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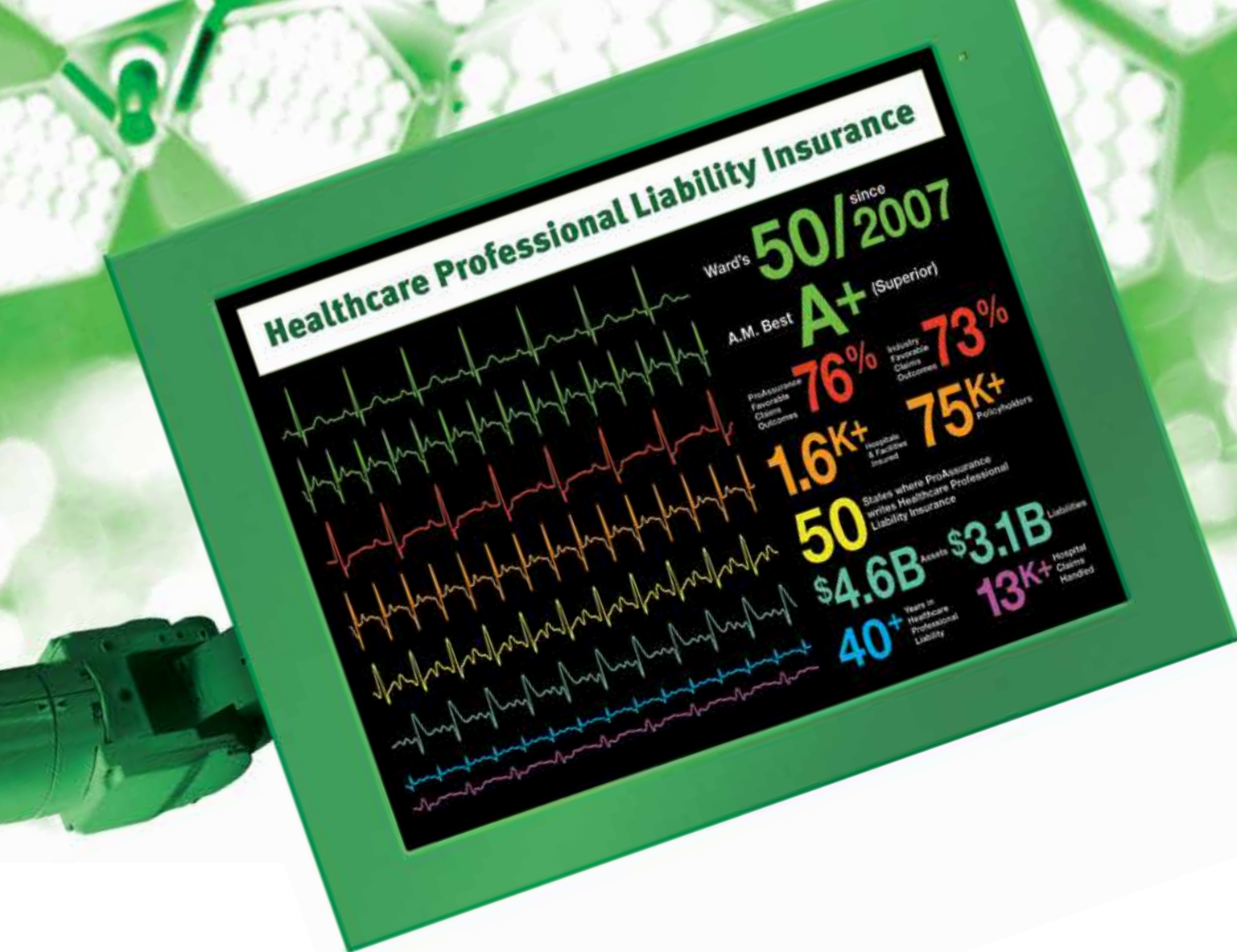
Issues in Physician Employment

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Becoming an Employed Physician: A Personal Journey

Questions to consider in choosing between employment and private practice

By Ramona Behshad, MD, Medical Society President



Medical Society President
Ramona Behshad, MD

My parents were careful to keep their work conversations away from my brother and me, but on occasion, we got to hear business matters and I was immediately interested.

For the first time, employed physicians outnumber independent physicians. The AMA's 2018 Practice Benchmark Survey, which queried 3,500 doctors, showed that 47% of all physicians were employed compared to 46% of physicians being self-employed.¹

The margin is small, but trends suggests that these margins will increase. Over the last six years, the percentage of employed physicians has increased 6%, while the percentage of self-employed physicians has fallen by 7%.

Who is choosing employment? Over 70% of physicians under 40 are employees, compared to 38% of physicians 55 years and older. Most of the employed group work directly for a hospital or for a practice partly owned by a hospital. I have several thoughts on these survey results, most of which are based on my personal journey from private practice to employment.

My Journey

I went into medicine expecting to be a small business owner, like my pediatrician father. My mother, who has a degree in management, has been his office manager for 20 years. As I observed as a teenager, their work and personal relationship seemed to balance perfectly. My parents were careful to keep their work conversations away from my brother and me, but on occasion, we got to hear business matters and I was immediately interested.

I saw him build the office, manage staff and receive financial rewards for working harder. He took off all necessary personal holidays and particular vacations during our school breaks, none of which needed several layers of approval. He had no EMR.

Fast forward 20 years, and he is still in private practice with three other physician co-owners. They are constantly approached by hospitals for buyouts and have started to use EMR.

The conversations I hear now are much less optimistic, but they continue to see value in their current model. They have strong opinions on how medicine ought to be practiced and would likely resist doing things the hospital's way anyway. Private practice is right for them.

With my father's situation at top of mind, I chose dermatology as a specialty because I loved every aspect of it. My passion for the field would be an asset when running my own practice. It was after choosing dermatology that I made a few realizations. First, the age of physician-owned practices was verging upon extinction. Second, my professional aspirations still included business ownership, so I joined my mentor in private practice right out of fellowship. After four years, he sold his practice to a venture capital firm. After carefully considering the two roads, I left to join Saint Louis University as an employed physician.

My Advice

I have learned to let life change my plans. Joining the academic world has been a blessing for me. While there are parts of private practice that I miss, I love training residents, interacting with medical students, and being able to participate in investigator-initiated research.

When I look at my employed colleagues, I see that they can be generally divided into two groups, each with significantly different attitudes and job expectations. Young physicians are more interested in their daily

practice than on operating an entrepreneurial enterprise. Established physicians, as in my mentor's case, are opting to sell their practices and move to employed positions because the future economics of traditional practice are uncertain.

Having indulged in both private practice and employment, I have compiled my thoughts for those either considering their first job or considering a job change. Here are several questions to ask yourself:

1. Do you need to be in control?

If you become employed, you must be willing to relinquish some control. In a 2016 Medscape survey, 42% of employed physicians indicated that they disagreed with their organization about patient care issues, and 57% disagreed over workplace policy. The most common disagreements were about deadlines for submitting medical records, work schedules and dealing with staff.²

Physical control over the office is definitely easier in private practice. As an employed physician, if I want a new chair, I have to fill out a requisition form and justify the new chair. In private practice, you can simply order the chair.

Employed physicians are subject to whatever choices management makes, and we typically have to follow those decisions with little input. For example, we get little say in which holidays the office will observe or how appointments will be scheduled. Employed physicians tend to find these decisions burdensome, while independent physicians find the ability to make these decisions a major bonus.

2. Can you tolerate delayed gratification?

Owners of successful independent practices have the opportunity to make a good deal more money than those in employed positions. **It requires patience.** It takes time to build a practice and revenue stream. Employed positions, on the other hand, often involve walking into a full schedule and an immediate guaranteed salary. With mounting student debt, I can see why young physicians are opting for guaranteed income.

3. Can you tolerate risk?

Starting a medical practice is similar to launching any other small business, and is subject to the same statistics as any other newly-established business venture. According to the U.S. Small Business Administration, roughly 50% of new businesses fold within five years. Because of this, **independent physicians take on significantly more financial risk for the chance to earn extra income.** Being comfortable with that risk along with a strong understanding of finances, cash controls and revenue cycle, to name a few, is necessary.

4. Is an unpredictable work and call schedule tolerable to you?

In the employed setting, vacations, continuing medical education requirements and sick time are covered. Hours are more consistent, although not necessarily shorter. Lifestyle is seen as improved, particularly for young physicians who wish to work based on family needs. In private practice, vacations and continuing medical education are paid out of the physician's own pocket. When you are away, no income is generated, and no coverage is guaranteed. Because of this, I took very little vacation while in private practice.

Owners of successful independent practices have the opportunity to make a good deal more money than those in employed positions. It requires patience.



Going Forward

No one gets it all: location and lifestyle, income, the perfect partners and the dream practice. The physician who gets two of these four is doing well. Compromises will have to be made.

Despite the trend toward employment, if you answered yes to the above questions, you may enjoy the business of medicine and should consider private practice. For it to continue being a viable option, however, we need to start training medical students and residents in business. In an era of tightening regulations, future physicians need to understand employee management and small business issues. They need to learn how to be a CEO, CFO and HR director. Without this training, it is easy to see how independent practice will give way to corporate medicine. ➡

Ramona Behshad, MD, is an assistant professor in the Department of Dermatology at Saint Louis University School of Medicine and director of the Division of Mohs Surgery and Cutaneous Oncology.

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2019 Hippocrates Lecture to Address “Medicare for All”



Dr. Ed Weisbart

“Health Care in Crisis: Medicare to the Rescue” will be the subject of the 17th annual Hippocrates Society Lecture sponsored by the St. Louis Society for Medical and Scientific Education (SLSMSE), the charitable foundation of the Medical Society, on Tuesday, September 17. The event will again be held at Spazio Westport, 12031 Lackland Rd. in Maryland Heights, with a cocktail reception beginning at 6:00 p.m., followed by dinner and the lecture at 7:00 p.m.

The featured presenter will be Ed Weisbart, MD, CPE, FAACP, chair of the Missouri chapter of Physicians for a National Health Program, a 32-year-old nonprofit research and education organization supporting an improved form of Medicare for all Americans.

Dr. Weisbart will address why “American physicians are among the least happy in the world. We spend far too much time away from our patients, managing a needlessly complex business of medicine and dealing with arcane burdens of the Byzantine insurance industry.

“Now the nation is considering restructuring the entire landscape through a ‘Medicare for All’ scheme,” he continued. “It’s critical that physicians have a strong voice at the table, that we understand how the current proposals would affect both us and our patients. What should we watch out for? What should we fight for? And what should we worry about?”

Dr. Weisbart is an assistant professor of clinical medicine at Washington University and a national speaker with multiple articles published in both national medical journals and local media regarding the health care needs of the uninsured. He volunteers in a variety of safety net clinics and other nonprofits across the St. Louis area, and serves as vice president of the Consumers Council of Missouri.

He received his medical degree from the University of Illinois–Chicago in 1979, and completed his family medicine residency and a fellowship in family medicine education at Michigan State University in 1982. He practiced family medicine at Rush Medical Center in Chicago for 20 years. He previously served as chief medical officer of Express Scripts from 2003 to 2010.

CME credit will be available for the lecture. The event is free and open to all SLMMS members, including medical student members. There is a \$40 per person fee for spouses, guests and non-members. Reservations are required and must be made before Wednesday, September 11, by contacting Liz Webb at 314-989-1014, ext. 100 or lizw@slmms.org.

Members may submit questions for Dr. Weisbart in advance of the lecture to dnowak@slmms.org. ➔

2019 SLMMS HIPPOCRATES LECTURE

Tuesday, September 17, 2019

Spazio Westport

12031 Lackland Rd., Maryland Heights

6:00 p.m. – Cocktail Reception

7:00 p.m. – Dinner immediately followed by lecture

Free for SLMMS members; \$40 for non-members and guests

Speaker

Ed Weisbart, MD, CPE, FAACP

Physicians for a National Health Program,
Missouri Chapter Chair

Reservations Required

RSVP: Liz Webb, 314-989-1014, ext. 100 or lizw@slmms.org

Discounted Medical Billing Available for Members

The Medical Society has partnered with Integrity Healthcare Solutions of St. Louis to provide discounted medical billing services and revenue cycle management consultation for SLMMS members.



Eric Knudtson, Integrity’s president and founder, is a certified professional coder with over a decade of experience in medical revenue management consultation and training and software implementation. Nancy Knudtson, vice president, is a veteran of the financial services industry as a senior business leader in development and operations.

Integrity will provide SLMMS members a 7% discount on medical billing services for the first year of service upon a signed and executed contract. They will also offer medical coding services (any specialty) and revenue cycle management (RCM) consultation. Members are entitled to one free consultation. They also provide software selection and implementation consulting, as well as workflow process creation and improvement. Also, the Medical Society will receive a small revenue share payment for services scheduled by SLMMS members.

For information, contact Eric Knudtson at 636-299-8088 or eknudtson@integrityhealthcommunity.com or visit www.integrityhealthcommunity.com. ➔

SLMMS Office Relocation

After 14 years in our current home at 680 Craig Road in Creve Coeur, the St. Louis Metropolitan Medical Society office is moving to a new space in August. Our new home will be approximately two miles west on Olive from our current office. You will soon find us at 1023 Executive Parkway, Suite 16, in the Bellerive Office Park at Olive and Mason Roads, just west of the Barnes-Jewish West County Hospital campus. Our sublease partner, the Missouri Physicians Health Program, will be relocating with us.

The new space allows us to reduce our office size from over 4,500 to just under 2,000 square feet, significantly trimming our monthly rent expense. As a result of our relocation, we will no longer have access to our large conference room space, so the monthly SLMMS Council meetings will be held in the West County Radiology Group offices located at 11475 Olde Cabin Road, Suite 200, beginning in September. SLMMS Committee meetings and other gatherings will be held in the small conference room located within the new office space.

The office move is scheduled for Thursday, August 15 and Friday, August 16, with the goal of being up and running in our new space on Monday, August 19. We anticipate having no phone or email capabilities during the move, so please keep those dates in mind if you need to contact the SLMMS office.

Watch for an announcement of an open house event in the new space sometime later this fall. In the meantime, members are invited to visit the new office following the move at any time during regular business hours or by appointment. ➡

NOTICE

ST. LOUIS METROPOLITAN MEDICAL SOCIETY GENERAL SOCIETY MEETING

Tuesday, September 10, 2019
6:00 p.m.

West County Radiology Group
11475 Olde Cabin Rd., Suite 200
Creve Coeur

**Nomination of 2020 Officers, Councilors and
MSMA Delegates**

All members are invited to attend.

Agenda

Call to Order

President Ramona Behshad, MD

Nominating Committee Report
Ravi S. Johar, MD, Committee Chair

**The committee will be recommending members
for nomination to the following offices:**

President-Elect ➡ Vice President
Secretary-Treasurer ➡ Councilors (4)

Physician Family Night at the Saint Louis Zoo Friday, August 30

Unwind from the busy workweek with fellow SLMMS physicians, Alliance members and our families. SLMMS and the SLMMS Alliance invite you to gather to enjoy the Saint Louis Zoo's weekly Jungle Boogie Concert Series on Friday, August 30. The whole family is welcome! Look for the SLMMS Alliance group when you arrive.

- Where:** Saint Louis Zoo, Schnuck Family Plaza (adjacent to the Lakeside Cafe)
- When:** 5 to 8 p.m. August 30
- Bring:** Lawn chairs, blankets
- Food/Drink:** Bring your own (no glass bottles) or purchase food and beverage from the Lakeside Cafe. Happy hour specials available along with discounted pricing on select beer, cider, wine and margaritas.
- Entertainment:** Ticket to The Beatles (faithfully recreating the energy and excitement of The Beatles)
- Plus:** Animal-related kids' activities focusing on the conservation of endangered species through the Zoo's WildCare Institute
Free gifts from the SLMMS Alliance
- Admission:** Free
- Questions?** Sue Ann Greco, suanngreco@sbcglobal.net

The SLMMS Alliance is organizing this gathering as part of the AMA Alliance Physician Family weekend.

The Fight to Save Health Care for Patients and Physicians

National grassroots, non-partisan coalition outlines physician-led roadmap to patient-centered care

By Scott Hardeman MD, FACS

In the battle to save medicine for patients and physicians, we are not alone.

Health care decisions affect everyone. Patients worry about drug costs, access to affordable insurance, finding a quality physician and pre-existing conditions. While committed to patient care, physicians also have many concerns. These include burdensome government regulations, vertical integration by large predatory hospital and corporate systems, often forcing doctors who prefer to stay independent into an employed status, as well as declining reimbursements. We are in a fight to save health care, and we need to focus on the physician's role in the battle.

I have spent my career working to empower the independent physician. Years ago, my colleagues and I merged groups of otolaryngologists to form a larger single specialty organization in order to maintain our private practice. During the last six years, together with others, we formed an independent group of nearly 700 doctors and one of the most successful ACOs in the state. It is my passion that physicians be able to care for patients in the way we desire. More recently, I am pleased to be involved with non-partisan physician and patient advocacy groups on a more national level.

I am involved in these groups because over the last 10 years, as the physician workforce has moved to a more hospital-employed structure, there has been an escalation of costs and the leveling out or even decline in the quality of medicine. Another concerning trend taking shape is the insurance industry purchasing physician practices. In some southern states, a single insurance company controls over 80% of insured lives. These trends are putting patients and health care at risk

by creating monopolies in the delivery of care model and eliminating choice. It is largely an issue of misaligned incentives. Sadly, this plays out as increased health care costs, increased premiums, massive increases in pharmaceutical costs, less accessible care for the underprivileged, rising physician burnout and less free market choice in health care.

It is overdue that we, the physicians, take a front seat in all health care matters including legislation. To that end, I have the privilege of being connected with hundreds of other physicians, representing many thousands more. This group, along with patient advocacy groups, make up a non-partisan grassroots effort to improve health care for patients and physicians.

It is of utmost importance that we stay engaged in the legislative efforts that so greatly affect us and our ability to practice our craft. The future of medicine lies in our hands.



One of the group's efforts was to form the movement known as Free to Care, free2care.org. Recently, Free to Care held a symposium in Washington, D.C., and subsequently produced a white paper outlining a physician-led roadmap to patient-centered care. This roadmap identifies key issues facing doctors and patients in the battle to keep American medicine at the forefront. This paper also exposes ways to reduce cost and waste.

Since that meeting, the Free to Care movement has continued to gain strength, largely fueled by the fact that health care is the number one political agenda issue and because it has the support of thousands of physicians and patients who are the foundation of medicine. While I am sure not all physicians will agree with everything laid out in Free to Care's white paper, it is clear that doctors need to be part of any change that happens to health care.



Dr. Scott Hardeman

Scott Hardeman MD, FACS, is a board-certified otolaryngologist with Gateway ENT, a division of Sound Health Services. He is chairman of the St. Louis Physician Alliance and ACO, and chief strategy and innovation officer of Urgent Specialists LLC. He can be reached at hardemansh@yahoo.com.

The Free to Care movement is tackling five primary issues:

1. Drive down drug prices and increase supply.

Drug and medical device costs are out of control. Exorbitant pricing is a complex problem. However, the key factor driving prices can be traced to 1987 when a law was enacted providing a “safe harbor” for rebate kickbacks to group purchasing organizations (GPOs) in a pay-to-play market. In 2003, this kickback safe harbor was extended to the pharmacy benefit manager (PBM) industry. Outside of the pharmaceutical and medical device industries, kickbacks such as these are illegal in any other health care endeavor. Multiple meetings of the Senate Antitrust Subcommittee exposed the safe harbor law as being the root cause of both drug and medical device shortages as well as the increased cost of medicines. It is estimated that this safe harbor allowance adds \$250 billion of unnecessary costs to the nation’s health care bill. Therefore, it is recommended the safe harbor law be repealed.

2. Strengthen the safety net for the vulnerable.

It is necessary to create and strengthen the safety net for the most vulnerable of our society. One of the initiatives to help with this is to even the playing field for providers of pro-bono care. Presently, unlike hospitals, physicians are not able to write off charitable care. There is currently a proposed bill called the Physician Pro Bono Care Act of 2019 (HR 856). Passage of this bill will help provide medical care for patients in financial need and would increase access, encouraging more physicians to participate in charitable care. In addition to this bill, there is a specific movement for a tax deduction to be extended to physicians and nurses who donate time in public settings to educate the public on state-based pro-bono care.

3. Foster fresh models to pay for medical care.

There need to be new and innovative models to pay for medical care. Free to Care recommends an expansion of health savings accounts to decrease third-party interference. Additionally, expansion of the direct primary care (DPC) model has been shown to increase access and decrease the cost of care. This DPC model removes much of the waste associated with claims processing and insurance middleman involvement, producing savings for patients. It can be expanded to include direct specialty care as well.

4. Reverse the impending physician shortage.

Additionally, there is an impending physician shortage accompanied by high levels of career dissatisfaction, leading to early retirement. Federal mandates (HITECH, MACRA, ACA, EHR and MIPS) place onerous financial burdens on physicians and private practices. These data-collecting initiatives require reporting that is outside the scope of real patient care efforts. These lead to increased burnout of physicians and financially drive doctors, who often desire to remain in private practice, into an employed

status. These mandates need to be corrected by eliminating the Electronic Health Record and Merit-Based Incentive Payment System (MIPS) requirements for practices with less than 50 physicians. Additionally, the administrative burden of obtaining prior authorizations needs to be eliminated. This directly interferes with the doctor-patient relationship. Also tackled in Free to Care’s white paper is the need for true medical malpractice reform and the need to train more physicians.

5. Make health care prices transparent.

Lastly, there is significant support for and efforts being led to create price transparency. While the recent executive order from the President stands to help in this effort, the battle has just begun. Included in this effort is eliminating the tax-exempt status of nonprofit hospitals. Tax-exempt nonprofit hospitals are able to write off charitable care at chargemaster levels while also receiving disproportionate share (DSH) reimbursements from the federal government.

This “double-dipping” translates to writing off care while also receiving taxpayer funding for that same charitable care. Among addressed issues, another of significance is to create site neutrality between hospital-based practices and those in private practice. As hospitals are able to charge a facility fee when patients see an employed physician, an unnecessary cost is passed to the patient. Additionally, it creates more economic incentive for hospitals to employ physicians. While the American Hospital Association often claims that vertical integration reduces cost through consolidation, the increased revenue gained by such consolidation is most often retained by the hospital and not passed back to the patients whose health care expenditures increased in the process. This hospital-employed model clearly shows an increase in the overall cost of care to the patients.

The Free to Care coalition of physicians, patient advocacy groups and business leaders seeks to restore the doctor-patient relationship. While the details of these efforts continue to be evaluated, it is of utmost importance that we stay engaged in the legislative efforts that so greatly affect us and our ability to practice our craft. The future of medicine lies in our hands.

I would encourage you to find out more about these physician-led efforts and know that there is a coalition working for the best interests of doctors and patients. Although we are not alone in our efforts and desire to improve care, our patients and the future generations of physicians need our help. For too long, we have allowed the other players, none of whom have the same level of patient responsibility, to control the direction of health care. Visit free2care.org to download the entire white paper and to learn more about its efforts. Most importantly, consider lending your voice to the coalition. ➡

Editor’s note: A link to the Free to Care white paper is available on the SLMMS website www.slmms.org and on the SLMMS Facebook page, [saint.louis.metropolitan.medical.society](https://www.facebook.com/saint.louis.metropolitan.medical.society).

The Budding Friendship of HIPAA and Virtual Assistants



Amazon introduces six Alexa skills involving protected health information

By Kevin K. Peek, JD, and Killian R. Walsh, JD

Earlier this year, Amazon proudly announced to the world that its virtual assistant, Alexa, possesses new skills in the realm of health care that abide by the ever-formidable Health Insurance Portability and Accountability Act of 1996, also known as HIPAA. The popular voice assistant is best known for residing in Amazon's hefty army of Echo devices. However, winning over HIPAA is not a popularity contest. The well-known goal of HIPAA is to guard protected health information (PHI), a task the enforcers of HIPAA do not take lightly as evidenced by the many multi-million dollar fines handed out to health care professionals found to be in violation each year.

Health care is a field into which many top technology companies, including Apple and Google, are attempting to establish a larger presence. While small steps have been taken, none have been able to enter the health market with their most ideal product—their respective voice assistants. Their attempts are often thwarted (understandably so) by HIPAA and the need to protect patients' individual health information. However, that changed earlier this year with Amazon's announcement.

Amazon introduced six new Alexa health skills in April. These skills allow users to ask questions such as "Alexa, pull up my blood glucose readings" or "Alexa, find me a doctor." Amazon partnered with six different companies—including St. Louis-based pharmacy benefits manager Express Scripts along with



The new skills also allow users to schedule appointments with health care providers, find urgent care centers, receive updates from their health care providers, access their latest blood sugar reading, and check the status of their prescription deliveries.

the health insurer Cigna—for the development of these specific skills in an early effort to test the waters of merging health care with the growing availability of smart technology. The new skills also allow users to schedule appointments with health care providers, find urgent care centers, receive updates from their health care providers, access their latest blood sugar reading, and check the status of their prescription deliveries.

Straight from Amazon, below is a detailed listing of the new skills:

- **Express Scripts:** Members can check the status of a home delivery prescription and can request Alexa notifications when their prescription orders are shipped.
- **Cigna Health Today:** Eligible employees with one of Cigna's large national accounts can now manage their health improvement goals and increase opportunities for earning personalized wellness incentives.
- **My Children's Enhanced Recovery After Surgery (ERAS):** Parents and caregivers of children in the ERAS program at Boston Children's Hospital can provide their care teams with updates on recovery progress and receive information regarding their post-op appointments.
- **Swedish Health Connect** (by Providence St. Joseph Health, a health care system with 51 hospitals across 7 states and 829 clinics): Customers can find an urgent care center near them and schedule a same-day appointment.



Kevin K. Peek, JD

Kevin K. Peek, JD, is an associate in the St. Louis office of Sandberg Phoenix & von Gontard P.C. and focuses his practice on cases involving medical malpractice defense and the defense of providers in correctional health care. He can be reached at kpeek@sandbergphoenix.com.



Killian R. Walsh, JD

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Amazon is leading the charge in becoming a sort of “middle man” company that has access to health care information by transmitting it only.

- **Atrium Health** (a health care system with more than 40 hospitals and 900 care locations throughout North and South Carolina and Georgia): Customers in North and South Carolina can find an urgent care location near them and schedule a same-day appointment.
- **Livongo** (a leading consumer digital health company that creates new and different experiences for people with chronic conditions): Members can query their last blood sugar reading, blood sugar measurement trends, and receive insights and “Health Nudges” that are personalized to them.

Amazon stated that it plans to work with other companies on an invitation-only basis. Amazon, along with the companies it invites, will work together to develop new skills that are HIPAA-compliant by offering business associate agreements to meet HIPAA requirements. So what does this mean? How do these skills get around HIPAA and ensure patient information is protected?

Navigating HIPAA

Typically, health care workers can only share a patient’s health information with the patient and others in the health care system. Amazon, and other businesses like it that are not health care companies, would not be able to handle this data. However, there is no hard and fast rule for becoming HIPAA compliant. Rather, it is a self-implemented process, generated by a company’s ability to follow various HIPAA requirements, like the Privacy Rule, the Breach Notification Rule, and the Security Rule.

Amazon is leading the charge in becoming a sort of “middle man” company that has access to health care information

by transmitting it only. The way they are getting around the notion that only providers can access information is by entering into agreements with health care companies related to data. For example, with one of the skill partners, Livongo, their agreement provides for Livongo to store the information and for Alexa only to transmit the information. Alexa is not able to store any information and therefore is not able to do anything further with the data, theoretically.

While there are numerous details left to hash out, the obvious merging of health care and virtual assistants will undeniably provide ample benefits to consumers. However, providing that same level of privacy protection for patients, while also allowing such a merger, is a significant complication.

The task of creating the ability for a virtual assistant to protect and utilize PHI is no small feat. While these new available skills are a great step, virtual assistants are still not approved to provide any other kind of assistance for medical personnel related to PHI. Tasks not yet ready include note taking by doctors about a patient visit, reminders about patient appointments, and sending prescriptions to pharmacies. However, with the never-ending advances in technology and the brilliant minds behind these early steps to work with HIPAA, patients’ protected health information will continue to remain in good hands, whether they be real or virtual. ◀

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When Can You Disclose Patient Information to Law Enforcement?

By Hernan Serrano, Jr., and Anna Belmonte

When law enforcement enters your practice demanding patient information, it can be intimidating. You know that the Health Insurance Portability and Accountability Act (HIPAA) requires you to keep patients' protected health information (PHI) private. Ordinarily, HIPAA only allows you to disclose PHI for treatment, payment and health care operations or after first getting the patient's signed authorization. But the urgency of law enforcement requests can pressure physicians into saying "no" or, even worse, making mistakes that violate their patients' rights under HIPAA.

But what should you say when law enforcement comes knocking on your door? Sometimes "no" is the right answer. However, there are many situations in which you can—and should—disclose PHI to law enforcement. This article will clarify:

- When you may disclose PHI and when to limit the disclosures
- When you must disclose PHI
- When you must not disclose PHI

When You ... May Disclose PHI to Law Enforcement

Warrant, subpoena or summons. You may disclose PHI without patient authorization when law enforcement provides you with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer or grand jury subpoena. You should confirm that the document is valid and then only disclose the requested information.



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The urgency of law enforcement requests can pressure physicians into saying "no" or, even worse, making mistakes that violate their patients' rights under HIPAA.

Administrative request, subpoena or investigation. You may disclose PHI in response to an administrative request, such as an administrative subpoena, investigative demand or other written request from a law enforcement official. However, the request must meet three requirements:

1. The requested information must be relevant and material to a legitimate investigation;
2. The requested information must be specific and limited in scope to only what is necessary; and
3. De-identified information could not reasonably be used.

The patient is a victim of a crime. You may also disclose PHI to law enforcement when the patient is a victim of a crime and agrees to the disclosure. If the person is incapacitated and can't agree, you should not disclose their PHI unless law enforcement confirms that:

- They do not intend to use the PHI against the victim;
- They need the PHI to determine whether another person broke the law;
- The investigation would be materially and adversely affected by waiting until the victim could agree; and
- You believe in your professional judgment the disclosure is in the best interest of the patient.



There are many situations in which you can—and should—disclose PHI to law enforcement.

Death of a patient. You may also alert law enforcement about the death of a patient if you suspect that the death resulted from a crime.

Cases of abuse, neglect or domestic violence. You may disclose PHI to law enforcement in cases of adult abuse, neglect or domestic violence as long as:

- The individual consents;
- The law requires the report (check with your state law); and
- You believe in your professional judgement the disclosure is necessary to prevent serious harm to the person or other victims.

Crime on your premises. You may disclose PHI that you believe, in good faith, is evidence of a crime that occurred on your premises.

When to ... *Limit the Disclosures*

In some situations, you may disclose limited PHI to law enforcement. In each of the following situations, you should only disclose the PHI that law enforcement needs.

Locating a person. You may disclose limited PHI to help identify or locate a suspect, fugitive, material witness or missing person.

The patient is a suspect. You may disclose limited PHI when the patient is a suspected perpetrator of a crime when a member of your workforce is the victim of the crime and makes the report.

Identifying or apprehending a person. You may disclose limited PHI to help identify or apprehend an individual who has admitted to participating in a violent crime that you believe may have caused serious physical harm to a victim. However, the admission must be outside of therapy, counseling or treatment related to the propensity to commit violent acts.

In each of these situations, you can only disclose the following information, as needed, to law enforcement:

- Name and address
- Date and place of birth
- Social Security Number
- ABO blood type and rh factor
- Type of injury
- Date and time of treatment
- Date and time of death
- Description of distinguishing physical characteristics

Unless law enforcement provides you with a court order, warrant or administrative request, you cannot disclose:

- DNA information
- Dental records
- Body fluid or tissue typing, samples or analysis

When You ... *Must Disclose PHI to Law Enforcement*

The federal HIPAA law rarely requires you to disclose patient information. You only have to disclose PHI when:

1. You are communicating with the patient themselves;
2. The secretary of the Department of Health and Human Services requests PHI; or
3. State law requires certain disclosures.

In Missouri—and in many other states—you must notify law enforcement about any victim that suffers a gunshot wound, knife wound or other non-accidental injury. The Missouri statute reads:

MO Rev. Stat. § 578.350¹

“A person licensed under chapter 334 or 335 who treats a person for a wound inflicted by gunshot commits the infraction of medical deception if he or she knowingly fails to immediately report to a local law enforcement official the name and address of the person, if known, and if unknown, a description of the person, together with an explanation of the nature of the wound and the circumstances under which the treatment was rendered.”

When You ... *Must Not Disclose PHI to Law Enforcement*

In a 2017 incident at the University of Utah Hospital, a law enforcement officer requested a blood draw from an unconscious car crash victim.² However, the officer didn't have a warrant. The charge nurse explained why she couldn't draw blood without a warrant, the patient's consent, or the patient being in custody. She also presented the hospital policy to the officer. The officer roughly forced her outside and handcuffed her, but she was soon released without a charge. This shocking incident shows how crucial it is for health care employees to know and stand up for their patients' rights.

If a law enforcement officer requests PHI without a valid need (as in the Utah case), you must not disclose PHI. In any situation, except those mentioned in this article, you should not disclose PHI without patient authorization or legal counsel.

In Conclusion

It is your duty to protect patient privacy. However, the framers of HIPAA recognized that there are times when disclosures are in a patient's best interest. So, in some situations, federal and state law allow—or even require—disclosures to law enforcement. Be prepared to give an answer next time law enforcement approaches you about a patient. If there is any doubt, consult with your HIPAA privacy officer before responding to a law enforcement request. ➤

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The Anatomy of an Employment Agreement

Making sure the most important issues are addressed in your contract

By Sanja Ord, JD

The ever-changing landscape of health care delivery and strict federal and state regulations of the health care industry have made it common practice for employers to require documentation of employment arrangements. The terms to which the parties agree are very important for all involved, as they address important legal issues that can affect both the employer and the physician, now and in the future.

Employment offers and corresponding agreements will be unique but contain many typical provisions. In some cases, medical groups or other institutional providers will have “standard” agreements which, because of a desire to maintain consistency or to address some prior past experience within the group, may not be subject to much negotiation. As an example, some employers may require all of their employed physicians to agree to a non-compete provision to protect the group’s business interests. In those situations, there may be little room for negotiation.

In other cases, more negotiation is possible. A physician will typically know, from his or her conversations with the potential employer, how much (if at all) the potential employer is willing to negotiate. Other times, having an attorney discuss specific provisions (as they apply to a physician’s particular situation) with the employer’s attorney can result in the employer modifying some provisions.

This article will outline some of the most critical issues to consider in these negotiations, and provide some negotiation tips on getting these issues addressed in your employment agreement. This article is not intended to be and it does not constitute legal advice, but it is only a general overview of issues relating to employment agreements for physicians.

Term and Termination of the Agreement

A typical employment agreement will usually have a fixed term (such as a one- or two-year term) but may also be an “at-will” arrangement in which there is no specified term. Some agreements will automatically renew for subsequent one- or two-year terms. Other agreements may require that compensation or other terms be revisited at the end of each defined term and the parties agree in writing before the agreement renews for additional periods. It is important to know the length of the employment arrangement, as well as how and when the agreement will terminate.

For example, the required notice for terminating an “at-will” agreement is typically governed by state law and in many cases may only require 30 days’ notice prior to termination. Some agreements have provisions that allow both parties to terminate the agreement for any reason or no reason. Such terminations may require that an advance notice be given to the other party such as a 30-, 60- or 90-day notice ahead of the termination. Termination of the agreement may trigger other provisions, such as restrictive covenants. A physician should consider whether the notice period is sufficient to either move out of the area, if necessary, or find another job in the same area.

Employment agreements also typically contain provisions that allow an employer to immediately terminate a physician’s employment without notice of termination. Such events may include the loss, suspension or restriction of a physician’s license, loss of medical staff membership or clinical privileges at hospitals where practice is required, loss of professional liability insurance or failure to qualify for professional liability insurance, conviction of a felony or a physician’s exclusion from Medicare or Medicaid programs, etc.

Termination of an employment agreement may also affect a physician’s medical staff membership and clinical privileges at the various hospitals where he or she practices, if the physician’s employment requires hospital privileges. It is important that a physician know whether his or her clinical privileges will terminate upon termination of the employment agreement. Automatic terminations of clinical privileges are known as “clean sweep” provisions. If there is a “clean sweep” provision in the employment agreement, the physician will not be entitled to any due process rights under any applicable medical staff bylaws.



Sanja Ord, JD

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Duties and Responsibilities

A physician should ensure that his or her duties are clearly stated in the agreement. Are there specific office hours required? Does this include nights or weekends? Are there specific on-call requirements? If so, how often? Will call obligations be equitably divided among the physicians in the group? Broadly written statements such as “physician shall be subject to call responsibilities” do not give the physician a clear outline of what the call responsibilities entail. A statement such as “the physician shall take calls one Saturday a month between 7 a.m. and 7 p.m.” is a much better statement and serves to protect the physician. In addition, some employment arrangements include administrative responsibilities in addition to clinical responsibilities. The employment agreement should clearly outline the administrative duties required and how the physician will be compensated for those duties, especially if the physician’s compensation is based on clinical productivity.

Outside Activities, Vacation Time and CME Activities

Often times, physicians like to “moonlight” to earn additional income or to explore additional opportunities outside of their full-time employment. If a physician knows that he or she may be interested in such outside activities, it is important to create carve-outs for those activities during the negotiation process. The agreement should address how approval for outside activity will be handled, who gets to keep the income from such activities (the employer or the physician), and whether additional professional liability insurance for those activities will be required. Therefore, the discussion of outside

activities and documentation of the understanding between the employer and the physician is important to ensure the physician’s ability to pursue those outside activities.

Physicians should also ensure that their vacation, sick leave, CME leave (and reimbursement for CME expenses) and maternity leave if applicable, are clearly set forth in the agreement, employer policy or in a side letter signed by both the employer and the physician if the employer is not willing to include these details in the agreement.

Are there specific office hours required?
Does this include nights or weekends?
Are there specific on-call requirements?
If so, how often?

Compensation

Federal law and some state laws mandate that a physician’s compensation must be fair market value and that it cannot be based on the value or volume of his or her referrals. Compensation ranges vary based on a physician’s specialty and regional considerations. There are a variety of objective resources for physicians to determine their salary ranges, such as surveys published by the Medical Group Management Association (MGMA), SullivanCotter or the American Medical Group Association (AMGA).

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**PHYSICIANS SHOULD CAREFULLY REVIEW
AND UNDERSTAND THE TERMS OF EMPLOYMENT
OFFERED, ASK QUESTIONS AND ATTEMPT TO
RESOLVE ANY POTENTIALLY UNFAVORABLE TERMS.**

The Anatomy of an Employment Agreement ➤ *continued from page 13*

A physician's compensation can be in the form of a set annual base salary, a mix of an annual base and a productivity model, or a pure productivity compensation model. Some employers may also offer sign-on bonuses, relocation expense reimbursement, loan forgiveness, retirement benefits, etc. It is crucial that any such offers be included in the employment agreement and described with specificity. Some of these offers may include other agreements with hospitals (for recruitment assistance agreements), and require signing of promissory notes or ancillary agreements.

Malpractice Insurance

During the employment agreement review process, a physician should be aware of (1) what type of malpractice insurance will be provided; (2) what the policy limits are; (3) who will pay for the insurance; and (4) whether tail insurance will be necessary. In Missouri and Illinois, the typical limits are \$1 million per occurrence and \$3 million in the aggregate, but these limits may vary according to applicable state law.

There are two types of policies: claims-made and occurrence-based coverage. An occurrence-based policy covers any claims that occur during the time the policy was in effect, regardless of when the claim is made. If the employment terminates, no tail insurance will be necessary for this type of coverage. On the other hand, a claims-made policy will only cover claims that are made during the time the policy was in effect. If the physician leaves employment and the policy expires, the physician will not be covered unless the physician obtains an extended reporting endorsement or "tail insurance" policy that will extend the coverage back to the date when his or her employment began.

Claims-made policies are more prevalent because they are not as expensive as occurrence-based policies. However, some larger institutional employers may have self-insurance programs that provide occurrence-based coverage. Typically, employers will pay for the insurance premiums during the employment period, and the physician will be responsible for obtaining and paying for tail insurance after the employment ends. Tail insurance can be expensive, and physicians should negotiate to require the employer to cover tail insurance costs if the employer terminates the agreement without cause, or if the physician has to terminate the agreement because of the employer's uncured breach.

Non-Compete and Non-Solicitation Provisions

It is important for the physician to know when any type of restrictive covenant (such as a non-compete and/or non-solicitation provision) will apply. It may not be appropriate for a non-compete to apply in all circumstances (for example, if the physician terminates due to the employer's uncured

breach). Non-compete provisions should be specific in terms of time and geography. For example, a non-compete that states: "the physician shall not practice within 10 miles of Employer's office at ABC address for a term of two years" is clear with respect to both time and geography. However, the following provision: "the physician shall not practice within 10 miles of the Employer's office(s)" could subject the physician to multiple restrictions measured from any office the employer has currently, or may add in the future, and the timeframe for the restriction is not stated.

Non-solicitation provisions typically preclude a physician from offering to provide services to patients from the employer's practice or offering jobs to the employer's employees after the physician has left employment and are often written very broadly.

Ideally, language should be included
outlining the employer's agreement to consider
the physician for equity participation, and the
time frame for consideration.

Knowing the specific terms of non-competition and non-solicitation agreements are critical in a physician's consideration of an employment agreement, as it can affect his or her future practice. Often, language can be negotiated to reasonably limit the scope of these restrictions.

Opportunities to Become a Shareholder, If the Employer Is a Physician Practice

Finally, if a physician joins an independent physician practice, it is often with the expectation of eventually becoming an equity participant in the practice after a certain time period of employment. Ideally, language should be included outlining the employer's agreement to consider the physician for equity participation, and the timeframe for consideration. The language should include the employer's obligation to inform the physician, within a reasonable time following the physician's eligibility to become a shareholder, of the employer's decision relating to the physician's shareholder status.

There are many issues addressed in physician employment agreements, and the issues discussed in this article will most likely appear in some form in most. Physicians should carefully review and understand the terms of employment offered, ask questions and attempt to resolve any potentially unfavorable terms. If negotiation is difficult, engage competent counsel to assist with the negotiation to ensure these critical issues are adequately addressed. ➤

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The #MeToo Movement and Medicine

Challenges of addressing sexual harassment in medicine and suggestions for improvement

By Julie Z. Devine, JD

As we approach the two-year anniversary of the #MeToo movement, it is clear that it has had a large impact on a number of industries. Across our TVs and phone screens, we have seen high-profile examples of sexual harassment allegations in entertainment, politics and media. Although we have not seen as many #MeToo headlines in the medical field, this movement has also affected and will continue to impact it.

In this article, we will discuss the data about sexual harassment and the unique challenges of addressing sexual harassment in medicine. We will also outline concrete steps that individual physicians can take to address sexual harassment in their workplaces.

The #MeToo movement has also brought much-needed attention to racial inequities as well as illegal interactions between physicians and patients. Although these are clearly very important topics to discuss, the focus on this article is on sexual harassment in an employment context.

Data on Sexual Harassment in Medicine

According to a report by the National Academies of Sciences, Engineering and Medicine (NASEM), the prevalence of sexual harassment in academic medicine is almost double that of other science and engineering specialties, with almost half of all trainees at surveyed institutions reporting harassment from faculty or staff. Although the NASEM study is only one report and focusing on one type of health care workplace, the NASEM report is cause for concern because it shows higher rates of sexual harassment in medicine than other industries.¹ According to a study by the Equal Employment Opportunity Commission (EEOC), at least 25% of women experience sexual harassment in the workplace.²

Also noteworthy is the data about reluctance to report sexual harassment. The annual Association of American Medical Colleges' Graduation Questionnaire (AAMC GQ) shows that medical students in the United States experience moderately high rates of sexually harassing behavior and often do not subsequently report it. Only 21% of students who experienced harassment or other offensive behaviors reported the incidents to faculty members or administrators, the report found. The reasons they did not report the behavior ranged from 'I did not think anything would be done about it' (37%) to 'The incident did not seem important enough to report' (57%) to 'Fear of reprisal' (28%) and 'I did not know what to do' (9%).³

The prevalence of sexual harassment in academic medicine is almost double that of other science and engineering specialties, with almost half of all trainees at surveyed institutions reporting harassment from faculty or staff.

Increased Enforcement of and Focus on Sexual Harassment Complaints

Although it is too early to determine whether the #MeToo movement will result in a deluge of litigation, one way to measure the trends is to look at the number of sexual harassment charges filed with the EEOC and Missouri Commission on Human Rights. This is a helpful proxy because an employee in Missouri must first file a charge before filing a lawsuit for sexual harassment. Since the #MeToo movement, the EEOC has reported a 12% increase in EEOC charges nationwide, which is the first increase in a decade. The Missouri Commission on Human Rights data shows similar increase (about 13%). The #MeToo movement has also led to greater enforcement of sexual harassment complaints, at least from the federal government. The EEOC is filing more lawsuits based on sexual harassment (50% increase).



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#MeToo Lawsuits in Medicine

One of the largest verdicts in a sexual harassment case is from the medical field, and it actually came before the #MeToo movement. In 2012, a federal jury in California in *Chopourian v. Mercy General* awarded a former physician assistant \$168 million. The plaintiff claimed she was sexually harassed by surgeons and the medical staff in the cardiac surgery center for a period of two years, and filed multiple complaints to no avail. Witnesses testified that a surgeon made inappropriate sexual comments and discussed his sex life. The large verdict may also have been a result of testimony that the hospital's actions made it difficult for the plaintiff to obtain work at another hospital.

Residents may be particularly reluctant to report sexual harassment because retaliation could mean they do not obtain key recommendation letters, which would directly affect their career advancement.

One of the more high-profile #MeToo cases involving a physician in the past year has been at Yale University, where Dr. Michael Simons, a cardiologist and researcher, received a prestigious endowed chair despite a history of sexual harassment. Yale later stripped Dr. Simons of the honor after public outcry. Dr. Simons then sued Yale, arguing, “Whatever merit there may have been to the University’s

decision to discipline Dr. Simons in 2013, the punishment was imposed, the penalty has been paid.” In his complaint, Dr. Simons also claimed that activities were “galvanized by an intolerance to perceived sexual misconduct, known colloquially by the symbol ‘#MeToo.’”

Challenges of Addressing Sexual Harassment

Across industries, there are certain common factors that make addressing sexual harassment challenging, including power disparities and fear of retaliation. In the medical field, however, there are certain additional obstacles:

- **The medical training model.** This model can increase the power imbalance, making trainees even more afraid to report sexual harassment. Residents may be particularly reluctant to report sexual harassment because retaliation could mean they do not obtain key recommendation letters, which would directly affect their career advancement.
- **Certain physicians appear untouchable.** Sexual harassment can be particularly pernicious if some employees are perceived as so important to an organization that they appear above the policies and procedures of the organization. This may be a faculty member who is very valuable to the institution, or a surgeon who brings in significant revenue to a hospital. It can be difficult to enforce the idea that sexual harassment rules apply to all employees, no matter how important or powerful, if the reality on the ground sends a different message to employees.

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The #MeToo Movement and Medicine ➤ *continued from page 17*

- **Medical training has always been difficult, and health care workplaces can be highly stressful.** There is a widespread perception that certain training, residency or fellowships are supposed to be difficult. There can be a slippery slope between arduous training and belittling/disrespectful experiences. Moreover, in a work environment where small mistakes can have tragic consequences, it can be difficult to prioritize employee culture (even though there is certainly some evidence that shows that employees perform better when working in more supportive environments).
- **Small workplaces.** Although many physicians practice in large hospitals or organizations, there also are many who practice in small medical offices where there are not employee policies or human resource departments/positions. If there are sexual harassment concerns in these smaller workplaces, there may not be the infrastructure to handle the issue.

How Physicians Can Address #MeToo Issues

Although there are many obstacles to addressing the #MeToo movement in the medical field, there are many concrete steps physicians can take to combat sexual harassment in medicine:

- **Collect/review data about complaints and investigations.** Organizations big and small often do not have a good handle on harassment in their workplaces. Collecting data can mean conducting a climate survey, reviewing exit interviews, or scanning social media and blogs. It also means looking for red flags, such as high turnover or low morale in certain departments.
- **Insist on sexual harassment policies.** Having a written policy in place is a key first step in addressing sexual harassment (and one of the first questions the EEOC or MCHR will ask about when investigating a complaint). According to *Becker's Hospital Review*, 12% of health care practices do not even have a sexual harassment policy. For those physicians who are part of organizations that already have harassment policies, they can insist these policies are updated to provide specific example of behavior that is considered inappropriate, provide multiple avenues to report harassment, require employees to cooperate honestly in investigations, and ensure there is strong anti-retaliation language.
- **Advocate for yearly training in anti-harassment and anti-discrimination.** There is skepticism among many that sitting for a sexual harassment training can lead to any real change. However, trainings on anti-harassment and anti-discrimination can be effective if 1) there is true leadership buy-in, and 2) it can lead to frank discussions

about improving the climate. I recommend live trainings (as opposed to a generic video) which specifically address your organization's policies and procedures and provide an opportunity for questions and discussions.

- **Encourage diverse leadership.** Research confirms sexual harassment is less likely to occur when leaders are more diverse. In academic medicine, data from the Association of American Medical Colleges reveals that just 15% of department chairs and 16% of deans are women.
- **Emphasize respect in the workplace.** It is often difficult to tell the difference between rude or disrespectful behavior and sexual harassment. Insisting on a climate that is respectful to all employees, and having sometimes difficult conversations about those expectations, is one of the best ways to improve the workplace climate. Conversations should also include how feedback is provided when performance improvements are needed.⁴
- **Raise concerns and/or complaints.** This is not easy. First, the fear of retaliation is real. The #MeToo movement, however, is beginning to change the atmosphere, and there is more support for those who bring complaints and more resources to investigate the concerns. Second, there is a reluctance to raise concerns or make a complaint because there are many who do not want to jeopardize a colleague or supervisor's livelihood. Keep in mind, however, that raising a complaint or a concern does not mean that an employee will necessarily be terminated. In fact, making a complaint or raising a concern early on is often the best way to ensure the situation does not escalate, and gives the employee an opportunity to improve.

The #MeToo movement has shown no signs of slowing down, and continues to require us to take a critical look at our workplaces to ensure that there is effective compliance with state and federal laws on harassment. Although change will not be easy or occur overnight, there are affirmative steps that can be taken to directly address sexual harassment in the medical field. ➤

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Non-Compete Agreements – What Physicians Need to Know

In Missouri, there are more reported non-compete cases involving the medical profession than any other single profession

By Bill Corrigan, JD, and Michael Kass, JD

Physicians are very often required to sign non-compete agreements and other restrictions as a condition of employment with a medical practice or hospital. Both physicians and their employers should be aware of the basic legal concepts surrounding this area of law, and in particular the fact that courts often do enforce such agreements. Indeed, in Missouri, there are more reported non-compete cases involving the medical profession than any other single profession. Of course, there are many more cases that are not reported because they are resolved at the trial court level and not appealed. The purpose of this article is to provide a brief overview of this important area of the law.

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.”

An employer may only seek to protect certain narrowly defined and well-recognized interests—its trade secrets and its stock in customers (i.e., in the case of medical practices, the 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.

An employer may only seek to protect certain narrowly defined and well-recognized interests—its trade secrets and its stock in customers.

Cases Enforcing Covenants

Most reported Missouri cases involve the successful enforcement of restrictive covenants against physicians, usually prohibiting them from practicing within a certain geographic area for a limited time period. The duration of restrictions enforced by the courts have been as long as five years and as short as one year. The geographic restriction is commonly anywhere from several miles to even a 75-mile radius from the offices of the employer. 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 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 physician’s public policy argument.

Continued on page 20



Bill Corrigan, JD



Michael Kass, JD

Bill Corrigan, JD, and Michael Kass, JD, are both partners in the St. Louis office of Armstrong Teasdale LLP, where they serve as co-chairs of the firm’s Non-Compete and Trade Secrets Practice Group. Bill is also a past president of the Missouri Bar. They can be reached at (314) 621-5070, wcorrigan@ArmstrongTeasdale.com and mkass@ArmstrongTeasdale.com. Special thanks to Armstrong Teasdale summer associate Dana Kramer for her research and editing assistance on this article.

Non-Compete Agreements... ➤ *continued from page 19*

In another case, a physician (the court did not indicate the specialty) was enjoined from the practice of medicine within a 60-mile radius 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% 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 (i.e., a court order specifically prohibiting violation of the restrictions). 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."

The court held that the covenant was necessary to protect the employer's legitimate business interest in his practice at that hospital and enforced the agreement.

In a case involving a cardiologist who worked with the corporate cardiology practice for 15 months, the court issued an order prohibiting 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 physician who was the sole owner had established the practice initially and developed his practice for several years before he hired the defendant cardiologist as an employee (the latter had never been in private practice). In this case, the cardiologist/employee was hired to expand his new employer's existing 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 and enforced the agreement. The court rejected defenses that the non-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 a court order because of "unclean hands."

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% 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 another 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. However, the court of appeals, after discussing a number of the Missouri non-compete cases involving medical professionals, 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." Two reported cases that have upheld at least one of 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 to be agreed to 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.

It is important to be aware that Missouri courts may, in their discretion, modify (instead of not enforcing) a restrictive covenant if the court believes it is too restrictive.

The trial court refused to enforce the covenant not to compete based on the material breaches of the employment 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 reason was the employer did not have a protectable interest in its patient contacts related to the nephrologist. The threshold issue was whether a non-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. Because he had no patient contacts as medical director, the employer did not prove a protectable interest in its patient relationships.

Finally, it is important to be aware that Missouri courts may, in their discretion, modify (instead of not enforcing) a restrictive covenant if the court believes it is too restrictive. For instance, a restriction covering a 100-mile radius may be deemed overbroad depending on the circumstances, but then the court may nevertheless enforce it for a much narrower geographic area. 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 patient relationships, and are narrowly tailored to protect that interest in terms of the duration and geographic scope of the restrictions. ■

HARRY'S HOMILIES[©]

Harry L.S. Knopf, MD

ON INDEPENDENCE

Independence is defined as the state of being free from the control or power of another.

— Merriam Webster

When I graduated from my residency (many) years ago, there was little thought about entering into employment as a physician, especially in a specialty like ophthalmology. I was fortunate to find a practice (and a partner) that I retired from 33 years later. Today, the tide is turning toward employment. Some still try for independent practice, but the economics and general climate are not so conducive as they were for me. Are there advantages to "self-employment?" For one, **you** are the boss! The only person who can hire or fire you is the patient. The only contract you have is with the patient. Yes, there are still rules of practice—in both cases, but the superstructure that accompanies "corporate" practice can be daunting. This issue of *St. Louis Metropolitan Medicine* gives you a taste of each, i.e., some from column A and some from column B. Your menu is before you; the choice is still yours. ■

Dr. Knopf is editor of Harry's Homilies.[©] He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

Completing Six of the World's Top Marathons Puts SLMMS Member in Elite Club

By Jim Braibish, St. Louis Metropolitan Medicine

When urologist and SLMMS member Elizabeth Williams, MD, completed the Tokyo Marathon in March, she joined an elite group of runners worldwide who have attained the Six Star medal.

The Six Star medal is awarded to runners who have finished each of the six largest and most renowned marathons in the world—Boston, Chicago, New York, Berlin, London and Tokyo. Only 1,138 runners in the United States and 6,133 worldwide have achieved the Six Star Finisher award, which is presented by the Chicago-based Abbott World Marathon Majors, a group that promotes elite running.

Dr. Williams was among about 100 runners who earned the Six Star by finishing the Tokyo contest and were honored in a reception after the race.

“The whole experience was incredible. My husband and daughters were there with me. It was everything I hoped it would be,” she said.

Dr. Williams ran her first Six Star marathon in 2014, the Chicago Marathon. That helped her qualify for the 2016 Boston Marathon. She also ran New York in 2016, then London and Berlin in 2018.

The Six Star medal is awarded to runners who have finished each of the six largest and most renowned marathons in the world—Boston, Chicago, New York, Berlin, London and Tokyo.

Compared to many runners, her times among the Six Star marathons over the past five years are very consistent, ranging from 3 hours and 26 minutes, to 3 hours and 41 minutes, a variation of only 15 minutes. That averages out to a pace of about eight minutes per mile over the 26.2 miles in each race. Her times are almost an hour faster than the 4:20 women's average among Six Star Finishers.

She began running in college in the late 1990s and kept it up through medical school and residency. Today, she continues to find great satisfaction in running.

“I enjoy setting goals and achieving them,” she said. “Running helps me work out the stressors. That makes me a better person and a better doctor. I enjoy challenging myself.”



Dr. Williams shows her Six Star medal. The six points on the medal have engraved graphics representing each major city on the Six Star marathon series.

With the help of a supportive husband, she balances her schedule of early morning training runs with the demands of surgery and clinic. Dr. Williams practices with Urology of St. Louis. Her clinical focus includes female urology as well as vaginal and robotic surgery. She is the only female fellowship-trained urologist in female urology in the St. Louis area.



Now that she has earned the Six Star medal, what's next?

“I will be focusing on shorter distances and trying to improve my half marathon time,” she noted. However, she is not giving up marathons. “Someday I would like to have run a marathon on all seven continents. Only a few hundred people have done it.”

She enjoys sharing the international marathons with her husband and daughters, ages 9 and 12, who are both competitive swimmers as well as talented runners. They accompanied her to Chicago, Boston, London and Tokyo.

Dr. Williams noted the value of the travel experience: “It's great to see the international crowd at these races and how everyone comes together despite their differences.” —

Richard J. Kloecker, MD

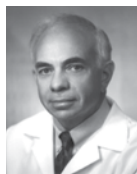


Richard J. Kloecker, MD, a vascular surgeon, died June 9, 2019, at the age of 90.

Born in Omaha, Neb., Dr. Kloecker received his undergraduate degree from the University of Notre Dame and his medical degree from Loyola University Chicago. He completed his internship at the SSM Health DePaul Hospital in 1955 and served in the U.S. Navy from 1955-1957. He completed residency at the University of Cincinnati from 1957-1963. Besides his private practice, he was a clinical instructor of surgery at Saint Louis University. Dr. Kloecker joined the St. Louis Metropolitan Medical Society in 1963.

Dr. Kloecker was predeceased by his wife, Phyllis M. Kloecker. SLMMS extends its condolences to his children: Julianne Abell, Suzanne O'Donnell, Richard J. Kloecker Jr. and the late Charles Kloecker; his seven grandchildren and five great-grandchildren. —

Jerome F. Levy, MD



Jerome F. Levy, MD, a surgeon, died June 12, 2019, at the age of 84.

Born in St. Louis, Dr. Levy received his undergraduate and medical degrees from Washington University. He completed his internship and residency at Barnes-Jewish Hospital, where he was chief resident in surgery. Dr. Levy served as captain in the U.S. Army from 1966-68. He returned to Washington University where he served as an instructor in surgery, then as assistant and associate professor in clinical surgery. He became one of the first Barnes surgeons to perform laparoscopic surgery to remove gallbladders. He then focused his practice on the treatment of breast cancer, and was one of the first surgeons to perform immediate reconstruction surgery after a mastectomy. He wrote a book entitled *Your Breasts*, aimed at educating lay audiences in breast care. Dr. Levy joined the St. Louis Metropolitan Medical Society in 1981.

SLMMS extends its condolences to his wife, Judith Weiss Levy; his children: Rebecca Levy Williams, JoAnn Levy, Ellen Levy, Jerry Lunsgaard, Nancy Levy, David Levy; his 12 grandchildren and three great-grandchildren. —

2019-2020 Officers Installed



The SLMMS Alliance installed its 2019-2020 officers on May 24. Pictured, from left: Gill Waltman, recording secretary, vice president-foundations and MSMA Alliance president; Jean Raybuck, corresponding secretary; Kelly O'Leary, co-president; Sue Ann Greco, co-vice president for membership; Angela Zylka, co-president and vice president for health; and Sandra Murdock, treasurer and co-vice president for membership.

National Award and Office

The SLMMS Alliance was honored with the **2019 Health Awareness Promotion (HAP) Award** at the recent AMA Alliance Annual meeting in Chicago in June. The award is for the Alliance's work with the *Drugs Are Not for Me* opioid awareness program at Loyola Academy of St. Louis.

Congratulations to **Sue Ann Greco** who was elected to the 2019-2020 AMA Alliance board as secretary and chair of the bylaws committee —

Will Lead AMA Academic Physicians' Section



Gary M. Gaddis, MD, PhD, a SLMMS member and professor of emergency medicine at Washington University School of Medicine, was elected as the chair-elect of the Academic Physicians' Section (APS) of the American Medical Association (AMA), at the recently concluded meeting of the APS in conjunction with the AMA House of Delegates meeting in Chicago in June. He will assume the position of APS chair in June 2020. Last October, Dr. Gaddis was named a fellow of the International Federation for Emergency Medicine. He joined Washington University in 2016 after serving on the faculty of the University of Missouri-Kansas City School of Medicine for 17 years. —

To Be or Not to Be, That Is the Occupation

By Richard J. Gimpelson, MD

After residency a physician has to choose between two practice pathways: 1) Private practice (solo or group) or 2) Group practice (teaching or non-teaching hospital).

The following describes my experience with both options. My first 34 years were in solo private practice. The last six years were at Mercy Hospital St. Louis (a community teaching hospital with 24 ob-gyn residents) as co-director of minimally invasive gynecology. There were pluses and minus issues with both choices, but the pluses so outweighed the minuses that I would choose the same path if I had to do everything over again.

Building a Private Practice

In 1977, I began my self-employed solo practice. To get started, I had some money saved and along with the help of a family loan, I was able to buy most of the equipment and supplies to start my practice. I was able to rent space in a new medical building that was close to my home and close to my two hospitals. Family expenses were covered by my wife, Nan, who was the head nurse in the Mercy Hospital operating room (St. John's Mercy Medical Center at that time). Additional income came from being the medical director at the St. Charles Family Planning Clinic and as a gynecologist at the Washington University main campus Student Health Clinic.

I was able to get new equipment after reading the inspirational story of Daniel Ludwig, developer of the super tankers for transporting oil. Mr. Ludwig convinced the petroleum producers that he could ship oil faster and in larger volumes with his super tankers. He obtained contracts to ship the oil. Then with loans from the bankers, he had money to build his ships. The rest was history. Daniel Ludwig was #1 on the first Forbes 400 Richest Americans list published in 1982.

I was not quite as successful as Mr. Ludwig, but his guidance helped me build up my patient volume at a faster rate. When I took over as medical director of the St. Charles Family Planning Clinic, the nurses informed me that there were a number of patients with abnormal Pap smears that had never been evaluated. I contacted vendors of equipment for evaluating and treating abnormal Pap smears. The patients were contacted to get evaluated. Evaluations were done with demo devices and when the treatment charges were received, I was able to buy what I considered the best equipment available at the time.

Another lucky break came when my cousin, Irwin Rosen, opened a pharmacy in the same medical building right next to my office. He had a small lounge and served coffee all day. Since I was only seeing two to three patients per day, I had plenty of time to spend in his lounge. Women would ask Mr. Rosen if he knew a good gynecologist and, of course, he would introduce me to the women. I was able to see them that day (actually within the hour), and most of those patients stayed with me until I retired in 2017.

Two more fortunate and related occurrences enabled my solo practice to succeed. My good friend Henry Rappold, MD, taught me laparoscopic surgery during my final year of residency. This was a new procedure for female sterilization (bilateral tubal ligation). Additionally, Dr. Rappold saw a presentation on hysteroscopic surgery and recommended that I look into this type of intrauterine surgery. I took his advice and became a pioneer in operative hysteroscopy. With expertise in these two types of surgery, I realized that there was need for improved instrumentation. I was able to obtain five U.S. patents and between a nice source of royalties and increased patient volume, my solo private practice thrived. In addition, a number of FDA research trials followed.

Moving to Employed and Teaching Practice

After about 25 years in practice, I began to collaborate with David Levine, MD, who was another pioneer in minimally invasive gynecology and coincidentally also in private solo practice. We were doing very well, but we needed to expand our surgery to benefit more women. Along came an offer from Mercy Hospital to move our practice to Mercy Clinic and join their ob-gyn residency teaching faculty. After nine months of negotiations, Dr. Levine and I were now employed and part of



Dr. Richard J. Gimpelson

Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. He shares his opinions here to stimulate thought and discussion, but these do not necessarily represent the opinion of the Medical Society. Your comments on this column are most welcome and may be sent to editor@slmms.org.

a large group practice. An immediate benefit was the purchase of our equipment for a nice signing bonus. Dr. Levine and I each had two employees that came to Mercy with us and became employees of Mercy Hospital. This retaining of our employees made the transition to Mercy nearly seamless.

The bottom line for me was that I benefited significantly from both my private solo practice and my Mercy employed and teaching practice.



I was very lucky to experience the growth of my solo practice and have the good people who helped shape my career. The two most important people who influenced my practice the most were my wife, Nan, who ran my practice for 20 years before I moved to Mercy Hospital, and Eileen Abernathy, who started work with me in my second year of practice, and was flawless as a medical assistant, surgical assistant and unbelievable research coordinator from 1981 until I retired on Dec. 31, 2017.

Finally, here is a summary of the pluses and minuses of my two ob-gyn practices.

Solo private practice (July 1, 1977 - May 10, 2011)

- I decide free time, family time, vacation time
- I pay all practice-related expenses
- Able to choose educational and practice-building goals

- No income when I am away from practice
- Able to keep all patent royalties
- Able to set office hours
- I control my professional future
- Employees work for me
- I control the FDA research trials

Hospital-employed group practice (May 11, 2011 - Dec. 31, 2017)

- Minimal to no practice expense
- Hospital controls many aspects of the practice
- Employees work for the hospital
- Guaranteed income
- Hospital discipline may be biased
- Can be terminated and require to move on short notice
- Excellent retirement plan
- Hospital may take all or part of patent royalties
- Hospital has final word on all FDA research trials

It should be noted that the solo private practices are essentially non-negotiable, whereas the hospital-employed practice negatives may have room for compromise.

As a final note, the bottom line for me was that I benefited significantly from both my private solo practice and my Mercy-employed and teaching practice. ➤

Welcome New Members

Thank you for your investment in advocacy, education, networking and community service for medicine.

Asim Ali, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, Dow Medical College, Pakistan, 1994
Born 1970, Licensed 2003 ➤ **Active**
Certified: Internal Medicine

Michael E. Cannon, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, Saint Louis Univ., 1987
Born 1954, Licensed 1988 ➤ **Active**
Certified: Family Practice

M. Laurin Council, MD

969 Mason Rd., #200, 63141-6338
MD, Washington Univ., 2004
Born 1978, Licensed 2005 ➤ **Active**
Certified: Dermatology

Richard DiValerio, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, Washington Univ., 1988
Born 1962, Licensed 1989 ➤ **Active**
Certified: Rheumatology

Ying Du, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, West China University of Medical Sciences, 1986
Born 1964, Licensed 2004 ➤ **Active**
Certified: Rheumatology

Marc Mendelsohn, MD

3865 Connecticut St., 63116-4836
MD, Stony Brook Medical School, 2013
Born 1984, Licensed 2019 ➤ **Active**
Emergency Medicine

Rebecca D. Peck, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, Washington Univ., 1986
Born 1960, Licensed 1992 ➤ **Active**
Certified: Dermatology

Barry N. Rosenblum, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, Univ. of Missouri-Kansas City, 1980
Born 1956, Licensed 1984 ➤ **Active**
Certified: Otolaryngology

Nabeela Saeed, MD

3535 S. Jefferson Ave., Ste. 2, 63118-3930
MD, Khyber Medical College, Pakistan, 1989
Born 1964, Licensed 2004 ➤ **Active**
Internal Medicine

Maureen E. Stoffa, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, Jefferson Medical College, 1993
Born 1967, Licensed 1996 ➤ **Active**
Certified: Internal Medicine

L. Tyler Wadsworth, MD

3009 N. Ballas Rd., #B100, 63131-2322
MD, Univ. of North Carolina, 1986
Born 1960, Licensed 1993 ➤ **Active**
Certified: Sports Medicine

Dannie E. Williams, MD

5621 Delmar Blvd. #108, 63112-2660
MD, Univ. of Texas Medical Branch, 2008
Born 1979, Licensed 2013 ➤ **Active**
Surgery



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