Summary of Dr. Reeves’s presentation on behalf of MUSC-P

1. Tegrity recording of the session was not activated, ostensibly to preserve anonymity of speakers at the Town Hall, despite requests from some faculty who could not attend.

2. There is as yet no draft of a new non-compete. MUSC-P committee has only gathered information so far.

3. There is no rush to revise the non-compete; it will not necessarily be ready for July 1 contracts. There will be future Town halls as a draft is prepared.

4. Sending a letter to one’s patients indicating one’s practice is moving is an example of “solicitation”, not just “notification”. (Comment from the floor: this concept is contradictory to AMA Medical Ethics statement. Patients have a right to choose a physician; if they are not notified, they are deprived of that ability.)

5. Some academic institutions have non-compete contracts, but others in the SE (Vanderbilt, UAB, Mayo Jacksonville) do not. The term “industry standard” was used. Only universities with a non-compete were shown in the Power Point presentation. Radies were said to vary between 10 and 20 miles in most, and time limit is 1-2 yrs. Dr. Reeves noted in the Midwest and smaller communities, the radius can be larger; but there is great geographic variation. (Comment from the floor: the “damages”/buy-out is often lower than MUSC’s.)

6. Dr. Reeves pointed out the 15-25 mi radius used in prior non-competes (most recent was 5 mi for Primary care, and 15 mi for Specialty care) were based on excluding the major competing hospitals (Roper, E. Cooper) and extended to include Summerville.

7. A SC cardiologist’s non-compete was upheld one month ago in Columbia SC, potentially the first physician case-law. The details were not presented.

8. Dr. Reeves discussed losses attributed to “competition”. He cited the multimillion dollar production of the joint group that left MUSC, all consisting of individuals who were grand fathered out of the non-compete. (Comment from the floor: the dollar figure was the leaving group’s productivity, not the net loss in the group’s revenue, or the loss only related to competition, rather than simply “leaving”. This may not be an accurate number since many of the operated patients remained behind in the MUSC system and were being seen by remaining physicians—clearly retention of staff is paramount for growth and productivity. The question why long time faculty have all left so suddenly was asked but not answered.)

9. Dr. Reeves cited a “ripple effect” of faculty leaving to practice in the community, and that new recruits would be worried there are too many specialists in the community. Physicians with busy clinical practices generated patient volumes for other physician’s research projects.
10. Dr. Reeves conceded that marketing at MUSC was mostly the “MUSC brand” rather than marketing individual physicians, but MUSC-P feels this “brand” is carried with people when they leave.

11. The dollar value of “investment” and ongoing “reinvestment” in new faculty was claimed to be in the hundreds of thousands. (Comment from the floor: this number included major expenses like nursing and clinic support that are part of facility fee and overhead taxes, rather than investment in an individual.)

*It is not clear how item 8 above (which implies clinical faculty make money for MUSC that is potentially lost to competition), is consistent with this claim on cost of investment (which implies clinical faculty are an ongoing financial loss).

12. Dr. Reeves conceded that in special circumstances (illness and inability to leave town, real estate and spouse employment issues, limited competing practice), relief from the non-compete could be granted through the appeals process.

13. MUSC-P will compile similar questions and post answers as a FAQ-type resource on their site.

14. Other methods of retention of clinical faculty, as an alternative and/or complement to the non-compete, were not discussed.

Questions by Faculty at Town Hall:

1. Do you have data on the difference between what one loses when someone competes in town vs someone who leaves town? The productivity of the individual while at MUSC is not necessarily an accurate value of what would be gained by preventing “competition” (or even by preventing leaving, in fact, as other faculty often pick up the slack).

   Answer: data not readily available.

2. Doesn’t the AMA recommend that patients be allowed notification of a physician’s departure thus allowing continuity of care? How is this different from solicitation?

   Answer: no answer.

3. An orthopedic surgeon whose department was most affected by the orthopedics group that left to practice in-town, said that 1) loss claimed is not actual loss; most patients seen in the new group’s practice were new patients (rather than patients taken from MUSC); 2) keeping their old patients seemed to make no sense from either patient care or financial point of view because follow-up care pays little; and 3) as non-operating physicians they were not familiar with details of the surgical procedures. He said this impacted their ability to care for the patients optimally.

   Answer: they used MUSC’s “Brand” and the skills they honed at MUSC to acquire their new patients. It was acknowledged the number figure wasn’t actual loss, but that the actual loss was a large amount nonetheless.
4. Aren’t there many other institutions, and in fact other entire states, that do not allow non-competes for physicians, which were not shown in the table presented? Do we have an idea of how many have one and how many do not?

Answer: it was conceded some states do not allow non-competes, nor do other academic centers in the Southeast (e.g. Vanderbilt, UAB). It was claimed that UAB may be thinking of starting one. The data on who has and who does not have a non-compete is difficult to acquire.

5. Could MUSC-P damages related to initial investment be amortized over time, so that after a period of time they were negligible?

Answer: they could consider this.

6. Might the new non-compete also include those “grandfathered” previously? Was this “legal”?

Answer: it was acknowledged this was a possibility, but not decided. The point was raised that the new non-compete will be a retrospective arrangement counter to the standard concept of non-competes as prospective. In 2004, the non-compete did not include retrospectively physicians already in practice at MUSC. Nor have physicians who signed the 2004 non-compete been required to re-sign the non-compete each year. So, there is clearly precedent at MUSC for the new non-compete to be a prospective document but not retrospective. Dr. Reeves said that the new non-compete with limited radius was so much better than the old. Comment from the floor: other facets of the new non-compete including paying the MUSC legal bills are hugely problematic. Dr. Reeves said that he did not want to talk about problems with the new non-compete.

7. Can the language in the document be changed such that “every practice location” gets changed back to the “primary practice location” so that the effective radius does not become enormous, and so that faculty do not become de-incentivized to take on work in a satellite clinic?

Answer: yes, they would consider this, but Dr. Reeves thought that new non-compete was not every practice location.

8. How does “telemedicine” and “tele-radiology” play into this, if the latter includes reading radiology for an institution within the competing radius?

Answer: deferred, but approach is being considered.

9. Why is termination “for any reason” needed in the language, when someone who may be unhappy with their job due to a change in leadership, pay, or available resources, should be able to leave?

Answer: deferred, but they would consider changes to this section.

10. Can the “overlap of referral base” language be altered so that the effective radius is not enormous, as many specialists see patients and take referrals from physicians all over the state and outside the state? It was emphasized that one could not agree to signing this if in this situation.
Answer: they would consider this.

11. Is there a malpractice/liability issue of MUSC-P not being directly overseen by MUSC in these matters? The question of who faculty sign a contract with may be key; this is the first time we have been asked to sign a contract with MUSC-P.

Answer: directed to legal counsel, who deferred.

12. How is the matter of “termination” to be handled, when termination may effectively cause someone to be unable to perform their MUSC functions, and unable to fulfill their contract obligations? The issue was raised that the Chairman of a department can terminate an employee without recourse for the employee and over any issue that the Chairman raises-according to the new non-compete.

Answer: they are working through this process, otherwise deferred.

13. How will the final document be reviewed after it is drafted, and vetted by the University and the Faculty Senate? The point was raised directly that the Faculty Senate be included in the vetting process and that the Faculty Senate’s request to participate in the MUSC-P Ad Hoc Non-Compete Committee has been rejected several times.

Answer: not decided, deferred.

14. Can the appeals process include an independent panel, perhaps including someone from the Faculty Senate?

Answer: this was considered a possibility.

15. Can the appeals process be changed so that one does not have to be represented by one’s Chair, as a reason for leaving might involve the Chair?

Answer: yes, this is being considered.

16. Will the non-compete be required for part-time faculty?

Answer: not resolved at this time

17. Would it be possible for most people not to have a non-compete, and those with a significant investment/reinvestment would have amortized non-competes individually negotiated, with legal counsel, for an amount and time reasonable compared to the investment, as Cleveland Clinic seems to do?

Answer: it was felt this was too cumbersome.

18. Can’t the ripple effect of people leaving be seen when physicians don’t choose to compete within the radius? Aren’t physicians just as likely to ask why is everyone leaving?

Answer: it was felt it was not the same magnitude of effect compared to leaving to practice in-town.
19. Do we have data on how much revenue is lost by faculty choosing not to come here because of the non-compete clause?

   Answer: it was conceded that it is possible some recruits may decide not to come because of this, but specific data were not available.

20. Can some of this energy regarding preventing competition be redirected to increasing retention, and finding out why faculty are leaving and trying to correct that?

   Answer: it was agreed this was important, and that “exit interviews” through the Dean’s office was the mechanism.