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LEGAL ISSUES AND MEDICINE

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**Missouri Board of
Healing Arts *page 18***

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**St. Louis Metropolitan
Medicine**

www.slmms.org

Thomas A. Watters, CAE
Managing Editor
twatters@slmms.org

James Braibish
Braibish Communications
Associate Editor
editor@slmms.org

Publication Committee

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Gregory R. Galakatos, MD
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In Search of the Perfect Health-Care System

Issues that should be brought to the forefront of the health-care debate



Medical Society President
Elie C. Azrak, MD

As the debate over health-care reform moves forward and the special interest groups start to assert their different positions in this debate, arguably the most important question is posed: What will be the extent of the government's role in the new health system?

Will "*We, the People*," through our legislators, consent to a system of health care as a universal

right, with its own afforded choices, where every man, woman and child has access to the doctor they, and only they determine to trust, and the hospital or testing facility they want to seek; or will a new system be imposed, whereby the "*Wal-Mart*" model of health care will ensure that we receive only the cheapest product (if available or allowed), while quality and durability (our health outcomes) come second to price and availability (cost and access)?

The new health-care system will also be different for physicians: in this day and age, it is virtually impossible to separate the practice of medicine from the "*business*" of medicine. The fact is, the majority of medical practices are considered small businesses, and are subject to all the pressures and tensions facing small business – rising overhead expenses, including employee benefits (not the least of which is health coverage), reduced return on the investment we make to become physicians (ever-rising educational loans and ever-decreasing reimbursement), and the unrelenting attacks on the integrity of our profession through the guilt-assuming, stigmatizing professional liability system.

In this environment physicians face the gargantuan task of trying to maintain their autonomy and preserve their economic independence in the midst of strong conflicting currents; add to that the trend of employment by hospital chains or corporations with ballooning administrative bureaucracies, focusing on profit, often detached from the core principle of the profession: providing medical care in the context of a constructive, trusting physician-patient relationship.

This "alienation" of the central role of the physician is strongly manifested at the level of health-care policy: the Democrat-controlled Congress is forging a reform plan which includes a government health-insurance program to compete with private health plans; five House and Senate committees are working on various aspects of health-care reform, all aiming at telling us exactly how, when and where to provide care, how much care we can provide, and how much we can be paid for providing this care. The most prominent Congressional actors are the Senate Finance Committee, chaired by Sen. Max Baucus (D-MT), and the Senate Health, Education, Labor and Pensions (HELP) Committee, chaired by Sen. Edward Kennedy (D-MA). The latter recently marked up a 600-page bill entitled the *Affordable Health Choices Act*, calling for insurance reform and a re-designing of the reimbursement structure to physicians to account for "high-quality care, implementation of the medical home, chronic disease management and care coordination." Some of the above items, including "high-quality" care, are obviously very difficult to define. How they will plausibly be written into law remains to be seen.

The three House committees have authored their own version of reform loaded with "supertaxes" and fees to pay for the \$1-trillion dollar cost. Viable alternatives are far and few between.

To the surprise of many within as well as outside the physician community, the American Medical Association recently endorsed the House of Representatives Resolution 3200 (H.R. 3200), the so-called *America's Affordable Health Care Choices Act*. While there is certainly a need for the AMA to assert its place at the discussion table, this endorsement is now widely believed (including by the author) to have been misguided, premature and even naïve on part of the AMA, particularly in light of the lack of several essential components of what the physician community considers *sine-qua-non* in health care reform.

In this context of continuing politicization of health care, more intensified regulations and inevitably reduced reimbursement, I believe that organized medicine needs to get to work, even outside its traditional "comfort zone," to find the right formula for improving the value of health services we provide to our patients, and then stand firmly behind it (with our dollar contributions!). This will enable us to maintain our rightful place as the focal cen-

“Let our voices be heard in the halls of Congress.”

ter of health delivery, and prevent further bureaucratic takeover and manipulation of health system policy on political grounds. Following are some reform items that should be brought to the forefront of the health-care debate, and perhaps be included in any physician-supported legislation:

1. Insurance companies need to be mandated to *cover all comers*, without regard to pre-existing conditions, or particular discriminatory factors, such as age or gender, and resort to *community rating* of risk, rather than using experience rating. This will allow risk-sharing among a much larger pool of beneficiaries, and thereby reduce the cost of insuring any individual, regardless of their particular health status.
2. Physicians ought to make it clear that only fair reimbursement within a framework of outcomes-based best practices can improve the quality *and* reduce the price of health-care services at the same time. The current system of health-care financing where Medicare artificially “fixes” prices (rather cuts or freezes them year after year) has not caused the increase in health-care costs, but does create the festering and very expensive problem of fraud and abuse of health-care dollars.
3. Physicians also ought to make it clear that unless professional liability expenses are controlled, a significant portion of health-care dollars will continue to go where it does not belong: outrageously high noneconomic damages and unscrupulous trial lawyer contingency fees.
4. The reporting of health-care processes is currently being imposed on physicians as the answer to the need for transparency in health care, and therefore as a means of reducing health-care costs. This is a “fake” remedy, particularly in light of its erroneous methods and designs, the measures it calls to report and the poor management of the database under the Physician Quality Reporting Initiative (PQRI) administered by the Center for Medicare and Medicaid Services (CMS). Scientific guidelines are often incomplete and sometimes slow to change. Reporting based solely on these guidelines paints a partial picture of what works and what doesn’t. On the other hand, experience reporting by physicians of specific outcomes based on medical conditions, and the procedures and treatment approaches used to achieve those outcomes, may lead to a better understanding of best practices.
5. Assessment of new medical technologies, as they develop, should be based on scientific grounds and driven by outcomes research. Bureaucratic and political decisions regarding the use of new technology can delay the implementation of useful or even life-saving procedures or tests.

Everybody now seems to agree that health care should be a right rather than a privilege. But finding a one-size-fits-all prescription for the way we offer, manage, finance, deliver and evaluate the health-care system is an unrealistic expectation. In a society where diversity is valued, and freedom to decide one’s own fate is cherished, a single-payer health system, or the liking of a single payer (a public plan eventually supplanting private insurers) is incompatible with our mode of life. Therefore, an ideal system of health care should remain flexible and reflect the freedom of choice in this society.

I have recently witnessed an aspect of health-care delivery in a developing country, where private health insurance is in its infancy, and state coverage of health care is inadequate – primarily due to limited government resources. Health services are primarily an out-of-pocket expenditure, and consequently are a privilege only the well-to-do can afford, out of the reach of those with fixed incomes. This experience allowed me some insight into the dynamics of health-care policy and its implications on health services and outcomes: in the field of cardiovascular disease, a problem of epidemic proportions in most societies, a particular patient presenting to a private health clinic or hospital seeking medical attention, would often not receive the care he or she may need, but only the care he or she can afford. In a government-run system, the patient receives only what the government can afford (that is called rationing).

This is a saddening and frustrating situation for the physician intending to provide life-saving care, and often results in inadequate, delayed care, or no care at all. Many patients with severe coronary artery disease leave the hospital without proper treatment, in hopes of finding the necessary finances at a later date by borrowing from family or selling their home, or seek government services which are available but scarce, leading to long waits and giving way to corruption, nepotism, or otherwise poor health outcomes. Even the threat of mortality may not stand in the face of financial limitations.

Either of these two systems – purely government-based insurance and no insurance at all – should be unacceptable to the American people. Let then our voices be heard in the halls of Congress, as this may be the most important health-care fight since Medicare was legislated into law, the fight for the next two or three generations to come.



Foundation Supports Physician Education and Community Service

Contributions needed to fund programs; donation envelope included in magazine

By Tom Watters, CAE
SLMMS Executive Vice President



**Medical Society
Executive Vice President
Thomas A. Watters, CAE**

The history of our foundation – the St. Louis Society for Medical and Scientific Education – goes back to 1966 when first incorporated. It received its 501(c)(3) not-for-profit tax status shortly thereafter, allowing for tax-deductible contributions by individuals and corporations. Its original objectives are much the same today as then – “exclusively charitable, scientific and educational.” This includes funding of educational “matters of scientific and cultural interest,” as well as

“the making of distributions to (other) organizations that qualify as exempt organizations.”

Early in its history, much of its efforts went toward the creation and operation of a medical library, which was housed in the old headquarters building on Lindell Boulevard. As times changed, much of the library was placed on loan to area universities. This includes our rather massive rare book collections, primarily the Paracelsus Collection and the James Moore Ball Collection – totaling nearly 2,000 volumes together. Both of these collections are now on display in the rare book archives at the Bernard Becker Library at the Washington University Medical School, where they are protected in an environmentally controlled fire-proof room 24 hours a day.

A second project for many years was the maintenance of a medical museum. Again, with changing times, it became prudent to turn this task over to experts. The Medical Society’s collection was donated to the St. Louis Science Center, where items are periodically displayed to the general public.

As the day-to-day maintenance of the library and the museum became memories of the past, the foundation (SLSMSE) was able to focus on other goals. Recent years have seen most of its activity focused on the funding of CME events for area doctors, and grants to other organizations with activities that further its own goals. These have included the Medical Society Alliance, the MO-1-DMAT program for disaster aid, the Hippocrates Society, and for the last two years, the Missouri Physicians Health Program, which has received a grant of \$10,000 in each of the last two years.

SLSMSE has also funded a number of projects administered by

SLMMS. These included programs on HIV/AIDS awareness, teen pregnancy prevention, smoking cessation, gang tattoo removal, teen alcohol use prevention and syphilis awareness.

Although we amassed some valuable assets over the years, many of these are limited to our rare book collections, which the Society has always considered to be an untouchable part of our history. With our building on Lindell gone, much of our cultural and organizational heritage disappeared. Our book collections, however, have proven to be our connection with our past, and although they could be sold for a considerable amount, we have relied on other assets to meet our financial goals.

Today, the need for continued contributions by members and outside interested parties is as important as ever. With the declining fortunes of the investment markets, funding worthy programs is a continuing challenge.

Our foundation has always depended on the benevolence of our members. The book collections are prime examples. The hard work of two of our biggest contributors resulted in our ownership of these valuable collections. In 1928, James Moore Ball presented us with his personal collection of more than 1,000 historical volumes of medical relevance collected during his lifetime. These books dated from the early 16th century. In 1968, Robert E. Schlueter, MD, presented us with his rare Paracelsus Collection containing over 500 volumes dating from 1530, all associated with the philosopher and medical practitioner Paracelsus. These books represented a lifetime of collecting and roaming bookstores of Europe. Imagine how highly these individuals must have thought of the St. Louis Society when they willed us these grand collections.

Through the years we have had many other significant contributions – too many to describe. The value of these contributions has made it possible for us to continue the work of the foundation. However, we can only rely on these for so long; it is essential that today’s members continue to support our foundation if it is to be allowed to continue its work today. Please consider our foundation and help support its goals.

Enclosed within this issue is a contribution envelope for SLSMSE. Consider making a tax deductible contribution today. All members contributing to SLSMSE this year will receive special recognition in a future issue of the magazine, as well as at the annual meeting and installation dinner in January. I sincerely hope you will be one of those recognized.





An Imperfect Shield

Suggestions to avoid a malpractice suit

By Ken Vuylsteke, JD

My five-year old son always wants to get into a gunfight, laser cannon or other battle involving some type of advanced weaponry. He always wins, because no matter how many shots, beams or waves I fire at him – he is completely protected by some invisible shield. Of course, no such protection is available to physicians practicing medicine in our country. Following are several key ways physicians can avoid being sued for medical negligence.

Inform Patients Fully

Too many patients equate a “bad outcome” with medical negligence. This conclusion is partly due to unreasonable expectations of patients fostered by their belief in doctors as omnipotent healers. While faith in their physician’s skill and training may enhance compliance, patients must understand the physician cannot guarantee a cure.

Too many practitioners gloss over possible complications of treatments or procedures. Even more dangerously, they delegate the informed consent process to a nurse or other staff. Concern over “scaring a patient” is no excuse for minimizing possible adverse results. This too often leads to patient dissatisfaction, resulting in a call to a lawyer.

Attorneys confronted with a bad medical outcome will at least investigate whether medical negligence is to blame. Given the shortened two-year statute of limitations (all other negligence claims are subject to a five-year statute in Missouri) lawyers often must file a lawsuit to get a complete set of records before the statute of limitations expires. This is particularly true in cases involving multiple health-care entities.

A thorough and complete *personal* explanation of potential adverse outcomes by the physician to the patient will usually prevent a patient’s misconception they will be completely cured or healed.

Show Your Empathy

Your compassion is the rock that anchors the professional judgment and skill needed to effectively treat patients. Each day the physician is involved in patients’ personal pain and family tragedies. A certain hardness is needed to insulate the doctor from the emotional



whirlwinds surrounding medical decisions and treatment.

Nevertheless, if a patient and/or their family experience a bad outcome, they look foremost to the physician for an explanation. Why did this happen? Could it have been prevented?

Showing sensitivity to and understanding of the family’s grief following the death of a patient is not only the physician’s first instinct, it will often prevent the family from seeking those answers from an attorney. Fortunately, physicians are now allowed to say “I’m sorry” without fear these condolences will be used as admissions of fault.¹

A family seeks closure following the death of a loved one. The family’s knowledge that the physician did all that medical science could do and also valued the life of the deceased, allows them to accept the sad truth that medicine cannot guarantee the perpetuation of life. The failure to personally and sincerely share this loss with the patient’s family is a leading cause for my office phone to ring.

Document Your Care

How many times do you have to hear, “if it is not documented, it wasn’t done”? Doctors frequently argue they can’t document everything they do – otherwise they would be writing all day instead of taking care of patients. However, others can help you document, be it a physician assistant, a nurse practitioner or nursing staff.

By the time depositions are taken in a lawsuit, very few physicians or support personnel will have an independent recollection of what happened in an operation or office visit. Accordingly, the written records become essential to show your care if your treatment is called into question. Avoiding a malpractice claim is well worth the time taken to document that care.

1. “Benevolent gestures” by a physician “which convey a sense of compassion or commiseration emanating from humane impulses . . . shall be inadmissible as evidence of an admission of fault in a civil action.” Missouri Revised Statute §538.229 (2005).



Be Honest

Too many people come to lawyers to find out why they have been left disabled or a family member has died during a hospitalization. Too often they believe they have been lied to by hospital administrators or medical personnel. Communicating in detail what happened and why it happened is crucial in avoiding a medical malpractice claim.

As an added caveat, avoid any tone that would cause the patient to view you as somehow uncaring or condescending. Clearly you have greater medical knowledge and experience. However, use that experience and knowledge to communicate respectfully and as completely as possible. Remember to use the patient's name during this explanation. People need to understand you know they are much more than just a patient identification number.

Obviously, this is more difficult for physicians practicing in specialties where patient contact is limited by the very nature of the service rendered (anesthesia, pathology). Even so, being direct with a patient or their family can go a long way to keep them out of a lawyer's office.

Practice Within Your Expertise

"If you are doing it, do it a lot." This especially applies to operative procedures. For example, if you need to change out defibrillator wires, make sure you have done enough of these procedures. Many procedures are fraught with possible complications if they are not performed on a routine basis (i.e., elbow arthroscopy). Think twice before picking up the endoscope, especially if you have had some problems in the past and consider narrowing the scope of your practice. There is no shortage of patients seeking your expertise, and you may be doing both yourself and the patient a favor if you refer them to a specialist.

Be Ready For a Known Complication

Most medical procedures have anticipated complications. Having the appropriate equipment available to deal with complications will not only help avoid a bad outcome but will also lessen the chance of a lawsuit. As the surgeon, you are expected to know what complications may arise and have a plan for dealing with

them. Make sure those equipping your operative suite or facility know your expectations and ensure your professional responsibility is fulfilled.

Listen to Patients

Both attorneys and physicians must be great listeners. Surprisingly, this is a shortcoming often demonstrated by the most experienced professionals. Older doctors may tend to pigeonhole patients. They believe they have seen it all before and instead of listening carefully to a patient's history, they routinely cut them off or give them a shortened period of time to describe all their ailments or complaints. By doing this, they may miss the real problem and end up being subjected to the most common malpractice claim: "failure to diagnose."

The time constraints brought about by managed care and reduced reimbursement rates compel physicians to see more patients in less time. Unlike managed care medical directors, front-line practicing physicians face malpractice as a result of their medical misjudgments and mistakes. While it is human to err, it does not mean that error has to result in a malpractice claim.

Physicians and lawyers can achieve the greatest good, not as adversaries but by working together to advocate for patients. I sincerely hope our next encounter will be at a meeting of the Hippocrates Society rather than in a courtroom.



Ken Vuylsteke is an attorney with Fox & Vuylsteke LLP and has been handling malpractice cases for almost 30 years. He chairs the Medical Legal Committee for the Bar Association of Metropolitan St. Louis and the HMO/Health Law Committee for the Missouri Association of Trial Attorneys. He can be reached at (314) 961-3222 or foxandv2@sbcglobal.net.



Communication Strategies to Prevent Medical Malpractice

Physicians must facilitate effective communication not only with patients, but also with other members of the health-care team

By Erol Amon, MD, JD

Large-ticket malpractice cases can result from serious adverse outcomes in hospitalized patients. To minimize professional liability and patient injury, we must facilitate communication to more than just the patient and her family. Communication of pertinent patient-related information in a timely, accurate and thorough fashion to and from the growing array of health-care providers and others is essential. The list seems to keep growing and it includes multiple shifts of nurses, pharmacists, radiologists, consultants, residents, covering physicians, medical record personnel, laboratory personnel, one's office staff and referring physicians.



The communication task is not easy. As the patient's condition changes and new data are generated, serious gaps in timely identification of a clinical condition and appropriate responsiveness can occur. These potential errors in care need to be intercepted and remedied before patient injury arises. Accordingly, the task of orchestrating error-free, injury-free, clinical care becomes increasingly difficult and challenging to achieve.

Physician orders are not always carried out in a timely and accurate manner. Medication orders are subject to the 5 w's; wrong drug, wrong dose, wrong patient, wrong time and wrong route. The potential for medication error is magnified by verbal orders and illegibility. Speaking orders to a nurse without looking face to face, speaking with an accent, and speaking amidst noisy surroundings and interruptions are potential communication pitfalls. Sound-alike drugs such as carboplatin and cisplatin (chemotherapy isomers for ovarian cancer), or sound-alike numbers such as 15 mg and 50 mg can be confused.

To avoid misunderstanding, the speaker should ask the listener to repeat specific orders, including numbers such as "one five" instead of 15. Verbal orders should be allowed only when the physician is not physically present or the chart is unavailable. Illegibility transpires as often among physicians as other professionals (lawyers, pilots, engineers, teachers and accountants) yet consequences may or may not be as severe. Correcting the entire written word and not just letters, using the same word(s) consistently, not using abbreviations, and not crowding words at the end of an

order sheet or progress note may prevent errors. The use of computerized charting may avoid illegibility, but "boiler plate" notes and plans may fail to effectively emphasize pertinent findings and plan details and individual susceptibility to treatments.

Checklists, protocols and "care pathways" are useful to efficiently communicate patient care orders and avoid mistakes. These serve to protect against forgetfulness or interruptions during order writing. Alternatively, certain pre-existing orders should be stricken through and verbally communicated to the nurse, e.g., consider striking the standing order for "Motrin," for postpartum pain in women with co-morbid platelet disorders. Other-

wise, the unsuspecting nurse may be so habituated to routine order sets and task completion that she may not be attentive to order changes.

When patients with similar names receive care, clerical errors in X-ray, laboratory and charting can occur. Wrong patients have gone to the operating room, wrong drugs have been administered, and wrong X-ray and laboratory data have been placed in the chart. Even when names are dissimilar, clerical errors result in wrong X-ray and laboratory reports found in the chart.

Human factors, heightened emotions and disrespect among professionals influence care. Slips of the tongue or forgetfulness by the overworked or distracted physician or nurse do occur more frequently than we hope for. The fatigued or overly busy physician under time constraints can become short, sharp, and even "chew out" a resident, nurse, or ward clerk, unwittingly setting up the patient for a subsequent "failure-to-communicate syndrome." Consequently, physicians may not be updated on a patient's condition in a timely manner. When the clinician is overcome by illness, fatigue or undue stress, assistance should be requested to prevent errors.

continued on page 14

“ Checklists, protocols and “care pathways” are useful to efficiently communicate patient care orders and avoid mistakes. ”



Communication Strategies to Prevent Medical Malpractice *(continued from page 12)*

Effective communication procedures are needed to bridge anticipated normally occurring gaps in patient care. Pertinent information is not always transmitted verbally when responsibility shifts for patient care, such as during change-of-shift nursing reports and physician sign-outs. Standardized sign-outs can limit miscommunications. Omissions are magnified when a patient's location shifts, e.g., between hospitals and between outpatient and inpatient status. Here, timely transfer of pertinent medical record information is essential. It is hoped that a comprehensive inpatient and outpatient electronic health record can mitigate these potential pitfalls in information drop-out.

Whenever clinician responsibility (shift-change or cross coverage) and/or patient location shifts, would-be hazards and "what if" scenarios and responses should be anticipated, planned for and communicated appropriately. Rather than through an intermediary practitioner, physicians should communicate potentially serious concerns directly with each other. Inexperienced clinicians receiving new patients may need more detail and time.

Physicians should encourage nurses to notify them whenever they perceive a potentially unsafe situation. This includes creating a respectful environment so nurses can feel free to politely raise questions that relate to patient safety, particularly in stressful circumstances. These notifications should also include patient and family dissatisfaction complaints before they escalate. Physicians should respond promptly to requests from nursing to see the patient, as this can be one of the most important risk-management procedures.

The physician anticipates and plans for emergencies by communicating with the hospital staff to ensure timely availability of medical specialists, anesthesia, surgical personnel and an operat-



ing room. Ideally, communication protocols to assemble these teams should be in place and activated by a single phone call, as in a code-blue emergency. These can be useful for acute and sub-acute clinical situations such as cesarean sections, cardiac and respiratory failure, invasive cardiac interventions, intubations and surgical interventions. When these communication protocols are lacking in a given facility, physicians should request and expect that they be created.

To minimize professional liability, physicians should continually identify situations in daily practice that pose risky communication failures and work with the hospital quality and risk departments and the medical vice president to produce systemic remedies that will protect patients from adverse outcomes and protect professionals from liability.



Erol Amon, MD, JD, is professor and director of the Division of Maternal-Fetal Medicine in the Department of Obstetrics, Gynecology and Women's Health at Saint Louis University School of Medicine. He is also a licensed attorney and counselor in the state of Missouri. He can be reached at amone@slu.edu.

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Special donation envelope enclosed with this magazine



Covenants Not to Compete – What Physicians Need to Know

Many physicians are being asked to sign such agreements

By Bill Corrigan, JD

There are more reported covenant-not-to-compete cases involving the medical profession than any other profession. Moreover, Missouri courts often enforce covenants not to compete with respect to medical practitioners. Furthermore, there have been many other cases that are not reported, because they are resolved at the trial court level and not appealed. Because of the increased competition and basic economics in medicine today, many physicians have increasingly been required to sign, or may be asked to sign, covenants not to compete. The purpose of this article is to provide an overview of this important area of the law.



court should weigh the benefit to the people of this part of Missouri which would result from not enforcing the covenant, compared with the benefit to the employer seeking to enforce it. Simply stated, the community could not afford the loss of this surgeon. The Supreme Court rejected this public policy argument for the reason that many communities are short of physicians and their services are as valuable and necessary in one community as in another. A more fundamental public policy is served, said the court, by the preservation of the obligations of contracts. More recent Missouri cases have also rejected this public policy argument.

Purpose of Covenants

The Supreme Court of Missouri has stated that “agreements of this kind restrain commerce and limit the employee’s freedom to pursue his or her trade.” Therefore, “enforcement of such ... agreements is carefully restricted.” The purpose of enforcing a non-compete agreement is to protect the employer from unfair competition by a former employee without imposing unreasonable restraints on the latter. “Protection of the employer, not punishment of the employee, is the essence of the law.” [Citations omitted].

An employer may only seek to protect certain narrowly defined and well-recognized interests – its trade secrets and its stock in customers (*i.e.* patients). The enforcing party must also show that the agreement is reasonable in scope, both as to time and place. The burden of demonstrating the covenant’s validity is on the party seeking to enforce it.

Cases Enforcing Covenants

As stated above, most of the recent Missouri cases have enforced restrictive covenants with respect to physicians. The durations of the injunctions have been as long as five years and as short as one year. The geographic restriction is often a 50- to 75-mile radius from the employer’s office. In order to provide physicians a better understanding of the factors that the courts consider, a more detailed discussion of those cases is set forth below.

In the last Missouri Supreme Court case concerning a physician, the court enforced a covenant preventing a surgeon from practicing medicine for a period of five years within a 20-mile radius of St. Joseph, Mo. The defendant/physician completed his residency and then worked with the employer/physician for three years, when the partnership was terminated. The defendant argued that there was a need in Northwest Missouri for the services of a skilled surgeon, and that in determining whether to enforce this restrictive covenant, the

In one case, a physician (the court did not indicate the physician’s specialty) was enjoined from the practice of medicine within a radius of 60 miles of the City of Butler for five years after termination of his employment. The defendant/physician worked with the plaintiff during his internship. After completing a few years of employment, the defendant left to begin his own practice. He admitted that during the first month of his own practice he sent requests for medical records to the plaintiff’s clinic, and about 80 percent were concerning patients of his former employer. In this case, the court stated that contracts of non-competition between physicians will often be enforced through injunctive relief. The court further stated that the established public policy of Missouri does not prohibit enforcement of an otherwise valid non-competition employment contract between medical practitioners. Furthermore, “the competition which marks the medical practice and the time required to gain the confidence of a [patient] makes the insistence on such protection not only reasonable but a practical necessity.”

In a case involving a cardiologist who worked with the corporate cardiology practice for 15 months, the court enjoined him from providing any services to any patients of the cardiology practice or engaging in general cardiology at certain hospitals in the St. Louis area for one year. The court rejected defenses that the covenant not to compete was procured by fraud and duress, that there was a prior material breach of the agreement or that the cardiology practice was barred from seeking an injunction because of “unclean hands.”

The physician who was the sole owner of the cardiology practice had established and developed his practice for several years before he associated with the cardiologist/employee, who had never been in private practice. In this case, the cardiologist/employee was hired to expand the cardiologist’s practice at a particular hospital. The court held that the covenant was necessary to protect the employer’s legitimate business interest in his practice at that hospital.

In another case, a neurologist was enjoined from practicing neurology for two years within a 75-mile radius of the employer’s office.



Interestingly, the neurologist only worked for the neurology group in Columbia, Mo., for six months. Moreover, he was an experienced neurologist, having practiced for six years before accepting employment with the neurology group, including practicing in the Columbia area. However, what influenced the court was the neurologist's conduct of becoming a shareholder in a competing neurology group in Rolla shortly after signing his employment agreement with the Columbia neurology group. The employment agreement with the Columbia neurology group required that he devote substantially

all of his time and attention to that corporation. After the neurology group in Columbia raised this issue to him, he informed them that he would no longer be involved in the group in Rolla; however, he continued seeing patients there, and discharged some of these patients in Columbia to the clinic in Rolla.

The neurologist argued that the court should not enjoin him because his exposure to the Columbia neurology group's patients was limited. However, the court stated that he saw over 500 patients while there and that 80-90 percent of the patients he treated were first-time patients.

The neurologist also argued that given his short tenure with the clinic in Columbia, it did not have a protectable interest in its patient base. The court disagreed. The court concluded that he had significant influence over the patients he saw while employed by the Columbia clinic. This was demonstrated by the fact that he was able to direct former Columbia patients to see him in his Rolla clinic for follow up. Finally, in addition to the injunction, the court also entered a money judgment against the neurologist for \$40,000.

Finally, in a more recent case, a pediatrician filed a declaratory judgment suit seeking a declaration from the court that his non-compete agreement was overly broad, and thus, unenforceable. The pediatrician filed a motion with the trial court requesting that the trial court rule, as a matter of law (without hearing any evidence), that the non-compete agreement was overly broad and unenforceable. Surprisingly, the trial court granted the motion. The Court of Appeals, after discussing a number of the Missouri non-compete cases involving medical practitioners, reversed and concluded that the pediatrician's 60-mile, three-year restriction was not overly broad as a matter of law.

Defenses

The most common defenses in attacking the enforceability of a non-compete agreement are the following: (1) the employer did not have a protectable interest in the physician's patients; (2) a prior material breach of the agreement; and (3) "unclean hands." The two most recent cases that upheld these defenses are discussed below.

In the first case, the court refused to enforce a three-year, non-compete agreement involving an ophthalmologist. During the course of the contract negotiations between the ophthalmologist and the eye

clinic, it became apparent that a new agreement was not likely before the existing one expired. The eye clinic notified all hospitals and patients which the physician served that he would be leaving the Kansas

City area at the expiration of his contract, terminated all his on-call duties, prohibited him from treating patients, cancelled surgeries he was scheduled to perform and locked his office. In effect, the clinic relegated him to a compulsory vacation for the remainder of the contract term.

The trial court refused to enforce the covenant not to compete based on the material breaches of the employ-

ment agreement by the clinic. The Court of Appeals agreed, holding that the actions of the clinic in informing hospitals and other physicians that the ophthalmologist was no longer practicing in the area and prohibiting his access to patients for treatment or surgery – all before the termination of the existing contract term – prevented him from the exercise of his profession when he was entitled to practice and constituted a material breach of the agreement. Moreover, by not allowing him to work for a month, he was deprived of an additional \$25,000 of compensation under his agreement, and this also constituted a material breach by the eye clinic.

In the second case, the court refused to enforce a non-competition agreement with respect to a nephrologist who served as a medical director and independent contractor of the plaintiff's dialysis treatment centers. The threshold issue was whether a covenant not to compete applies to an independent contractor. The court, in a case of first impression, held that non-compete covenants are applicable to an independent contractor relationship. However, the court refused to enforce the covenant in this case, because the nephrologist was only prohibited from serving as a medical director and not as a private physician, and since he had no patient contacts as medical director, the employer did not prove a protectable interest in its patient contacts as to the nephrologist.

Finally, it is important to be aware that Missouri courts will modify (instead of not enforcing) a restrictive covenant if the court believes it is too restrictive. For instance, a restriction covering all of St. Louis for two years might instead be limited to certain hospitals for one year. Both sides to a non-compete case should consider this principle in determining how to proceed.

In summary, covenants not to compete are enforceable if they serve to protect a legitimate business interest of the former employer, usually the loss of patients, and are reasonable in scope.



Bill Corrigan is a partner in the St. Louis office of Armstrong Teasdale LLP and is a past President of the Missouri Bar. He can be reached at (314) 621-5070.



The Regulation and Discipline of Physicians in Missouri

Principles to keep in mind in preventing and responding to disciplinary action

By Edward Crites, JD

The Missouri State Board of Registration for the Healing Arts is responsible for disciplining physicians. With over 40 separate bases for discipline, and over 14 available disciplines, imposed singly or in combination, negotiating a disciplinary process can be intimidating. It can also be quite serious, as in some instances license revocation is mandated.

In negotiating the process, the preliminary determination must be whether the disciplinary charge is one that carries mandatory license revocation. For instance, if a physician is convicted of a felony involving fraud or moral turpitude, or if a medical license is revoked in another state upon grounds for which revocation is authorized in Missouri, the Board must revoke the license. In such instances, the physician should address the underlying issue *before* the matter gets to the disciplinary stage. It would be imprudent to allow a criminal prosecution or license action in another state to go uncontested and rely upon the Board's leniency. The Board has no discretion.

Aside from the need for early action in the instances involving mandatory revocation, three principles must be kept in mind in responding to disciplinary actions. *First*, where possible the Board works with physicians to correct problems while protecting patients and promoting ethical standards within the medical profession. *Second*, the Board favorably responds to being dealt with in a cooperative and straightforward manner. *Third*, the Board rewards good-faith, meaningful corrective action.

The following illustrates how these principles apply to specific situations. For ease and clarity, this analysis groups the multiple statutory bases of discipline into 13 categories.

1. Inadequate Patient Care. Inadequate patient care has many causes, some of which are correctable by good faith effort. For instance, in cases that arise from a personal issue, such as drug dependency, the best strategy might mean admitting the problem and enrolling in a treatment program. Similarly, if the case arises from a poor medical decision, voluntarily taking additional CME training might resolve the Board's concern about quality of care. Take advantage of opportunities to self-correct problems, and advise the Board of your action. Likewise, to the extent that some prohibited



conduct was intentionally performed, such as delegating professional duties to unlicensed persons, the activity should be stopped and action taken to satisfy the Board that it will not recur. By taking the initiative in correcting any problems the physician increases the Board's confidence that it can protect patients and the profession, even with less severe discipline.

Also bear in mind that, should a severe punishment be imposed, the Board may, upon the physician's demonstration of good-faith, full compliance with the discipline, favorably receive a petition to reduce or terminate the discipline.

2. Criminal Conviction. Not all felony convictions mandate revocation, but all generally draw severe discipline. This is true even for crimes wholly unrelated to medicine, such as violating orders of protection, DWI or leaving the scene of an accident. Given that severe discipline is normally imposed for criminal conduct, physicians must vigorously seek to avoid the felony conviction. And, if that is not possible, real steps to correct any underlying problem (e.g., chemical dependency treatment) is recommended.

3. Discipline by Medical Society/Hospital. Discipline imposed by a hospital or medical society must be reported to the Board. Although the Board appears disinclined to match the severity of discipline imposed by a hospital or medical society, surprisingly severe discipline is occasionally imposed. Moreover, even minor hospital discipline can have a disproportionate deleterious effect in competing for fellowships. Accordingly, physicians should vigorously defend such discipline at the hospital/medical society level.

4. Mishandling Prescription Drugs. Although by far the most common cause of Board discipline, mishandling prescription drugs is an area that lends itself to proactive self-corrective measures. By enrolling in a treatment program, undertaking appropriate CME, or revising office procedures, the physician can show the Board that the problem is recognized, responsibility accepted and that it will not happen again. Of course, any self-corrective action must take into account the possibility of criminal prosecution and BNDD and DEA issues.



5. Personal Chemical/Drug/Mental Health Issues. Like patient care and mishandling prescription drugs, the Board appears highly receptive to good-faith efforts to take corrective action in matters involving personal chemical, drug or mental health issues.

6. Discipline by Another State.

Where discipline has been imposed by another state, a Missouri physician can expect to have comparable, or more severe, discipline imposed by the Board. In part, this is due to the mandatory revocation that accompanies another state's license revocation. Regardless, do not expect more lenient treatment from the Board than from another state's disciplinary authority. When another state initiates disciplinary action, the physician must fully defend against it at that time. Once the other state has revoked a license, the Board may have to do likewise, and once the other state has taken a lesser action, the Board will likely do the same.

7. Sex with Patient. Although nonconsensual sex carries a real risk of harsh discipline and of possible license revocation, offenses

involving consensual sex receive only marginally less severe discipline. If applicable, one strategy would be to undertake voluntary treatment for related issues, such as drug dependency. Also helpful would be preventative measures, such as using a chaperone.

8. Discipline by Drug Licensing Authority.

The Board is not obligated to impose the same discipline imposed by a drug licensing authority. As with other offenses, however, to the extent underlying personal issues, such as drug dependency, are involved, seeking treatment might minimize the discipline imposed, or allow for the petition for an early

end to, or lessening of, restrictions. Of course, such decisions must factor in the need to avoid a criminal conviction.

9. Violations of Probation/Previous Agreement with Board.

If a physician is placed on probation or enters into an agreement with the Board, it is highly advisable to fully comply. Failure to comply will likely result in more severe discipline.

Notably, it appears the Board is inclined to use suspension to

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“ Where possible the Board works with physicians to correct problems while protecting patients and promoting ethical standards within the medical profession. ”

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The Regulation and Discipline of Physicians in Missouri *(continued)*

gain the attention of noncompliant physicians. Also, enthusiastic corrective action, such as obtaining treatment or CMEs or using mentors, tends to be rewarded. Moreover, it was not uncommon for a discipline to be lessened early when the physician has fully complied with ordered discipline. Compliance is rewarded, and failure to comply is a recipe for turning a reprimand into a probation or suspension.

10. Failure of Qualifications. The Board often allows multiple attempts to pass the licensing exams, but at some point the test must be passed.

11. Fraud. For fraud unconnected to criminal conviction, the Board seems relatively lenient, with reprimands as the most common discipline. If there is a claim of fraud, the goal must be to avoid criminal conviction and its mandatory license revocation.

12. Relations with Board. Lying to, or not cooperating with, the Board brings severe discipline. Recognizing the limitation that one might not want to cooperate with the Board if that risks criminal prosecution, physicians should generally be scrupulous in dealing with Board. Keep it abreast of address changes; advise it of any discipline by other states/hospitals; do not misrepresent your background or qualifications; do not make misstatements on applications; and cooperate when asked.

13. CME. Fortunately, this discipline for this offense has been limited to a reprimand plus taking the required CME.

Conclusion

In responding to Board disciplinary actions it is important to know whether the subject offense carries a mandatory revocation. If so, the underlying offense must be vigorously challenged. For offenses with discretionary penalties, cooperating fully with the Board and complying with the remedial steps imposed is recommended, except to the extent that it increases exposure to criminal liability. Finally, when discipline is imposed by another state's licensing authority the physician should expect a similar penalty in Missouri, and efforts to defend against those claims must be begun by defending the action in the other state.



Edward Crites is an attorney with Behr, McCarter & Potter, PC. His practice includes representing physicians before the Missouri Board of Healing Arts. He can be reached at (314) 862-3800 or ecrites@bmplaw.com. The firm's Web site is www.behrmmcarterpotter.com.

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