health Law Association and Board of Directors of Southeastern Pennsylvania Area Health Education Center. Ms. Davidson speaks regularly to professional groups providing insight into legal issues in professional practice. She can be reached by telephone at (610) 940-4041 or email at karend@kdavidsonlaw.com, or through www.kdavidsonlaw.com website. Copyright 2024 Law Offices of Karen E. Davidson, LLC

2 This article is solely for informational purposes and does not constitute legal advice. The advice of a qualified attorney should be sought in connection with review, interpretation and negotiation of any employment contract.

For Joseph Merrick

You invited me in.
I was excited to join.

We show all the interesting cases Friday morning
For the medical students and doctors in training
A dermatology jamboree
I, a premedical student ravaged by chemo
Violaceous pustules cobbled
My face, my head, trunk and legs
Oral ulcers puffed my cheeks
Studded my lips
My hair like a drunken watchman fell.

Each assigned a stool in an empty classroom.
Please stand. Remove your shirts.
White-coated student like maggots
Swarmed, probed, sampled, pressed, and tugged.
The bow-tied, mustachioed professor
A dandy astride a shiny carousel
Pontificating at each station.

A London circus barker
Exhibiting the elephant man
Both of us ill and breathless
He, by compressing tumors
Me, from contempt.

You invited me in.
I was excited to join.

PENNSYLVANIA SOCIETY OF GASTROENTEROLOGY

2024 PSG ANNUAL SCIENTIFIC MEETING

September 13-15, 2024 ▪ The Hotel Hershey, Hershey PA

Register Now for PSG's Annual Scientific Meeting in Hershey!

Step 1: Members Login*
(non-members) Create Profile

** This is the SAME log in you used when paying your dues online.*

Step 2: Register

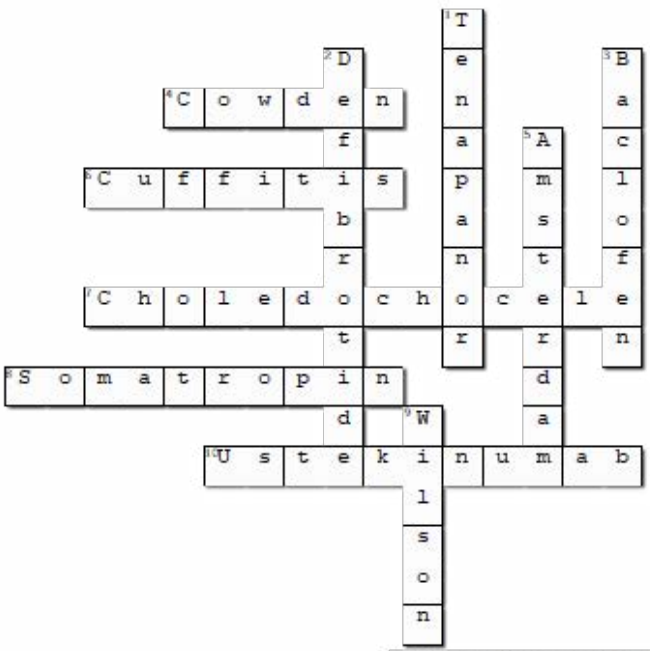
Hands-On Course

Participants will have hands-on exposure to the latest technologies in endoscopy while interacting with the faculty experts to learn optimal techniques and approaches. Topics include (1) Hemostasis, (2) Endoscopic Mucosal Resection, (3) Endoscopic Defect Closure, (4) Endoscopic Suturing, (5) ERCP, (6) Luminal Stent Placement. *Additional fees apply.*

HersheyPark Picnic

This year, PSG will host a picnic inside HersheyPark on Saturday, September 14 from 5pm-6pm. Admission to HersheyPark is required to attend (multiple ticket options available). Fees apply.

Crossword Puzzle Answers



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ANNUAL MEETING AGENDA

Friday, September 13, 2024

12noon-2:00 p.m.	Corporate Sponsor Lunch
3:30-5:30 p.m.	Board Meeting at the Hotel
6:00-8:30 p.m.	**Welcome Reception at the Hotel** Attendees and guests are invited to join us for cocktails and hors d'oeuvres at the hotel.

Saturday, September 14, 2024

7:00-7:30 a.m.	**Registration/Continental Breakfast with Exhibitors/View Posters**
7:30-7:45 a.m.	**Welcome/Presidential Address/Annual Business Meeting** Karen Krok, MD
Liver and Pancreas Moderator: Karen Krok, MD	
7:45-8:05 a.m.	**Metabolic Associated Steatotic Liver Disease: Nomenclature, Non-invasive Testing and Management Options** Maria Lagarde, MD
8:05-8:25 a.m.	**Endoscopic Hepatology: Diagnostic and Therapeutic and Emerging Technologies** Manish Dhawan, MD
8:25-8:45 a.m.	**Navigating Autoimmune Liver Disease through Case Studies** Benyam D. Addissie, MD
8:45-9:05 a.m.	**Advances in the Managing Acute Pancreatitis and Its Complications** David Loren, MD
9:05-9:15 a.m.	**Q & A**
General Gastroenterology Moderator: Zubair Malik, MD	
9:20-9:40 a.m.	**Gastroenterologists in the Era of New Weight Loss Medications** Jessica Briscoe, MD
9:40-10:00 a.m.	**Evaluation and Treatment of Pelvic Floor Dyssynergia** Asyia S. Ahmad, MD
10:00-10:20 a.m.	**Tackling IBS: An Algorithmic Approach to IBS-C and IBS-D** Swapna Gayam, MD
10:20-10:40 a.m.	**"Future of AI in GI" What it Means for GI Physicians and Practices** Austin Chiang, MD
10:20-10:30 a.m.	**Q & A**
10:30-10:45 a.m.	**Break/Visit Exhibitors/View Poster Displays**
Endoscopy "Movies at PSG" Moderator: Harshit Khara, MD	
10:55-11:15 a.m.	**Video-based Cases: Current Applications of Interventional EUS** Shyam Thakkar, MD
11:15 – 11:35 a.m.	**Endoscopic Management of Gastrointestinal Perforation and Fistula** Anand Kumar, MD
11:35 – 11:55 a.m.	**GI Bleeding: What's in my Toolbox** Malorie Simons, MD
11:55 a.m. -12:15 p.m.	**Video Based Cases: Endoscopic Classification and Resection of Colorectal Polyps** Sultan Mahmood, MD
12:15-12:25 p.m.	**Q & A**

ANNUAL MEETING AGENDA

FIT Program
Moderator: Harshit Khara, MD

12:45 – 1:45 p.m.	**Fellows GI Jeopardy Competition for the Gastro Cup (Lunch Provided) Non-CME**
1:45 p.m.	**Adjourn for the day. Enjoy free time at the sweetest place on earth!**

Sunday, September 15, 2024

7:00-7:45 a.m.	**Registration/Continental Breakfast with Exhibitors/View Posters**

IBD
Moderator: Kofi Clarke, MD

7:45-8:05 a.m.	**New and Emerging Drugs for IBD** Jennifer Hadam, MD
8:05-8:25 a.m.	**Management of Acute Severe Ulcerative Colitis Beyond Steroids** Jefferey Dueker, MD
8:25-8:45 a.m.	**Non-IBD Colitis: Microscopic, Indeterminant, and Diverticular Disease-Associated Colitis** Kim Chaput, DO
8:45-8:55 a.m.	Q & A
8:55 – 9:10 a.m.	**Break/Exhibits/View Posters**

Practice Management
Moderators: Neil Nandi, MD and Areeb Alikhan, MD

9:10-9:30 a.m.	**Updates on Billing and Coding for Gastroenterology Providers** Kristin Vaughn, CPC
9:30-10:00 a.m.	**Panel Discussion: Navigating Careers in Private Practice, Academic Medicine, and as a GI Hospitalist** Kofi Clarke, MD, Ravi Ghanta, MD, David Loren, MD, Zain Sobani, MD, and R. Fraser Stokes, MD
10:00-10:10 a.m.	**2023 PSG Research Grant Presentation** Matthew Kraft, MD
10:10-10:25 a.m.	**Abstract Awards & Closing Remarks** Karen Krok, MD and Shailendra Singh, MD
10:30 a.m.-12:30 p.m.	**Hands-on Session** Moderators: Matthew Krafft, MD and Hadie Razjouyan MD

Hemostasis
Manish Dhawan, MD

Endoscopic Mucosal Resection
Anand Kumar, MD

Endoscopic Defect Closure
Harshit Khara, MD

Endoscopic suturing
Austin Chiang, MD

ERCP
David Loren, MD

Luminal Stent Placement
Shyam Thakkar, MD

Pennsylvania Society of Gastroenterology

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