A Bitter Pill to Swallow: The Negative Impact of Non-Compete Clauses in Physician Employment Contracts

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Abstract

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In today’s modern world of medicine, most, if not all, physician employment contracts contain non-compete clauses. Non-competes, also known as restrictive covenants, essentially function as restraints on trade. Non-competes act as a restraint in the medical arena by preventing physicians from taking patients with them when physicians begin new employment or, alternatively, depart on a self-employment basis. They also restrain physicians from competitively practicing medicine in a predetermined geographic area for a specified period of time.

Restraints on trade have a long noteworthy history. One case that emphasized the importance of having checks and balances on such restraints is *Lochner v. New York*. While not relating to the practice of medicine and non-compete provisions, *Lochner* is nonetheless an important case to the analysis of non-compete provisions in physician employment contracts. *Lochner* is necessary to the discussion of non-competes because it emphasizes how the history of restrictions on restraints on trade have changed so that now private parties, and not just the government, are allowed to implement restrictions. Additionally, these restrictions vary depending on the profession and where professionals practice.

Non-compete provisions are found in contracts created by both small private medical practices, as well as bigger entities, such as hospitals and managed care organizations. Therefore, this is not an issue limited to the size of the practice. The physician-patient relationship has gradually become more and more of an impersonal one
due to managed care organizations and legislation such as the Affordable Care Act (ACA). This does not, however, mean that physicians and patients approve of this interference and push towards an impersonal relationship. Thus, if patients are unhappy with the resulting impersonal relationship from managed care plans and legislation, patients may suffer further from these non-compete clauses interfering with the patients’ utilization of physician services.

These clauses hurt not only the physicians trying to practice, but also have the capacity to conflict with patient choice in regard to selecting the physician they want for treatment purposes. More importantly, such non-competes negatively interfere with the continuity of patient care. It is for these aforementioned reasons that it would behoove the American Medical Association (AMA) to model its non-compete guidelines after those found in the American Bar Association (ABA), which strictly limit the use of such non-compete provisions in attorney employment contracts.
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I. Introduction

When people think of the medical profession, scenarios from well-known medical dramas may come to mind. These mental images will most likely involve situations where critically ill patients are rushed to emergency rooms for mystery illnesses, pregnant women making it to the hospital in a nick of time to give birth, or even complicated, near-impossible surgeries for life-threatening conditions. It is very easy to overlook the mundane in such an exciting profession. One such area that is typically overlooked in the medical arena involves non-compete clauses, also known as restrictive covenants.

Non-compete clauses in the medical arena are typically found in physician employment contracts. These clauses require physicians “not to compete” with whomever has employed the physicians.¹ While not as exciting as the scenarios previously mentioned, non-competes in physician employment contracts, nonetheless, have a significant, and potentially negative, impact on physicians’ treatment of their patients, and on the patients themselves.²

This thesis argues that doctors, patients, and the doctor-patient relationship itself, would be better protected if the American Medical Association (AMA) modeled its non-compete guidelines after the American Bar Association’s (ABA) guidelines, which place significant restrictions on such clauses in attorney employment contracts. In order to support this argument, this thesis will discuss: the history behind the physician and patient relationship, what a non-compete clause entails, contract law and its affect on

such clauses, contract law’s prohibitory categories regarding non-compete clauses (and the lack of uniformity in following these prohibitions), the outside push towards an impersonal physician-patient relationship, the social and economic undercurrents that have impacted the evolution of medicine, the differences between non-compete clauses in the legal and medical professions, the significance of continuity of care, and the aforementioned negative impacts that both doctors and patients are ultimately faced with because of the existence of non-competes in physician employment contracts.

II. An Examination of the Relationship Between Physicians and Patients: Past and Present

The physician-patient relationship is an important one that, much like the contract-employment relationship, reaches far back in time. Aside from having a long-standing history, the relationship is one that is imperative for patients, especially those with serious conditions, “as they experience a heightened reliance on the physician’s competence, skills, and good will.” Additionally, the relationship between doctors and their patients “is remarkable for its centrality during life-altering and meaningful times in [people]’s lives, times of birth, death, severe illness, and healing.” The relationship is so personal that “an incompetent doctor is judged not merely to be a poor businessperson,

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4 Id.
5 Id.
but also morally blameworthy, as having not lived up to the expectations of patients and as having violated the trust that is an essential and moral feature of [the] relationship.”

In the article, “The Evolution of the Doctor-Patient Relationship,” R. Kaba and P. Sooriakumaran evaluate and discuss the history of this relationship and demonstrate that it was not always an intimate and personal one. The article traces the relationship throughout the following time periods: “Ancient Egypt (approximately 4000 to 1000 B.C.), Greek enlightenment (approximately 600 to 100 B.C.), Medieval Europe and the Inquisition (approximately 1200 to 1600 A.D.), The French Revolution (late 18th century), and [the] Doctor-patient relationship 1700-present.”

In Ancient Egypt, the doctor-patient relationship is believed to have “evolved from the priest-suppliant relationship.” Ancient Egypt had a physician-patient relationship that heavily relied on the doctor to act as a “parent-figure to manipulate events on behalf of the patient.” During this time period, physicians mostly treated “external and visible disorders such as fractures.” During the Greek enlightenment, a system known as the “empirico-rational approach” was developed. This means that the Greeks utilized techniques such as “naturalistic observation, enhanced by practical trial and error experience” altogether abandoning the previous methods of “magical and religious justifications of human bodily dysfunction.” Additionally, the Greeks were...

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6 Id. (“Trust is a fragile state. Deception or other, even minor, betrayals are given weight disproportional to their occurrence, probably because of the vulnerability of the trusting party.”).  
8 Id. at 58.  
9 Id. (“Healers were as much magicians and priests as they were doctors and magic was an integral part of care”).  
10 Id.  
11 Id.  
12 Id.  
13 Id.
one of the first to have a “democratic form of social organization.” This is important to note because through “establish[ing] equality among the electorate,” the physician-patient relationship, in turn, stepped away from the previously mentioned “parent-figure” relationship and became one in which, “guidance-cooperation and to a lesser degree mutual participation were the distinguishing factors of the . . . relationship.” Furthermore, the Greeks established what is known as the Hippocratic Oath, which is still utilized in the medical profession today. The Hippocratic Oath is important because it “provide[d] a higher degree of humanism in dealing with the needs, well-being, and interests of the people,” as well as, “rais[ing] medical ethics above the self-interests of class and status.”

During the time of Medieval Europe and the inquisition, there was “a weakening and regression of the doctor-patient relationship.” The relationship, unfortunately, seemed to fall back into the Ancient-Egypt belief of physicians having magical powers. Fortunately, this view was once again abandoned during the French Revolution. The French Revolution brought with it “Man’s search for liberalism, equality, dignity and empirical science . . .” It is believed that the “events that led to the French Revolution brought an end to an era in which the mentally ill and socially

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14 Id.
15 Id.
16 Id. (“The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for wrong. Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any seduction, of male or female, of bond free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart there from, which ought not be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets”).
17 Id.
18 Id. at 59.
19 Id. (“The magico-religious beliefs personified in the Old and New Testaments were revived and became widely accepted. The doctor, filled with magical powers, was in a glorious, high ranking position in society and his patients were regarded as helpless infants . . .”).
20 Id.
21 Id.
underprivileged were incarcerated in prisons.”  

Finally, when the 1700s rolled around, the relationship became one in which the physician, “found that it was less necessary to examine the patient but rather more important to be attentive to their needs and experiences manifest in the form of their symptoms.”  

It was during this time period that hospitals came into existence. The hospital is believed to “be a cornerstone of medical care.” This went hand in hand with the burgeoning “rapid growth in microbiological knowledge and surgical skills.” Because of these enhancements, medicine no longer focused solely on a patient’s symptom, instead it “[focused] on the accurate diagnosis of a pathological lesion inside the body.” Additionally, physicians believed it important to “follow the ‘criterion of beneficence’ as well as the principle ‘primum non nocere’ (not to hurt).” All of this resulted in physicians “acting in the best interests” of their patients. Later on, patients developed a more active role in the relationship, this was due to the emergence of psychology. There was a new emphasis on communicating with patients, and making patients more active in the relationship. It was this communicative development that ultimately led to what we have today, “the creation of patient-centered medicine.”

22 Id.
23 Id.
24 Id.
25 Id.
26 Id.
27 Id.
28 Id.
29 Id.
30 Id. (“The psychoanalytic and psychosocial theories proposed by Breuer and Freud (1955) in the late 19th century began to further constitute the patient as a person. This therapeutic model meant that, in terms of the doctor-patient relationship, it was of great importance to listen to the patient at great length.”).
31 Id.
32 Id.
III. Non-Compete Clauses

It is commonplace for employers in the medical field to institute non-compete clauses in physicians’ employment contracts. Non-competes generally prevent physician employees from: “(1) encouraging patients [to] follow the physician to his or her new place of employment—generally referred to as a ‘non-solicitation’ clause; and (2) practicing medicine for a set period of time within a certain distance of the prior employer’s location, or the location of clinics in which the physician worked.” In order for a non-compete to be deemed valid, it must be reasonable. A non-compete clause is considered to be reasonable, “only if it: (1) is no greater than is required for the protection of the employer, (2) does not impose undue hardship on the employee, and (3) is not injurious to the public.” Additionally, state courts will only enforce non-competes when certain criteria are met. These criteria include:

the employer [showing] that [they] ha[ve] a protectable business interest that would justify the restrictive covenant . . . the restriction at issue must be reasonably limited to the specific time period and geographical area necessary to protect the employer’s legitimate interest; and, finally, courts will only enforce

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34 Id. (Such clauses commonly also include, “the physician’s consent to the issuance of ‘immediate injunctive relief’ by a court in the event that physician breaches the noncompetition agreement. Most agreements also contain a ‘liquidated damages’ provision, which establishes a pre-set damages amount that the physician may be required to pay for breaching the noncompetition clause.”).
35 Joseph Parisi, Preparing for a Joint Venture (Part 2), Masuda Funai (Jan. 2010), available at http://www.masudafunai.com/showarticle.aspx?Show=5628 (It should be noted that non-compete clauses are not used exclusively in employment contracts. Another situation in which such clauses are utilized is joint ventures. When used in a joint venture, these clauses “restrict the joint venture partners’ right to manufacture or sell certain [] products during the life of the joint venture, and the non-competition restrictions will often apply for a period even after the joint venture agreement is terminated.”).
[such an] agreement to the extent that the employer can show it has a legally recognized, protectable business.\textsuperscript{38}

Some examples of protectable interests include, “confidential information, investment in specialized training provided to the employee, and customer or client relationships.”\textsuperscript{39} In context to the medical field, physicians are not found to have a protectable interest\textsuperscript{40} “in patient health information.”\textsuperscript{41} This, however, does not hold true to information that does not “relate directly back to the patient.”\textsuperscript{42} One example of an employer’s legitimate, and protectable, business interest is the specialized training that physicians receive while on the job.\textsuperscript{43}

Such a restraint may not be “unlimited in scope.”\textsuperscript{44} The restraint must be “within a reasonable geographic area.”\textsuperscript{45} A reasonable geographic area is determined by looking at both the “employer’s market and the size of the area serviced by the employee.”\textsuperscript{46} In regard to what constitutes reasonable, “[this] is typically determined on a case by case

\textsuperscript{39} Id.
\textsuperscript{40} US DEPARTMENT OF HEALTH AND HUMAN SERVICES, http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/medicalrecords.html (Under HIPPA, patients have complete access to their medical records. Thus, there is uncertainty as to how essential this clause is in today’s modern medical world since patients can easily take their medical records with them to any physician they choose to visit).
\textsuperscript{41} Horton, supra note 38, at 5 (“This class of information . . . is typically treated as belonging to the patient, and not to the doctor or medical practice providing treatment.”).
\textsuperscript{42} Id. at 6 (“If a physician is employed in an administrative or executive capacity and has responsibility for business operations in addition to, or in lieu of, patient care, the employer may be able to establish that certain information developed solely for business use is confidential and proprietary. Consequently, to protect such information, the employer may be able to restrain the physician from working in an executive or administrative capacity for a competing practice, even where a restraint on direct patient care would be impermissible.”).
\textsuperscript{43} Id. at 4.
\textsuperscript{44} Id. at 8.
\textsuperscript{45} Id.
\textsuperscript{46} Id. (“Other relevant factors include the number of [patients] existing within a specific region, the presence of other competitors within that region, and the scope of the employer’s efforts to market itself within a specific region.”).
basis, and therefore there can be substantial variation even within one state as to what restrictions are considered reasonable." Courts will determine what constitutes a reasonable territorial limitation by analyzing certain factors. These factors include: "(1) radius restrictions . . . in which the employer’s place of business is treated as a compass point and the employee is restricted from competing within a certain number of miles from that point; (2) zip code areas (typically zip codes within which a certain minimum number of the employer’s customers originate); and (3) municipal boundaries such as cities or counties."

For example, in Zellner v. Stephen D. Conrad, M.D., P.C., an ophthalmologist brought suit against his employer claiming the non-compete agreement in his employment contract was void due to what Zellner believed was unduly restrictive. The court ultimately found that the non-compete agreement in Zellner’s employment agreement was valid. The court held that:

while restrictive covenants tend[,] to prevent a person from pursuing his or her vocation after termination . . . [and are] disfavored by the law, they will generally be enforced against medical and dental professionals if such covenants are reasonably limited temporally and geographically and . . . serve the acceptable purpose of protecting the former employer or associate from unfair competition.

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47 *Id.*
48 *Id.* at 9.
49 *Id.*
50 Zellner v. Stephen D. Conrad, M.D., P.C., 183 A.D.2d 250, 251-53 (1992) (Zellner’s non-compete clause prevented him from practicing within a two-mile radius from his previous place of employment for a period of two years. “In his complaint, the plaintiff alleged, *inter alia*, wrongful and oppressive conduct by Conrad and that he expected the defendant to seek injunctive relief prohibiting the plaintiff from practicing ophthalmology or ophthalmic surgery. The plaintiff also alleged that the liquidated damages provision gave the defendant an adequate remedy at law. He sought a judgment declaring that the restrictive covenant limiting his ability to practice medicine was unenforceable”).
51 *Id.* at 253 (Zellner argued “that because his employment already had begun by the time he was presented with the agreement, the defendant was obliged to present him with some additional consideration in exchange for his promise not to compete after termination of their relationship.”).
52 *Id.* at 254.
We find . . . under the facts of this case, the covenant at issue has met these requirements. Thus, the geographic scope of Zellner’s non-compete provision was found to be appropriately restrictive and, therefore, was upheld.

The holding in *Zellner* is completely different from that of *Fox Valley Thoracic Surgical Associates, S.C. v. Ferrante*.

In *Fox Valley*, a heart surgeon, Dr. Ferrante, brought suit against his employer, arguing that the non-compete agreement in his employment contract was void because he believed the geographic restriction to be unreasonable.

The contract contained a non-compete that stated,

> At no time during the term of Employee’s employment with employer, or for one (1) year immediately following the termination of such employment . . . will Employee . . . engage in the practice of heart surgery or thoracic medicine, within the city limits of Appleton, Neenah or Manasha, Wisconsin, nor within the radius of thirty miles of the city limits of the Cities of Appleton, Neenah or Manasha, Wisconsin.

When comparing the facts of this case to those of *Zellner*, the differences between the non-compete clauses are overtly apparent. In *Zellner*, the geographic scope of the non-compete was a two-mile radius from his previous place of employment, whereas the one

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54 *Id.* at 5 (The court explains that, “there are two types of analyses for examining whether agreements violate antitrust laws. The first analysis applies the ‘per se’ rule, which employs a presumption that an agreement is an antitrust violation . . . The alternative to the to the ‘per se’ rule is the ‘rule of reason’ analysis, which requires the factfinder to decide whether, under all circumstances, the restrictive agreement imposes an unreasonable restraint on competition. An analysis of a restraint’s reasonableness includes an examination of the purpose of the restraint, market power, and the anticompetitive effect of the restraint. A restraint must have a significant impact on competition in the marketplace to be found unreasonable. In cases where rule of reason analysis applies, circumstantial evidence of a conspiracy in restraint of trade must be strong in order to survive summary judgment . . . Here . . . the ‘rule of reason’ analysis, rather than the ‘per se,’ analysis, applied.”).
55 *Id.* at 1-2.
57 *Fox*, *supra* note 53 at 1-2.
58 *Zellner*, *supra* note 50 at 251.
in *Fox* was broadly restricting Ferrante’s practice of medicine, as seen in the contract’s clause banning Ferrante from practicing in any of the cities noted in the employment contract.\(^{59}\)

The employers in *Fox* argued that the geographic restrictions were reasonable “in light of information regarding the zip codes of patients it has served.”\(^{60}\) The court ultimately disagreed with this presumption of reasonableness, stating that, “the patients’ addresses themselves, do not demonstrate the geographic area in which Heart Surgeons competes for referrals.”\(^{61}\) Additionally, the court found that “Heart Surgeons’ referrals came from a single source, Cardiology Associates,” and as such, Heart Surgeons’ were unable to “proffer[] evidence demonstrating how its geographic restriction is necessary to keep Ferrante from unfairly competing for those referrals.”\(^{62}\) Therefore, the non-compete was held to be void due to unreasonable geographic restrictions.

Aside from needing to meet the aforementioned requisite elements to have a valid non-compete clause, these covenants not to compete are also required to terminate within a reasonable amount of time.\(^{63}\) Courts will strike down any non-compete agreement it finds to be unreasonable in duration.\(^{64}\) Some factors that courts will take into consideration in determining whether such a non-compete is reasonable in time are:

1) the time needed for the employer to hire and train a replacement employee; 2) the time it will take so customers no longer associate the former employee with the employer’s business; 3) the time necessary to prove to the employer’s customers that it can continue to meet their needs in the absence of the former

\(^{59}\) *Fox*, *supra* note 53 at 1-2.

\(^{60}\) *Dreps*, *supra* note 26.

\(^{61}\) *Id.*

\(^{62}\) *Id.*

\(^{63}\) *Horton*, *supra* note 38, at 9 (“Most non-compete agreements prohibit competition during the employment relationship and for a period of months or years afterward.”).

\(^{64}\) *Id.*
employee; or 4) the time necessary for any confidential information in the employee’s possession to become obsolete.\textsuperscript{65}

When a non-compete is found by a court to be too broad in scope, a court may either alter the provision, or void the provision completely.\textsuperscript{66} This is known as the “blue pencil rule.”\textsuperscript{67}

Each individual state, “differ[s] on the appropriateness of blue penciling an over-broad covenant.”\textsuperscript{68} Thus, while this concept seems straightforward, in actuality, it may be employed in one of two ways.\textsuperscript{69} First, “in strict blue pencil states,” instead of “supplying missing terms or otherwise reformulat[ing] an overly broad provision,” courts mandate that “the provision deemed unlawful must be severable from the remainder of the agreement, and an enforceable restriction must remain after the offending provision is stricken.”\textsuperscript{70} A second way this blue pencil rule may be applied is through a “rule of reason standard.”\textsuperscript{71} When a court utilizes the rule of reason standard, “a court will effectively rewrite the offending provision(s) and enforce the agreement as modified.”\textsuperscript{72}

\textsuperscript{65} Id. at 9-10
\textsuperscript{66} Id. at 10.
\textsuperscript{67} Id. at 11 (“A judge may decide that a non-compete agreement is too broad as written, but instead of rejecting the provision entirely, he or she will cross out the unreasonable sections with a hypothetical ‘blue pencil’ and will enforce the provisions that remain.”).
\textsuperscript{68} Henry Perritt Jr., EMPLOYMENT LAW UPDATE 3-29 (2014 Ed.) available at https://books.google.com/books?id=qhL0AgAAQBAJ&pg=SA3-PA29&lpg=SA3-PA29&dq=Henry+Perritt+Jr+EMPLOYMENT+LAW+UPDATE+3-29+appropriateness+of+blue+penciling+an+over-broad+covenant.&source=bl&ots=rhF59ivPJA&sig=1uXbhFgP744jq1T7jG0KHKq9KJ8&hl=en&sa=X&ei=gmctVaDXLIq_SQs3ICQA&ved=0CCAQ6AEwAA#v=onepage&q=Henry%20Perritt%20Jr%20EMPLOYMENT%20LAW%20UPDATE%203-29%20appropriateness%20of%20blue%20penciling%20an%20over-broad+covenant.&f=false.
\textsuperscript{69} Horton, supra note 38, at 11.
\textsuperscript{70} Id.
\textsuperscript{71} Id.
\textsuperscript{72} Id.
There are, however, opponents of this blue pencil doctrine. These opponents argue the doctrine “violates two (2) basic principles of contract law.” The first argument against the blue pencil doctrine is that, “courts [are ultimately] intrud[ing] into what should be negotiated agreements between the [contracting] parties by substituting the courts’ own contract terms for those found in agreements.” The second argument against the blue pencil doctrine is that, “other courts have altered noncompete agreements by striking ‘unreasonable’ clauses and leaving the rest of the agreement as written.” In regard to both of these arguments, opponents believe that, “[they] essentially turn courts into attorneys after the fact,” which is not the courts’ intended purpose. These opponents state there is a need for more specificity and propose, “the [contractual] agreement pass a three-part specificity test before [a] court [be allowed to] further evaluate the contract’s enforceability.”

While opponents of the blue pencil doctrine argue that the doctrine violates contract law, non-compete agreements, perhaps ironically, are required to follow “the general principles of contract law” themselves. Some of the principles from contract law applicable to these agreements include: “(1) written agreements in the case of non-
compete clauses that typically exceed one year\textsuperscript{81} . . . should be in writing as required by applicable statutes of frauds; and (2) adequate consideration\textsuperscript{82} underlying the agreement.\textsuperscript{83} Despite these seemingly straightforward principles, issues are known to arise in regard to adequate consideration.

When the covenant not to compete is already in existence in an employment contract, “most courts hold that the employer’s promise of employment constitutes sufficient consideration to support the covenant not to compete.”\textsuperscript{84} There are, however, instances in which a covenant not to compete is pushed upon the employee after an employment contract is already agreed upon between the employer and employee.\textsuperscript{85} In this scenario, “many courts will enforce [the covenant] only if new consideration [is] given to the employee.”\textsuperscript{86} Some examples of new consideration include, but are not limited to, “an increase in compensation, a new (usually higher) position, a bonus or stock incentive program, or an extended fixed term of employment.”\textsuperscript{87} Courts do not consider a continuation of employment to be adequate consideration for enforcement of a covenant not to compete.\textsuperscript{88}

\textsuperscript{81} Id. at 10 (While non-competes that last for one year or longer are typically required to be in writing, this requirement varies from state to state.).
\textsuperscript{82} CRC-Evans Pipeline Int’l v. Myers, 927 S.W.2d 259, 263 (July 1996) (“An ‘otherwise enforceable agreement’ can emanate from at-will employment, but only so long as the consideration for a promise is not dependent on a period of continued employment. A promise dependent on a period of continued employment would be illusory because it fails to bind the promisor, who always retains the option of discontinuing employment in lieu of performance.”).
\textsuperscript{83} Horton, supra note 38, at 16. (“If a non-compete restriction is included as a provision in an employment contract, then in most cases, the initial offer of employment itself will be deemed adequate consideration,” however, “an agreement that is not executed until after employment has already begun might only be enforced if the employer provides additional compensation or benefits at the time of execution, or extends employment for a definite time.”).
\textsuperscript{84} John Dwight Ingram, Covenants Not to Compete, 36 AKRON L. REV. 49, 54 (2002).
\textsuperscript{85} Id.
\textsuperscript{86} Id.
\textsuperscript{87} Id.
\textsuperscript{88} Id. at 55.
IV. Contract Law, Trade Secrets & Non-Compete Clauses

Contract law and non-compete clauses are intertwined due to the fact that non-competes rely on principles of contract law.89 This history of the employment-contractual relationship dates far back in time, however, with a very different view on non-compete provisions.90 During the sixteenth century, “courts favored robust competition and regarded with hostility contractual restrictions on the ability to practice a trade.”91 Over time, this changed due to the “devising [of] new rules to govern ownership of ideas and skill.”92 In doing so, “judges, treatise-writers, and lawyers perceived the issue as one of economic policy and used the law to achieve certain economic goals.”93

Many believe that by enforcing contracts containing non-competes, “a new species of ‘intellectual property’ was created at the expense of older notions of artisanal independence.”94 By the early nineteenth century, courts and firms alike were assessing “firm ownership of workplace knowledge as much in ethical as in economic terms.”95 During this time period both the “changing assumptions about the duties of master and servant . . . [as well as] the expansion of scientific and technological research at

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90 Fisk, supra note 118 at 442.
91 Id. (“In sixteenth century England, this hostility stemmed from concern about the economic and political power of the guilds and the cities’ control of trades that effectively restricted the availability of products. In America, without the tradition of the guild and city control of trade, adherence to the English precedents’ hostility toward restrictions was a logical response to the endemic shortages of skilled labor and technological know-how.”).
92 Id. at 445.
93 Id.
94 Id. at 445-46 (“Here, a major part of the legal change was a gradual shift to recognizing knowledge, especially inchoate knowledge, as a form of property, and then recognizing that property as belonging to someone other than the employee who possessed it.”).
95 Id. at 446.
universities and the first corporate efforts to systemize . . . the development of new technology through research . . . made their mark on the law.”

While there is a past history of intolerance towards non-competes, it appears that both economic and intellectual growth have permanently changed the way in which we deal with such non-compete provisions. That is, non-competes are now likely to be tolerated in the work place. It may, however, come as a surprise to learn that despite having a working definition of trade-secret, as well as a modern tolerance for non-compete clauses, courts still struggle in their decision-making pertaining to when employers may place work restrictions on their employees.

Society’s perspective on non-competes changed from prohibiting such clauses to embracing their use and tolerating restrictions on competition. Another change that occurred was non-competes coming into existence via private contractual agreements, and not solely through governmental exertions. In the article, “Why Doctor’s Shouldn’t Practice Law: The American Medical Association’s Misdiagnosis of Physician Non-Compete Clauses,” Robert Steinbuch discusses, among other things, how contract law plays an important role in non-compete agreements. In order to accomplish this, Steinbuch discusses the importance of the history of the law of restraints on trade with the case *Lochner v. New York*. *Lochner* focused on the Bakeshop Act of 1897 and

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96 *Id.* at 446-47.
97 *Id.*
98 *Id.*
99 *Id.* at 535 (“[T]he definition of a trade secret has always been too slippery to give the courts much clarity in analysis or intellectual cover for the value judgments they have made in deciding when an employer can lawfully restrict an employee’s future freedom to work.”).
100 Steinbuch, supra note 37, at 1051.
101 *Id.*
102 *Id.*
103 *Id.*
how Lochner, an employer, allowed his employee to work over the sixty-hour a week mandate.\textsuperscript{105} Found guilty of violating the act, Lochner appealed, arguing that the Bakeshop Act of 1897 violated his freedom to contract, provided to him through the Due Process Clause of the 14\textsuperscript{th} Amendment.\textsuperscript{106}

The Court ultimately held that in order to determine whether a violation had occurred, it must look at whether, “[this is] a reasonable and appropriate exercise of the police power of the state, or [whether it is] an unreasonable, unnecessary, and arbitrary interference with the right of the individual to his personal liberty, or to enter into those contracts in relation to labor which may seem to him appropriate or necessary for the support of himself and his family.”\textsuperscript{107} Citing \textit{Allgeyer v. Louisiana}, the court went on to state, “the general right to make a contract in relation to [a] business is part of the liberty of the individual protected by the 14\textsuperscript{th} Amendment of the Federal Constitution.”\textsuperscript{108} The court went on to explain that, “we think the limit of the police power has been reached and passed in this case. . . . If this statute be valid . . . there would seem to be no length to

\textsuperscript{104} \textsc{Encyclopedia} Britannica, http://www.britannica.com/EBchecked/topic/345714 /Lochner-v-New-York#ref1182114 (“Modeled on the British Blakehouse Regulation Act (1863), the law established minimum sanitation standards, including prohibitions against keeping domestic animals in bakeries and against workers sleeping in the bake room. A key provision was a clause limiting hours of biscuit, cake and bread workers to 10 hours per day and 60 hours per week.”).

\textsuperscript{105} \textit{Lochner v. New York}, 198 U.S. 45, 52-53 (1905) (The indictment, it will be seen, charges that the plaintiff in error violated the 110\textsuperscript{th} section of article 8, chapter 415, of the laws of 1897, known as the labor law of the state of New York, in that he wrongfully and unlawfully required and permitted an employee working for him to work more than sixty hours in one week.”).

\textsuperscript{106} \textit{People v. Lochner}, 15 Bedell 145, 177 N.Y. 145, 69 N.E. 373, 147 (Jan. 1904) (“Defendant urges as ground for a reversal that article 8 . . . offends against the first section of the 14\textsuperscript{th} Amendment of the Constitution. That section provides that ‘no state shall make or enforce any law which shall abridge the privileges and immunities of citizens of the United States; nor shall any state deprive any person of life, liberty or property, without due process of law, nor deny any person within its jurisdiction the equal protection of the laws.’ It is also claimed that the statute violates the provisions of the state Constitution which declare that ‘no member of this state shall be disenfranchised, or deprived of any of the rights or privileges secured to any citizen thereof, unless by the law of the land, or the judgment of his peers (Const. art. 1 § 1), nor be deprived of life, liberty or property without due process of law (Const. art. 1 § 6).”)

\textsuperscript{107} Lochner, \textit{supra} note 105, at 56.

\textsuperscript{108} \textit{Id.} at 53.
which legislation of this nature might not go.”

Additionally, the court held that, “there must be more than the mere fact of the possible existence of some small amount of unhealthiness to warrant legislative interference with liberty.” While *Lochner* was later partly overruled by *Ferguson v. Skrupa*, there was still an exception to this police power principle while it was considered to be good law.

The reason it is important to mention *Lochner*, despite the fact that this thesis is examining private party contractual agreements, is because after the case was decided, the legal system expanded its acceptance of restraints. This is seen in the utilization of such practices between private parties, rather than solely through governmental entities. *Lochner* had limited how much the government was allowed to place restrictions on a person’s trade. These contractual agreements between private parties containing non-competes, while having to pass certain tests to test reasonableness (which will be discussed later), do not all have the same limitations. Rather, the reasonableness of such restrictions also depends upon different criteria such as the person’s profession.

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109 Id. at 58.
110 Id. at 59.
111 Id. at 57 (*Lochner* emphasized the importance of the notion that non-compete clauses must be reasonably related to the restrictions the clauses are enforcing. “The question of whether the act is valid as a labor law, pure and simple, may be dismissed in a few words. There is no reasonable ground for interfering with the liberty of person or the right of free contract, by determining the hours of labor, in the occupation of a baker. There is no contention that bakers as a class are not equal in intelligence and capacity to men in other trades or manual occupations, or that they are not able to assert their rights and care for themselves without the protecting arm of the State, interfering with their independence of judgment and of action. They are in no sense wards of the State . . . we think that the law before us involves neither the safety, the morals nor the welfare of the public, and that the interest of the public is not in the slightest degree affected by such an act.”).
113 Steinbuch, *supra* note 37, at 1052.
114 Id. at 1053.
115 Id. (The legal system, post-*Lochner*, was “more accepting of limitations on private contracts- somewhat paradoxically [the legal system] accepted the notion [that] in certain circumstances private parties may elect to employ restraints of trade.”).
116 Id.
and where the professional works. Society transformed from one in which restraints on trade were forbidden. Society, however, has evolved over time, as has its gradual acceptance of these restraints. While the notion of open and blatantly broad non-compete clauses is not tolerated, the aforementioned issues pertaining to their reasonableness and private parties utilizing such restraints on trade only emphasizes how in-depth of an analysis may be needed determine whether such clauses are valid and the likelihood of inconsistent rulings.

Today, questions pertaining to acceptance of the law of restraints on trade can be answered by referring to the Second Restatement of Contracts. Steinbuch explains that restraints on trade will be prohibited when such a restraint falls in one of two categories. The first prohibitory category is “[when] the restraint is greater than is needed to protect the promisee’s legitimate interest.” The second prohibitory category is “[when] the promisee’s need is outweighed by the hardship to the promisor and the

which have been used uniformly to prevent the enforcement of non-compete provisions for attorneys, physicians have not been so fortunate.”).

118 Maureen Gorman, A GLOBAL GUIDE TO ‘RESTRICTIVE COVENANTS’: USA, Mayer Brown LLP., available at http://www.mayerbrown.com/files/uploads/Documents%5CGuide%20to%20Restrictive%20Covenants /MB_restrictive_covenants_americas_apr14.pdf (“In looking at restrictive covenants in the United States, one generally has to look at how most of the 50 states treat restrictive covenants, and then how a minority of states, led by California, treat them . . . California is a good example of the minority view. It generally prohibits all manner of restrictions on one’s ability to carry on a business or vocation (Cal. Bus. & Prof.Code § 16600), so covenants not to compete are largely unenforceable in California . . . Most jurisdictions will view a covenant not to solicit customers/clients as what it is in practical effect: a covenant not to compete. Therefore, in those jurisdictions, courts will apply the same reasonableness analysis to these types of covenants as they would to a covenant not to compete. In a minority of jurisdictions, like California, courts will likewise disregard the fact that something is labeled a covenant not to solicit customers and clients and will readily deem it a covenant not to compete and treat it as such.”).


120 Id.

121 Steinbuch, supra note 37, at 1052.

122 Id.

123 Id.
likely injury to the public.”\textsuperscript{124} Additionally, restraints on trade are allowed “only when part of a broader enforceable contract.”\textsuperscript{125} The three scenarios in which restraints on trade are considered to be a part of a broader enforceable contract include: “(1) a promise by the seller of a business not to compete with the buyer in such a way as to injure the value of the business sold; (2) a promise by an employee or other agent not to compete with his employer or other principal; or (3) a promise by a partner not to compete with the partnership.”\textsuperscript{126} Thus, physician non-compete agreements in employment contracts fall under this second category. But how does one appropriately determine whether such a non-compete clause falls under the aforementioned two categories, which prohibit restraints on trade?

V. The Prohibitory Categories & Lack of Uniformity

Courts have demonstrated a lack of uniformity\textsuperscript{127} in upholding and voiding non-compete agreements in regard to the two aforementioned prohibitory categories (ie. “the restraint is greater than is needed to protect the promisee’s legitimate interest,” and, “the promisee’s need is outweighed by the hardship to the promisor and the likely injury to the public”).\textsuperscript{128} In \textit{Karlin v. Weinberg}, a dermatologist, Dr. Karlin, employed one Dr. Weinberg in his dermatology practice.\textsuperscript{129} In the employment agreement, there was a non-

\textsuperscript{124} Id.
\textsuperscript{125} Id. at 1054 (“If a restraint is not ancillary to some transaction or relationship that gives rise to an interest worthy of protection, the promise is necessarily unreasonable”).
\textsuperscript{126} Id.
\textsuperscript{128} Steinbuch, \textit{supra} note 37, at 1053.
\textsuperscript{129} Karlin v. Weinberg, 77 N.J. 408, 412 (1978).
compete agreement, which required Dr. Weinberg not to compete “in the practice of
dermatology within radius of 10 miles of Dr. Karlin’s office for five years after the
termination of [his] employment.”\textsuperscript{130} Before the contract terminated, the physicians
formed a partnership, however, there were never any formal documents established that
recognized this relationship; the only evidence of this partnership that existed was both
physicians stating they both held themselves out to be partners.\textsuperscript{131} The dispute that arose
between Dr. Karlin and Dr. Weinburg was whether there was a valid restraint against Dr.
Weinburg practicing after the work relationship terminated.\textsuperscript{132}

The court in \textit{Karlin} held that such a non-compete agreement is valid when it
meets the requisite reasonableness.\textsuperscript{133} This reasonableness is determined by evaluating:
(1) if [the non-compete] protects the legitimate interests of the employer, (2) imposes no
undue hardship on the employee, and (3) is not injurious to the public.\textsuperscript{134} In \textit{Karlin}, the
Court upheld the non-compete agreement, reasoning that:

(1) the restrictive covenant is necessary to preserve such ongoing relationships
with [Dr. Karlin’s] patients, (2) as an employee, Dr. Weinberg, while performing
services within the prohibited area after his employment terminated, had unjustly
utilized the relationships he developed with patients while employed by Dr.
Karlin, and (3) should [the Court] fail to enforce reasonable restrictive covenants,
established physicians may be fearful of employing younger physicians and

\textsuperscript{131} Karlin, \textit{supra} note 128, at 412-13.
\textsuperscript{132} \textit{Id.} at 413 (“Plaintiff continued to conduct his practice at the previous address . . . and defendant opened his new medical office just a few doors away . . . ”).
\textsuperscript{133} Schaff, \textit{supra} note 129, at 2.
established physicians may be hesitant of forming partnerships with other physicians, thereby harming the public.\textsuperscript{135}

Additionally, the Court in \textit{Karlin} held that the legitimate interests of Dr. Karlin consisted of things such as confidential business information and patient lists, no undue hardship would be implemented on Dr. Weinberg as he did not have to “uproot his family to practice medicine.”\textsuperscript{136} Finally, the Court felt that no harm would come to the public as “there are other physicians who practice in the restricted area.”\textsuperscript{137}

One can, however, easily make counter-arguments to the points the court laid out in its holding. In regard to the court’s first argument for upholding the non-compete agreement, one may counter argue that the need to preserve the relationship between Dr. Weinburg and his patients is greater than that of “protecting” Dr. Karlin. While working in Dr. Karlin’s practice, it is safe to assume Dr. Weinburg built up his own patient base, and that patients came to see Dr. Weinburg exclusively. By pushing Dr. Weinburg further out of the geographical area his patients previously traveled to obtain his services, Dr. Karlin was able to absorb those patients into his long-standing, and dominant, practice. In doing so, Dr. Karlin potentially prevented such patients from seeking Dr. Weinburg’s services due to distance they would now need to travel to see Dr. Weinburg.

In regard to the second prong, one may counter argue that Dr. Weinburg did not unjustly utilize the relationships he developed with patients from Dr. Karlin’s practice because those patients wanted to see him rather than Dr. Karlin. Dr. Weinburg did not force those patients from his previous place of employment to follow him to his new

\textsuperscript{135} Schaff, \textit{supra} note 129, at 2.
\textsuperscript{136} \textit{Id.} at 3.
\textsuperscript{137} \textit{Id.}
practice. Those patients clearly demonstrated free-will in choosing which physician they preferred to see for their health issues, and followed that physician to his new facility. Additionally, the total number of new patients Dr. Weinburg obtained in his new practice was greater than that of the patients that followed Dr. Weinburg to his new practice. It does not seem ethical or legally responsible to allow one physician to force another one out of the area when patients (both old and new) are clearly choosing, of their own volition, one physician over the other.

Finally, in regard to the court’s third reason for upholding the non-compete agreement, the counterargument is that physicians are not all created equally. There are physicians that patients view as being ‘good’, and others that are deemed to be ‘bad’. Thus, physicians are not as easily interchangeable as the court believes them to

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138 Karlin, supra note 128, at 413 (“The record contains an affidavit of Dr. Weinburg, dated March 6, 1976, in which he avers that from February 2, 1976, when he began to practice on his own, to the time of the affidavit he had treated approximately 130 patients, 60 of whom he had previously seen during his association with Dr. Karlin. Of the remaining 70 patients, 55 came to Dr. Weinburg in response to a newspaper advertisement announcing the opening of his new offices, and the other 15 were referred by other physicians”).

139 Id.

140 Angela Coulter, Patient’s Views of the Good Doctor: Doctors Have to Earn Patients’ Trust, 325 BMJ 668, 669 (Sep. 28, 2002), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1124204/ (“[D]octors’ lack of inclination or time, or both, means that patients’ desire for information, education, and empowerment is inadequately provided for in modern medical practice. Patients want to trust their doctors, but trust has to be earned by treating people as grown ups, answering their questions clearly and honestly, listening to their views, and involving them in decisions. This cannot be an optional extra. Failure to accommodate patients’ needs for involvement will diminish doctors’ standing in the long run.”).

141 Calvin Fones et al., What Makes a Good Doctor: Defining the Ideal End-product of Medical Education, 73 ACADEMIC MEDICINE (May 1998) (The National University of Singapore performed a study in which they evaluated the characteristics of what people associated with a good physician. “The traits were qualitatively categorized in four domains: (1) cognitive (knowledge, skill, intelligence and decision making), (2) conative (drive and motivation), (3) emotional and interpersonal (sensitivity, consideration, personality, teamwork, stability, and communication skills), and (4) moral-ethical (confidentiality, trustworthiness, and honesty . . . A 25-item questionnaire was designed, using the most common and consistently cited characteristics in the literature, and administered to a sample of doctors and patients . . . The findings show that the patients and doctors generally agreed as to the important characteristics of a good doctor. Both groups agreed on the prime importance of knowledge and cognitive factors. Moral-ethical items were also highly valued, but the physicians were especially concerned with these issues. The patients rated interpersonal and emotional domains as more important than the doctors did.”).
be. Patients are comfortable with the physicians they build a relationship with. To suddenly have that physician disappear and have to proverbially jump through hoops to contact that physician detrimentally impacts that relationship. It leaves the burden on the patient to hunt down that physician and either travel to their new place of employment, or, if that is not a possibility, start the search for a new physician and begin the whole dance all over again (and always being exposed to the same thing happening again).

A seminal case in which the Supreme Court of Tennessee voided a non-compete agreement in a physician employment contract is *Murfreesboro Medical Clinic, P.A. v. Udom.* In *Murfreesboro,* the Murfreesboro Medical Clinic (MMC) offered Dr. David Udom employment in their private medical facility. The agreement between MMC and Dr. Udom included a non-compete provision, which stated:

> Upon any termination of this Agreement . . . the Employee agrees not to engage in the practice of medicine within a twenty-five (25) mile radius of the public square of Murfreesboro, Tennessee for a period of eighteen (18) months following such termination.

In addition to this non-compete provision, the employment contract between MMC and Dr. Udom also included a buy-out provision. The buy-out provided that the

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142 Brian Hurwitz, *What’s a Good Doctor, and How Can You Make One?*, 325 BMJ 667, 668 (Sept. 2002) (“When it comes to doctoring, the term ‘good’ increasingly functions as a descriptive label that denotes having met certain tests of competency. A poor doctor is generally credited with good intentions but inadequate knowledge or skills required for the job . . . a bad doctor, however skilled, is one with bad intentions, undesirable values, suspect-occasionally evil-motives.”).

143 Michael D. Cabana et al., *Does Continuity of Care Improve Patient Outcomes?*, 53 J. OF FAMILY PRACTICE 974, 978-79 (Dec. 2004) (“Based on our study criteria, our analysis suggests an association between SCOC and patient satisfaction, as well as improved process of care and patient outcomes.”).


145 Id. at 676.

146 Id.

147 Id. at 677.
aforementioned non-compete agreement “would be ‘upon the payment by the Employee to the Corporation for any moving expenses paid to, or on behalf of, the Employee.’”

Dr. Udom agreed to the terms of the employment contract and worked for MMC from September 1, 2000 until August 2002. When Dr. Udom’s employment contract with MMC was about to expire, MMC informed Dr. Udom that it would not be renewing his contract and that MMC would enforce the non-compete agreement. When Dr. Udom spoke with MMC’s President and Chairman of the board about becoming a hospitalist at Middle Tennessee Medical Center (MTMC), he was told that would be a breach of the non-compete agreement, despite the fact that Dr. Udom would not be in direct competition with MMC. Dr. Udom informed MMC through letter that he was going to open a medical office in Smyrna, Tennessee and that he would not utilize the buy-out provision in his employment contract.

In February of 2003, Dr. Udom went against the judgment issued by the chancery court and opened a practice in Smyrna, Tennessee. On appeal, Dr. Udom argued that: “(1) the trial court erred in granting MMC the temporary injunction and (2) that the covenant not to compete [was] unenforceable because it [was] unreasonable in the

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148 *Id.*
149 *Id.*
150 *Id.*
151 *Id.* (“Dr. Udom was also told during this meeting that he could not accept a position at the Alvin C. York Veterans Administration Medical Center in Murfreesboro despite the fact that this facility did not directly compete for patients with MMC. In addition, Dr. Udom was informed that the non-compete provision would require him to relinquish his admitting privileges at MTMC.”).
152 *Id.* at 677-78 (“MMC filed a complaint against Dr. Udom seeking to enjoin him from violating the non-compete provision of his employment agreement. Following a hearing in the chancery court . . . MMC was granted a temporary injunction enjoining Dr. Udom from establishing a medical practice in Smyrna, Tennessee, or engaging in the practice of medicine at MTMC in Murfreesboro, Tennessee.”).
153 *Id.* (Dr. Udom’s new office was 15 miles from the public square in Murfreesboro, Tennessee.).
circumstance, does not secure a profitable interest, is overbroad, and is against public policy.”

Dr. Udom appealed after the Court of Appeals holding.

In its analysis of non-compete provisions, the Supreme Court of Tennessee discussed how such provisions are generally disfavored in the state of Tennessee and are generally viewed in favor of the employee, rather than the employer. The court did stipulate that, should there be a “legitimate business interest to be protected and the time and territorial limitations are reasonable then the non-compete agreements are enforceable.” Factors that would be considered by the court to determine whether or not to uphold the non-compete included: “(1) the consideration supporting the covenant; (2) the threatened danger to the employer in the absence of the covenant; (3) the economic hardship imposed on the employee by the covenant; and (4) whether the covenant is inimical to the public interest.”

The court in Murfreesboro went on to cite Spiegal v. Thomas, Mann & Smith, stating that, “covenants not to compete that implicate important public policy issues are even more strictly construed.” Additionally, the court in Spiegal found that, “because

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154 Id.
155 Id. (“The Court of Appeals reversed the grant of the temporary injunction against Dr. Udom but affirmed the holding that the covenant not to compete was enforceable. The Court of Appeals remanded the case [back to] the Chancery Court to determine ‘the reasonableness and specific amount to be used in satisfying the buy-out provision.’”).
156 Id.
157 Id.
158 Id. (“Also, the time and territorial limits must be no greater than necessary to protect the business interest of the employer.”).
159 Spiegal v. Thomas, Mann & Smith, 811 S.W. 2d 528, 529 (1991) (Spiegal worked for Thomas, Mann & Smith for five years, upon which the provision in question came into effect. After withdrawing from the law firm, Spiegal requested the deferred compensation that had been a part of his employment contract. Upon denial, “Spiegal contended that, pursuant to the terms of his employment agreement, he [was] entitled to deferred compensation because he [was] not involved in the practice of law. Additionally, [Spiegal] asserted that because the firm had completely dissolved, he was equitably entitled to deferred compensation. Spiegal amended his complaint to assert that the deferred compensation portion of the employment agreement was a ‘thinly-disguised non-competition agreement.’ [Spiegal] contended that, as such, it was unenforceable.”).
160 Murfreesboro, supra note 143, at 679.
‘concern for the public good is inherent in the purposes’ underlying the ethics rules governing the legal profession, [the court] looked to the legal ethics rules to guide [its] analysis.”  

Therefore, the court in *Spiegal* concluded that, “to enforce the clause in question would violate [the ABA’s] ethical standards and therefore held the clause to be void as against public policy.”  

The *Murfreesboro* court linked their case with *Spiegal*, noting that, “much like the restrictive covenants in the practice of law, restrictive covenants in the medical profession raise concern regarding the public good.”  

By allowing there to be an array of physicians in the community, the medical profession benefited the public interest at large. Additionally, the Supreme Court of Tennessee argued that, “increased competition for patients tends to improve quality of care and keep costs affordable.” Finally, the court argued that patients have the right to choose which physician the patient would like to treat them, as well as a right to “continue an on-going professional relationship with that physician.”  

The court continued its discussion making note of the AMA’s “strong[] discourage[ment] [of non-compete provisions.” Furthermore, the court noted that the AMA itself has viewed non-compete agreements in physician employment contracts to, “restrict competition, disrupt continuity of care, and potentially deprive the public of medical services” in addition to finding “that a person’s right to choose a physician and

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161 *Id.* at 679 (“[The court] noted the American Bar Association’s position that restrictive covenants were unethical. The ABA’s Ethics Committee views the practice of law as unlike a common business or trade because lawyers deal with clients, not merchandise, and lawyers have a duty to make legal counsel available to the public.”).

162 *Id.*

163 *Id.*

164 *Id.* (“Having a greater number of physicians practicing in a community benefits the public by providing greater access to health care.”).

165 *Id.*

166 *Id.* (“Enforcing covenants not to compete against physicians could impair or even deny this right altogether.”).

167 *Id.*
free competition among physicians are ‘prerequisites of ethical practice.’”

Taking all of this into consideration, the Murfreesboro court was puzzled by the overwhelming number of courts that decided to apply the aforementioned reasonableness standard in order to decide whether or not non-compete agreements in physician contracts are valid or void. The court was also taken aback by the fact that so few courts make note of the ethical concerns associated with the implementation of non-compete agreements in the medical arena.

The court did, however, find it encouraging that various states did have case law in which courts saw the public policy concerns associated with non-compete agreements and the medical profession. The court went on to state that there were even some states that recently held that it would be in the best interest of the public to completely prohibit non-compete agreements in physician employment contracts. Furthermore, the court made note of various states that have enacted antitrust statutes that have helped in preventing enforcement of non-competes in physician employment contracts.

Finally, the court discussed Tennessee law and the fact that no specific law that outright banned such non-compete agreements. However, Tennessee Code annotated § 63-6-204 (Supp. 1998) only allowed enforcement of non-compete clauses in two instances: “(1) when the employer is a hospital or an affiliate of the hospital and (2) when

168 Id.
169 Id. at 680.
170 Id.
171 Id.
172 Id. at 681 (“Also, three states have in recent years enacted statutes totally prohibiting non-compete clauses in physicians contracts.”).
173 Id. (“Additionally, antitrust statutes in several states, although not enacted specifically for this purpose, have been interpreted as prohibiting non-compete clauses between physicians.”).
174 Id.
the employer is a ‘faculty practice plan’." Implementation of these two instances in which non-compete agreements may be utilized are narrowed even further as this Tennessee statute “limits the restrictions that may be imposed in either of these [two] situations.”

However, this Tennessee statute does not allow non-compete clauses in either hospitals or faculty practice plans in which physicians “practice[] ophthalmology, radiology, pathology, anesthesiology or emergency medicine.”

The court in Murfreesboro was unable to find a great enough distinction between the practice of law and the practice of medicine that would explain prohibiting non-compete agreements the one profession while allowing it in the other. Ironically, the

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175 *Id.*

176 *Id.* at 681-82 (“For example, if the employer is a hospital and has made a bona fide purchase of the physician’s practice, the maximum geographical restriction in a non-compete agreement is (1) the county in which the primary practice site is located or (2) a ten mile radius from this site, whichever is greater. Also, the maximum duration of the restriction is two years. For physicians whose practices have not yet been purchased by the employer, the employer may only restrict the physician’s right to treat or solicit former patients (rather than all patients), and this only for a maximum of one year. Furthermore, if a physician’s employment is terminated by the employer for any reason other than ‘breach by the employee,’ then all non-compete restrictions are void.”).

177 Lisa M. Norris, New Restrictions on Physician Competition, Adams and Reese, LLP. (2007) available at http://arwebserver.arlaw.com/pdf/Fall%2007-Lisa%20Norris.pdf (“At the end of the 2007 Legislative Session, the Tennessee General Assembly passed a new law permitting physician non-compete agreements effective January 1, 2008 (Amending Tennessee Code Annotated, Title 63 with new designated § 63-1-48. The new law essentially allows physician practices to place non-compete clauses in physician employment contracts and in agreements for the purchase or sale of physician practices. However, the new law does impose some restrictions . . . the new law does not pertain to radiologists or emergency medicine physicians. All other physicians, dentists, ophthalmologists, psychiatrists, and chiropractors can be required to adhere to non-compete agreements . . . [An] interesting aspect of the new law is the exemption given to those physicians who have been employed or under contract with a group practice for six (6) years or longer.”).

178 GENERAL COUNSEL NOTE (2008) available at http://www.vanderbilt.edu/generalcounsel/June%202008%20(no.%205).pdf (“The Udom decision did not affect the rights of hospitals and hospital-affiliated employers and faculty practice plans to enter into non-competition agreements that were already permitted by statute at the time of the decision. The new non-competition statute . . . at the beginning of 2008 makes clear the Tennessee General Assembly’s intent that reasonable restrictive covenants should be enforceable notwithstanding the public policy analysis presented by the Udom court”).

179 Murfreesboro, supra note 111, at 682 (“Further, non-compete agreements are not permitted in either situation for physician practicing primary care, obstetrics, or pediatrics in an area which has a shortage of these services.”).

180 *Id.* (“We see no practical difference between the practice of law and the practice of medicine. Both professions involve a public interest generally not present in commercial contexts. Both entail a duty on the part of practitioners to make their services available to the public. Also, both are marked by a relationship between the professional and patient or client that goes well beyond merely providing goods or services.”).
The Murfreesboro court found that rules regarding professions other than the legal and medical professions need not be considered in the court’s analysis as “[those other professions] are not relevant to the legal or medical profession, as both often require the disclosure of private and confidential information.”

Thus, for all of these reasons, the court ultimately held that the non-compete in Dr. Udom’s physician employment contract was void as it went against public policy. The court ruled that, “public policy considerations such as the right to freedom of choice in physicians, the right to continue an ongoing relationship with a physician, and the benefits derived from having an increased number of physicians practicing in any given community all outweigh the business interests of an employer.”

Now the reader knows about two conflicting cases: both pertaining to non-compete clauses in the medical arena, both with very different outcomes. Karlin held that the Dr. Weinburg’s non-compete provision was valid, while Murfreesboro held that such provisions in physician employment contracts are void for public policy. It appears that this inconsistency in non-compete agreements in the medical arena stems

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181 Id. at 683 (Quoting the dissent of Justice Smith from Shankman v. Coastal Psychiatric Association, “The medical profession, like the legal profession, is one that of necessity must have the faith and confidence of its patients (clients) in order to give effective treatment. When a patient (client) has entrusted confidential information to the doctor (lawyer) this creates a relationship involuntarily terminated.”).
182 Id.
183 Id.
184 Id. at 683-84.
185 Karlin, supra note 128, at 413.
186 Murfreesboro, supra note 111, at 684.
from the AMA’s discouragement but simultaneous allowance of such provisions to exist in the medical profession.\footnote{Id. at 679 ("Since 1980 the AMA has taken the position that physicians’ non-compete agreements impact negatively on health care and are not in the public interest. Although stopping short of completely prohibiting covenants not to compete, the AMA strongly discourages them.").}

Looking across the nation, this inconsistency is overtly apparent.\footnote{Russell Beck, *Employee Noncompetes A State by State Survey*, BECK REED RIDEN LLP (2010-2013) available at http://www.beckreedriden.com/wp-content/uploads/2013/08/Noncompetes-50-State-Survey-Chart-20130814.pdf.} States vary in upholding non-compete agreements because they each protect very different legitimate interests of the employers.\footnote{Id.} Some of the legitimate interests that are specifically mentioned include: trade secrets, customer relationships, confidential information, customer relationships, recovery of training expenses for short-term employees, goodwill, specialized training, ability to succeed in a competitive market, loyalty, customer lists, protection from unfair competition, stability in the workforce, likely confidential information, the list goes on and on.\footnote{Id.}

Of the 50 states that make up the United States of America, physicians are exempt from employee non-compete agreements in only seven (7) states.\footnote{Id.} These seven states include: Alabama, Arizona, Delaware, Illinois, Massachusetts, Tennessee and Texas.\footnote{Id.} Alabama is included among the states exempting physicians from non-compete agreements as they exclude “professionals” from such covenants.\footnote{Id.} Tennessee and Texas are included as well, as both states exempt physicians “in certain circumstances.”\footnote{Id.}

*Murfreesboro* simply and eloquently demonstrated precisely why the medical profession should be held to the same standard as the legal profession. And that reason is
because patient care is not trade.\textsuperscript{195} Just like the legal profession, the medical profession is providing a service to people who should be allowed to pick and choose who they want to see, freely and without any encumbrances.\textsuperscript{196} \textit{Murfreesboro} serves to emphasize that ‘protecting’ employers in the medical profession is not as important as going against what is in the best interests of the public.\textsuperscript{197} Until the AMA adopts guidelines pursuant to those found in the ABA, courts across the country will likely continue to provide holdings that clearly conflict with one another, which will, unfortunately, only lead to even more inconsistency.

VI. The Physician-Patient Relationship And the Struggle to Keep It Personal

It is apparent from the earlier discussion on the history of the physician-patient relationship that it took a long time for physicians and patients to form the type of relationship that is both considered sacred and private. However, changes are still occurring in today and are further impacting this relationship. One way in which the relationship is affected in the modern world is through managed care plans.\textsuperscript{198} A managed care plan is “an organization that combines the functions of health insurance, delivery of care, and administration.”\textsuperscript{199} These managed care plans “determine how [someone] access[es] and receive[s] health care . . . and what [the patient] will have to pay out of pocket each time [the patient] receive[s] care.”\textsuperscript{200}

\textsuperscript{195} Murfreesboro, supra note 111, at 683.
\textsuperscript{196} Id.
\textsuperscript{197} Id. at 684.
\textsuperscript{198} Goold, supra note 213.
\textsuperscript{199} \textsc{The Free Dictionary}, http://medical-dictionary.thefreedictionary.com/managed+care+organization.
\textsuperscript{200} Michael Bihari, \textit{Understanding Managed Care: HMOs, PPOs, and POS Plans}, (Dec, 2014) available at http://healthinsurance.about.com/od/understandingmanagedcare/a/managed_careoverview.htm (Managed care plans typically cover a wide range of health services such as preventative care and immunizations for adults and children, general check ups, diagnosis and treatment of illness . . . and newborn care.)
There are three kinds of managed care plans: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service Plans (POS). HMOs require patients to receive medical care from a network provider. PPOs have contractual relationships with “a network of ‘preferred’ providers from which [the patient] can choose [from].” Unlike HMOs, PPOs do not require patients “to select a PCP.” Additionally, patients do not require referrals to see any in-network physicians. Finally, POS plans are essentially a mix of both an HMO and PPO. It has a network in which the patient is required to choose a PCP, and also allows the patient to choose a “provider that is not in the network. However, if the patient decides to go out-of-network for care, [the patient] will pay more.”

It becomes apparent how integrated these managed care plans are in the health care industry when looking over the aforementioned explanations. Many believe that these managed care plans, while having the potential to control health care costs, seriously injure the healthcare profession. Such injuries include, but are not limited to

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Additionally, most managed care plans offer some services for the diagnosis and treatment of mental health conditions and substance abuse problems.”).

201 Id.
202 Id. (“HMOs require that you choose a primary care physician who is responsible for managing and coordinating all of [the patient’s] health care. If a [patient] needs care from a physician specialist in the network or a diagnostic service . . . [the patient’s] primary care physician (PCP) will have to provide [the patient] with a referral. If [the patient] does not have a referral or choose[s] to go to a doctor outside the health plan’s network, [the patient] will likely have to pay all or most of the cost for that care”).

203 Id.
204 Id.
205 Id. (“If you receive your care from a doctor in the preferred network you will only be responsible for your annual deductible and a copayment for your visit. If you get health services from a doctor or hospital that is not in the preferred network [the patient] will pay a higher amount. And [the patient] will need to pay the doctor directly and file a claim with the PPO to get reimbursed”).

206 Id.
207 Id. (“These plans are known as point-of-service, because each time [the patient] needs health care, [they] can decide to stay in network and allow [the] PCP to manage [their] care or go outside the network on [their] own without a referral from the PCP”).
“restrictions on clinical research, the [] reduced funding for physician training programs, and the closing of hospitals in rural areas and small communities.” 209 Another serious injury stemming directly from such managed care plans includes harmful interference in the doctor-patient relationship. 210

In the article, “Preserving the Physician-Patient Relationship in the Era of Managed Care,” authors Dr. Ezekiel Emanuel and Ms. Nancy Dubler speak of the negative impact managed care organizations have on the doctor-patient relationship. The article touches upon “the 6 Cs: choice, competence, communication, compassion, continuity of care, and (no) conflict of interest.” 211 For purposes of this paper we will examine choice and continuity of care. Patients consider choice to be “a critical dimension of the ideal doctor-patient relationship.” 212 Four components to patient choice include: “(1) choice of practice type and setting, (2) choice of PCP, (3) choice of specialist or special facility in an emergency for a special condition, and (4) choice among treatment alternatives.” 213 It should come as no surprise that patients “fear being forced to receive care from a physician with whom they do not get along.” 214 Additionally, should a patient develop a serious health condition, “patients want to be sure they can choose to go to ‘the best.’ For many [patients], choice of the best is a critical element in feeling that ‘no stone is left unturned.’” 215 Furthermore, when there are

209 Id.
210 Id.
211 Id.
212 Id. at 324.
213 Id.
214 Id.
215 Id.
different treatment options for said serious health condition, “[patients] want to be able to choose for themselves which one to receive.”

Thus, once a patient has chosen a physician with whom they feel comfortable seeing, “the ideal physician-patient relationship requires a significant investment of time.” When patients have a continuous relationship with their physician of choice, this “ensure[s] that in times of stress patients can rely on their physicians secure in the knowledge that their history, attachments, values, and feelings are understood.” When patients are forced to continuously change physicians, “it is hard for them to develop a deep and understanding relationship.”

Managed care organizations interfere with the physician-patient relationship in a few ways. The first way the relationship is interrupted is “to hold down costs, many . . . managed care organizations may try to select out enrollees . . . likely to use fewer and cheaper services through selective marketing, increased use of exclusions, modifications of benefits offered, and other techniques.” Additionally, in an attempt to “restrain costs, a growing number of employers are restricting patient choice.” Employers do this by “requiring their employees to enroll in a particular managed care plan . . .”

Furthermore, the financial failure of a managed care plan can seriously harm the

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216 Id.
217 Id.
218 Id.
219 Id. (“Knowing a patient means that a physician more easily identifies therapies appropriate for the personality and capabilities of the patient. The physician will know what support services the patient can draw on. Similarly, patients are more likely to accept recommendations to ‘wait and see’ or to delay expensive diagnostic testing from a physician in whom they have confidence by virtue of having established a trusting relationship.”).
220 Id. at 327.
221 Id.
222 Id. (“Increasingly, managed care plans will compete for employers’ contracts and subscribers on the basis of price. Yet there is no guarantee that the cheapest plan this year will be the cheapest plan during the next enrollment period. . . In such a price-competitive marketplace, employers may switch health care plans from year to year and patients may be forced to choose between continuing with their current physician and managed care plan at a higher price or switching to a cheaper plan.”).
physician-patient relationship.223 Due to price competition, “inefficient plans will lose in the marketplace and close.”224 Another way in which the relationship may be harmed is when a physician is “de-selected by a managed care organization.”225 Each of these managed care interferences essentially destroy patient choice, which, as previously mentioned is imperative to having a successful physician-patient relationship.

These managed care organizations are attempting to, and for the most part are succeeding, in making the physician-patient relationship an impersonal one. While both physicians and the patients may not want the relationship to be impersonal, outside entities such as managed care organizations are forcing the practice of medicine more and more in that direction. In a study from 1993, “more than 17,000 patients [were dissatisfied] with health maintenance organizations.”226 Researchers found that, “patients were more likely to be satisfied with the explanations of their treatments from doctors working in their own offices or in small single-specialty groups than from H.M.O.’s.”227 Additionally, patients found “independent doctors were easier to reach by telephone and more apt to schedule office appointments on shorter notice than were doctors in large medical groups.”228

This issue of an impersonal physician-patient relationship is further emphasized in the article, “Medicine Becoming Impersonal.” The author, Dennis Feeley, argues that,

223 Id.
224 Id. (“Plan failure could pose a serious threat to patient choice and continuity of care, especially if the collapse happens between enrollment periods.”).
225 Id. (“In such circumstances, patients cannot choose that physician unless they are willing to go out of the plan. More important, patients who have been receiving care from that physician may be forced to switch to another physician in the managed care panel, again undermining the patient choice and continuity of care.”).
227 Id. (The researchers noted that, “patients also said independent doctors had showed more interest in their well being.”).
228 Id.
“more physician groups are selling their practices and being subsumed into large hospital conglomerates’ umbrella.” Feeley states this is happening solely because, “it’s more cost efficient to be a part of a hospital system that will take care of all the details associated with running a practice.” What many like Feeley fail to recognize in this type of argument, however, is that physicians are not jumping ship and becoming affiliated with larger medical entities for the sole purpose of convenience. Rather, physicians are being forced to take such action due to various external, and uncontrollable, factors, including, but not limited to the Affordable Care Act and reimbursements for services rendered.

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230 Id.

231 Gardiner Harris, More Doctors Give Up Private Practices, (Mar. 2010) available at http://www.nytimes.com/2010/03/26/health/policy/26docs.html?pagewanted=all&r=0 (“As recently as 2005, more than two-thirds of medical practices were physician-owned-a share that had been relatively constant for many years . . . But within three years, that share dropped below 50 percent, and analysts say the slide has continued. For patients, the transformation in medicine is a mixed blessing. Ideally, bigger health care organizations can provide better, more coordinated care. But the intimacy of longstanding doctor-patient relationships may be going the way of the house call . . . The trend away from small private practices is driven by growing concerns over medical errors and changes in governmental payments to doctors.” Another factor “may be . . . electronic medical records. The computerized systems are expensive and time-consuming for doctors, and their substantial benefits to patient safety, quality of care and system efficiency accrue almost entirely to large organizations, not small ones.”).

232 Ronni Caryn Rabin, Doctors Complain They Will Be Paid Less By Exchange Plans, (Nov. 2013) available at http://kaiserhealthnews.org/news/doctor-rates-marketplace-insurance-plans (“Many doctors are disturbed they will be paid less-often a lot less- to care for the millions of patients projected to buy coverage through the health law’s new insurance marketplaces . . . Insurance officials acknowledge they have reduced rates in some plans, saying they are under enormous pressure to keep premiums affordable. They say physicians will make up for the lower pay by seeing more patients, since the plans tend to have smaller networks of doctors. But many primary care physicians say they barely have time to take care of the patients they have now . . . A survey by The Medical Society of the State of New York found that 40 percent of more than 400 physicians who had responded so far said they chose not to participate in a health insurer’s exchange plan, and one-third said they did not know whether they were participating or not. Two-thirds indicated they had received no information about reimbursements; of those who did get that information, ‘a significant majority indicated that the reimbursement was well below what the insurer pays in other contracts.’”).

233 Jason Fodeman, M.D., The New Health Law, Bad For Doctors, Awful For Patients, available at http://www.theihec.com/en/communities/policy_legislation/the-new-health-law-bad-for-doctors-awful-for-patients_g17y01k.html (“Medicare’s physician reimbursement regimen is characterized by underpayments and perverse incentives. The brunt of Medicare’s declining reimbursements is shifted to patients in the form of decreased access to physicians and inferior care. Rather than trying to reform this flawed
While implemented with the intent to provide affordable healthcare to every citizen in the United States\(^{234}\), the ACA\(^{235}\) has had the unfortunate result of increasing the gap between physicians and patients. A 2014 study done by the Medical Group Management Association demonstrated that “as many as 214,524 American physicians [would] not be participating in any ACA\(^{236}\) exchange products.”\(^{237}\) While there were a number of reasons so many physicians decided to opt-out, “chief among them is the fact that the exchange plans are more likely to offer significantly lower reimbursement rates than private market plans, confusion among consumers about the obligations associated with high deductibles, and fear that patients will stop paying premiums and providers will be unable to recover their losses.”\(^{238}\) Where private plans “will pay physicians $1.00 for a

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\(^{235}\) Id. “The perceived major impact on practicing physicians in the ACA is related to growing regulatory authority with Independent Payment Advisory Board (IPAB) and the Patient Centered Outcomes Research Institute (PCORI). In addition to these specifics is a growth of the regulatory regime in association with further discounts in physician reimbursement. With regards to cost controls and projections, many believe that the ACA does not fix the finances of our health care system-neither public nor private. It has been suggested that the Congressional Budget Office (CBO) and the administration have used creative accounting to arrive at an alleged deficit reduction; however, if everything is included appropriately and accounted for, we will be facing a significant increase in deficits rather than a reduction.”).

\(^{236}\) Maksim Spivak, *The Effects of the Affordable Care Act on Large Companies*, CORNELL HR REV. (Dec. 2014) available at http://www.cornellhrreview.org/the-effects-of-the-affordable-care-act-on-large-companies-2 (“Human resource executives are [] changing their overall benefits strategies as a result of the ACA . . . Finance arms of companies are working closely with HR and Benefits on healthcare cost and strategy. Line items in healthcare expenses face more scrutiny than in the past, largely due to the looming 40% excise tax on plans that have a value of over $10,200 for self-coverage and $27,500 for family coverage. The excise tax, commonly referred to as the Cadillac tax, is designed to reduce the opulent benefits offered to many in the corporate world and attacks excessive spending on healthcare, which is driven by the lack of thoughtful marginal spending by consumers.” Thus, it appears that the ACA will quickly lead to tight networks through its emphasis on price and cost, as well as through its Cadillac tax. This tight networks may, as a result, further expand upon the gap between physicians and patients.).


\(^{238}\) Id.
service, Medicare pays $0.80, and the ACA exchange plans [pay] about $0.60. Many who support the ACA argue the point “that physicians will be able to recuperate this 40 percent cut in reimbursement by working for more and taking advantage of the higher volume of patients.”

What these proponents fail to take into their assessment is that the physicians “are already overburdened and have too many patients as it is, so the increase in volume will do nothing to offset their losses.” Additionally, should a majority of the exchange patients be “sicker than the average patient,” due to a long-term lack of insurance, such patients “will require more physician time at a lower pay.”

Furthermore, patients that are in an exchange plan have a unique payment setup for services rendered by their treating physician:

Exchange plans are required to provide their customers with a 90 day ‘grace period’ to pay their bills. During this grace period, the insurer is required to continue coverage for 30 days. After the first 30 days period, the individual’s status is changed to ‘pending.’ Any care provided to a patient whose insurance status is pending will be covered by the insurer if the overdue insurance premium is paid by the end of the 90 day period. If the individual does not become current on insurance premiums by the end of the 90 day period, the health care provider will be left to recover any charges incurred between the 31st and 90th day of the grace period directly from the patient. If the patient is unable to pay, the provider will remain uncompensated. This was reported as the number one reason for providers deciding not to participate in exchange plans.

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239 Id.
240 Id.
241 Id.
242 Id.
Thus, when physicians bring up the point that they are suffering a significant pay cut, they are trying to demonstrate the very real threat that they will not be able to remain open to provide healthcare to their patients.

The physicians’ offices, their staff, their equipment all cost money. And if a physician is not being compensated for services rendered to patients, then physicians literally cannot afford to remain open to render services. Some may raise the following question: how, then, are physicians any different than employers implementing non-compete agreements to protect their financial interest? The difference is that the employers implementing the non-competes are not suffering a severe economic hardship as the independent physicians are due to not being appropriately compensated. Employers that utilize non-compete agreements in physician contracts are trying to protect themselves against potential competition from peers. They don’t want their patients seeking out physician services that could potentially come into existence should an employee leave. The physicians in an independent practice that do not participate with exchange plans are trying to protect themselves from financial ruin and remain open to provide the services they have been trained to provide. The employers are trying to protect themselves against a financial hardship that may possibly arise should multiple prior employees open practices in the same geographical area. This is completely different than the independent physicians who are trying to protect themselves against a very real and very dangerous financial hardship.

While entities like managed care organizations and legislation such as the ACA may be driving the medical profession in an impersonal direction, this does not mean that the physician-patient relationship has to be impersonal. For example, one of the negative
results from the implementation of the ACA is a longer wait time for patients to see their treating physician.\textsuperscript{243} One way physicians have tried to compensate for this has been to create patient portals.\textsuperscript{244} This way, patients have easier access to their physicians off hours and can contact their physicians should any questions arise before or after an appointment and arguably more quickly than waiting for a telephone call back.

Simply calling the physician-patient relationship impersonal because of the creation of entities such as managed care organizations and legislation like the ACA disregards the fact that to physicians and patients still view this relationship as a deeply personal one. The fact that patient choice is deemed by patients as being an important part of their health care speaks volumes of how personal they view this relationship. Until entities and legislation such as managed care organizations and the ACA lose their authority to dictate the patient choice, the physician-patient relationship will continue to suffer.

\textsuperscript{243} Berg, \textit{supra} note 290 at 45.
\textsuperscript{244} SUMMIT MEDICAL GROUP, Patient Portal, \textit{available at} http://www.summitmedicalgroup.com/about/MyS MG.
VI. Social and Economic Undercurrents and the Evolution of Medicine

The aforementioned gap between physicians and patients has only expanded throughout the evolution of society. Social inequities are one cause in this gap expansion. One such social inequity is poverty. While America is not a third world country, many may be surprised to learn that, “despite the high level of affluence in the United States at the national level, Americans are not immune to the impact of poverty.” This is especially apparent when such persons try and obtain health care. It is documented that, “the world’s biggest killer and greatest cause of ill-health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given in code Z59.5-extreme poverty.”

Arguments have been made that, “urbanization and globalization are coupled in their impact upon social inequality and disease emergence.” This coupling and its negative impact reach far back in history, “the confluence of urban centers from 500 BCE until 1200 CE . . . created the first major disease pools in Eurasia.” Additionally, “the development of the Mongol Empire, from 1200 to 1500 CE, resulted in the second phase of globalization and emerging disease.” Furthermore, “transoceanic exchange from 1500 to 1700 CE was the third phase in the historic process of globalization, resulting in

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246 Id.
247 Id.
248 Id.
249 Id.
250 Id. at 292.
251 Id.
252 Id.
one of the great periods of disease exchange.”

Evolving from a “rural to an urban animal” has led to the formation of “city planet[s].”

Typically, “urbanization is associated with a decline in birth and death rates . . . and] [u]rbanities enjoy better health on average than rural inhabitants.” This, however, is not the case as of late due to the fact that, “there is an economic disparity, with the rich benefiting the most.” Some argue that, “urban living is now the keystone of modern human ecology, with a crucial role in shaping emerging infectious diseases.”

Additionally, urban cities are believed to be “the incubators and gateways for infectious diseases.” Furthermore, “the urban poor face the risk of vector-borne infections, lead and air pollution, traffic hazards, and urban heat load that is exacerbated by global warming.”

This economic disparity may be slightly combatted with the increase in acceptance of the corporate practice of medicine. The increased use of the corporate practice of medicine may come as a surprise since, “many state officials subscribe to a

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253 *Id.*
254 *Id.* (“Humankind’s radical transformation from a rural to an urban animal has created what Stewart Brand (2006) described as a ‘city planet.’ In the modern era, the process of urbanization that gained momentum in the 1880s, in tandem with rapid transportation and the ecological impact of technological development, has driven social transformations that are marked by social inequalities”).
255 *Id.* at 301.
256 *Id.* (“According to Christopher Dye (2008), about 3.3 billion people representing over half of the world’s population now live in an urban setting. He estimates that there are 50,000 settlements with 50,000 or more inhabitants. Within ten years, and continuing into the future, population growth will be in urban areas with 500 cities having between 1 and 10 million inhabitants, the majority of them in poorer, developing cities”).
257 *Id.*
258 *Id.*
259 *Id.*
260 David M. Cutler, Ph.D., *The Next Wave of Corporate Medicine-How We All Might Benefit*, 6 N ENGL J MED 361, 549 (Aug. 2009) (“The thought of ‘corporate medicine’ makes patients and providers panic. Medicine is individualistic; corporations are not. Doctors look out for patients, corporations make money. And yet the current economic situation is almost certain to increase the importance of corporate medicine”).
legal doctrine that prohibits a corporate entity from providing medical services."\textsuperscript{261} The corporate practice of medicine prohibition was favored in the past because there was a fear that, “if physicians were to work for corporations, corporations ultimately would control physicians’ level of income, their methods of treatment and diagnosis, and their relationships with the patient.”\textsuperscript{262} This prohibition,\textsuperscript{263} however, may be less rigorously adhered to over the course of time due to the fact that, “[it] stands as a formidable threat to lay entities attempting to establish health care provider services.”\textsuperscript{264}

What is particularly interesting in regard to this prohibition is the fact that “the doctrine suffered a significant blow when the Federal Trade Commission (FTC) ordered the AMA to modify its ethical restrictions on physicians’ contractual arrangements to bring them in line with federal antitrust laws.”\textsuperscript{265} The specific section “that was at issue, Section 6, stated that a physician should not provide services under conditions that might prevent the physician from exercising medical judgment with complete freedom or that might deteriorate the quality of medical care.”\textsuperscript{266} The FTC argued that the restrictions implicated from the prohibition brought about three anticompetitive effects:

\textsuperscript{261} Jeffrey F. Chase-Lubitz, \textit{The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry}, 40 \textit{VAND. L. REV.} 445, 447 (1987) (“This doctrine, generally known as the corporate practice of medicine, originated within the medical profession at the turn of the century as an ethical restriction on physicians’ economic relations.”).
\textsuperscript{262} \textit{Id.}
\textsuperscript{263} \textit{Id.} at 456 (“The early involvement of business corporations in medicine took two forms. In the first form, popularly known as contract practice, corporations employed physicians to serve the medical needs of employees. In isolated industries . . . doctors contracted to treat employees for a predetermined salary. Corporations in smaller and more urban industries contracted with independent physicians to provide medical care to the corporations’ employees for a set rate per worker per month. Under both schemes the corporation dictated the choice of physicians. In the second form, known as corporate practice, for-profit medical service companies marketed physicians’ services to the public . . . The corporations first employed their own doctors to perform these services, but later subcontracted the work to independent doctors. Although physicians founded these corporations, eventually they were managed by lay people. Corporate management maintained limited control over the doctors with whom they contracted.”).
\textsuperscript{264} \textit{Id.}
\textsuperscript{265} \textit{Id.} at 475.
\textsuperscript{266} \textit{Id.}
First, the provisions sought to limit price competition among doctors by fixing the adequacy of compensation and by prohibiting competitive bidding. Second, the provisions inhibited competition by limiting hospitals, prepaid health plans, and lay entities to the traditional fee-for-service method of compensation and by proscribing their use of salaries and other cost-efficient payment methods. Last, the provisions restricted arrangements between physicians and non-physicians and, therefore, prevented the creation of more economical business structure.\(^\text{267}\)

The FTC went so far as to order the AMA to “cease and desist from promulgating any ethical restraints concerning the payment method employed by physicians in contracting with any entity that offers the physician’s services to the public.”\(^\text{268}\) Additionally, the AMA was ordered to stop “inhibiting the development of any entity that offers physicians’ services to the public by commenting on the ethical propriety of non-physician ownership or management of that entity.”\(^\text{269}\)

If the AMA is able to cease and desist utilizing the corporate practice of medicine prohibition, the AMA should have no problem in stopping its overuse of non-compete clauses in physician employment contracts. The FTC was able to push the AMA to stop using this prohibition because in using it, the AMA was found to be violating antitrust law. By not limiting the use of non-compete clauses in physician employment contracts, as they are limited under the ABA, the AMA is setting itself up for further investigation and possible violation of antitrust law.

\(^{267}\) Id. at 467-77.
\(^{268}\) Id. at 477.
\(^{269}\) Id. at 477-78 (“Although antitrust violations, not the corporate practice doctrine, provided the impetus behind the FTC action against the AMA, the Commission’s Order does have important implications for the doctrine. As described earlier, the rule against corporate practice emerged from the AMA’s early efforts to protect the medical profession’s autonomy and prestige. The AMA’s adoption of restrictions on corporate into its ethical code helped establish the prohibition against contract-style schemes as accepted doctrine. Thus, the recent abolition of these ethical restrictions greatly weakens the foundation upon which the corporate practice of medicine doctrine was built.”).
VII. Non-compete Agreements: The Medical Profession vs. The Legal Profession

Attorneys, governed by the ABA guidelines, are not subject to non-compete provisions in employment contracts.\(^{270}\) Such a restraint is only allowed under very limited circumstances.\(^{271}\) One circumstance in which the ABA will allow a non-compete agreement is when the restraint is “incident to [the] sale of a law practice.”\(^{272}\) A noteworthy case exemplifying the ABA’s strict abhorrence to non-compete agreements in employment contracts is *Dwyer v. Jung.*\(^{273}\) In *Dwyer*, a partnership agreement was entered into, leading to the creation of the law practice ‘Jung, Dwyer and Lisbona.”\(^{274}\)

The agreement between the parties also included a provision, which stated that:

should the partnership terminate, all clients listed in exhibit A shall be designated to certain individual partners. Upon termination, and by virtue of this Agreement, all partners shall be restricted from doing business with a client designated as that of another partner for a period of 5 (five) years.\(^{275}\)

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\(^{270}\) Steinbuch, *supra* note 37, at 1060-61 (“Rule 5.6 of the Model Rules of Professional Conduct states that ‘a lawyer shall not participate in offering or making: [ ] a partnership, shareholders, operating, employment, or other similar type of agreement that restricts the right of a lawyer to practice after termination of the relationship, except an agreement concerning benefits upon retirement . . . The ABA Standing Committee on Ethics justified this rule in *Formal Opinion 300* . . . [stating] any employment agreement that restricted a lawyer’s post-employment practice through geographic or time limitations was unethical. In *Formal Opinion 1072*, the Ethics Committee extended this prohibition to partnership agreements . . . [it also] stated that any limitation on a lawyer’s freedom to practice would also restrict a prospective client’s ‘desire to engage [the lawyer’s] services.’”).

\(^{271}\) *Id.* at 1055

\(^{272}\) *Id.*

\(^{273}\) Loeser, *supra* note 33 at 286 (“Commercial standards may not be used to evaluate the reasonableness of lawyer restrictive covenants. Strong public policy considerations preclude their applicability. In that sense the lawyer restrictions are injurious to the public interest. A client is always entitled to be represented by counsel of his own choosing . . . The attorney-client relationship is consensual, highly fiduciary on the part of counsel, and he may do nothing which restricts the right of the client to repose confidence in any counsel of his choice.”).

\(^{274}\) *Dwyer v. Jung*, 336 A.2d 498, 499 (1975) (“Their agreement provided that each partner would contribute a stated amount for capital, cooperate in business of the partnership and share in the partnership net profits in a stated manner. Upon dissolution each partner would be entitled to a repayment of capital and a distributive share of remaining profits and net assets”).

\(^{275}\) *Id.* (“Exhibit A . . . contained a list of insurance carriers; 154 were designated to defendant Jung as his clients, 5 were designated to plaintiff Dwyer as his clients, and none [were] ascribed to plaintiff Lisbona”).
Despite the fact that defendant notified plaintiffs of the dissolution of the partnership, which occurred on June 1, 1974, the partnership continued to exist de facto until September 1, 1974. An action was brought against plaintiffs Dwyer and Lisbona for breach of the non-compete provision in the original partnership agreement. The plaintiffs argued that the provision in the partnership agreement was void due to its violation against public policy. The court emphasized that non-compete provisions pertaining to attorneys are different from those “incident to the sale of a business where the covenants are designed to protect the good will of the business for the benefit of the buyer.” The court was firm in its belief that, the sale of a legal practice aside, “lawyer restrictions are injurious to the public interest [and] a client is always entitled to be represented by counsel of his choosing.”

Additionally, the court explained that an attorney is not to be restricted post-employment from continuing to practice law, as is the case in other professions. Citing the Solari case, the court stated that while, “[non-compete agreements] will generally be found to be reasonable where [they] simply protect[] the legitimate interests of the employer, imposes no undue hardship on the employee, and is not injurious to the public,” such “commercial standards may not be used to evaluate the reasonableness of lawyer

276 Id. at 345-46 (“On June 7, 1974 defendant notified plaintiffs that the partnership was dissolved as of June 1, 1974. The business of the partnership continued in a de facto fashion until September 1, 1974 when the former partners went their separate ways. Plaintiffs then practiced under the name of ‘Dwyer and Lisbona.’ Defendant practiced under the name of ‘Jung and Howard’ . . . Plaintiffs [were] charged with attempting to pirate defendant’s clients and undermining his relationship with certain named insurance carriers.”).  
277 Id. at 345-46 (“Specifically, plaintiffs are charged with attempting to pirate the good will of the business for the benefit of the buyer.”).  
278 Id. at 346.  
279 Id. (Citing the case Solari Industries, Inc. v. Malady, the court explained that, “A lawyer’s clients are neither chattels nor merchandise, and his practice and good will may not be offered for sale. In this regard, Abraham Lincoln’s sage observation . . . is particularly appropriate: A lawyer’s time and advice is his stock in trade.”).  
280 Id. at 347.  
281 Id.
This stems from the glaringly obvious result (ie. interfering with, and potentially ending, the attorney-client relationship) such a restriction would have on attorneys and their clients. This interference is what makes non-compete provisions “injurious to the public interest” in attorney employment contracts and why they do not exist, except in limited areas. For these reasons, the court in Dwyer found the non-compete provision in the partnership agreement to be void due to its violating public policy.

Unlike the ABA, the AMA does not have similar protective measures in place for physicians and, consequently, are also lacking protections for those physicians’ patients. It is noted that the AMA “disfavors non-compete agreements, stating that they restrict competition, disrupt continuity of care, and potentially deprive the public of access to medical care.” While openly laying out these detrimental impacts non-compete agreements have on the physician-patient relationship, the AMA still does not “state that non-compete agreements are per se unethical, but instead concludes that they are unethical if they ‘fail to make reasonable accommodation to patients’ choice of physician.’ It seems counterintuitive of the AMA and its “judicial arm,” the Council on Ethical Judicial Affairs (CEJA), to ‘disfavor’ non-compete agreements, while simultaneously “recogniz[ing] the consensual, highly personal, and confidential nature of

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282 Id. at 500.
283 Id.
284 Id. (It should be noted that Dwyer v. Jung in June of 1975, an appeal was granted and the case was remanded back to the Superior Court.).
285 Loeser, supra note 33, at 286.
287 Horton, supra note 38, at 13.
288 Id.
289 Loeser, supra note 33, at 286.
the doctor-patient relationship,”290 which is exactly what makes such non-compete agreements in attorney employment contracts void.

In Judicial Enforcement Of Covenants Not to Compete Between Physicians: Protecting Doctors’ Interests At Patients’ Expense, Paula Berg delves deeper into the history of the AMA and its relationship with non-compete agreements.291 Berg explains that the AMA had, for a long period of time, “taken the position that non-competition agreements between physicians impact negatively on patient care.”292 It was in 1933 that, “the AMA’s House of Delegates approved a Judicial Council resolution [that] declared the contractual provisions that interfered with reasonable competition among physicians or prevented the ‘free choice of a physician’ were unethical.”293 This resolution remained in place for 30 years, and it was not until “1960 [that] the AMA’s Judicial Council published an opinion that retreated from the 1933 resolution.”294 This new take on physicians and covenants not to compete “stated that there were no ethical prescription[s] against a ‘reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made and understood.’”295

Then, in 1971, the Indiana Delegation of the AMA’s House of Delegates “introduced a resolution that unequivocally declared that restrictive covenants were unethical.”296 This resolution was ultimately rejected and, in its place, the delegation “adopted a substitute resolution that echoed the ambivalent position of the 1960

290 Id.
292 Id.
293 Id. at 6-7.
294 Id. at 7.
295 Id. (“This opinion, however, cautioned that it was still debatable whether such agreements are advisable as being in the best interests of the public.”).
296 Id.
opinion.”297 Only one year after this resolution was rejected, “the Judicial Council reported its findings and recommended banning restrictive covenants in all but exceptional circumstances.”298 After this recommendation, however, the AMA “rejected an outright ban on restrictive covenants and the matter was referred to the Judicial Council for further study.”299 Then, in 1977, a new version of the Judicial Council’s Opinions and Reports was published.300

The AMA’s hesitancy to restrict these non-compete agreements in physician employment contracts is believed to stem from the AMA’s previous interactions with the Federal Trade Commission (FTC).301 The 1977 revision was made after the FTC filed a complaint in 1975, stating that “[some] of the AMA’s ethical prohibitions violated Section 5 of the Federal Trade Commission Act.”302 Thus, the AMA had been viewed as previously using its code of ethics to manipulate the medical profession.303 This manipulation involved “discouraging behavior that emphasized commercialized competition in medicine.”304 It wasn’t until 1980 that “the AMA House of Delegates adopted an opinion of the Judicial Council that declared that noncompetition agreements were not ‘in the public interest.’”305 Despite this minute condemnation, the AMA has yet to deem non-compete agreements in physician employment contracts as unethical.306

297 Id.
298 Id.
299 Id.
300 Id.
301 Steinbuch, supra note 37, at 1069 (“In the 1970s, the FTC severely curtailed the AMA’s use of its ethical code to control its members because the AMA had been using the code achieve anticompetitive ends inconsistent with the public interest.”).
302 Berg, supra note 40 at 8.
303 Steinbuch, supra note 37, at 1069.
304 Id. at 1071 (“Because federal authorities largely looked at the practice of organized medicine as local in character with a federal structure, organized medicine largely escaped antitrust scrutiny until the 1970s.”).
305 Berg, supra note 40 at 9.
306 Id. (“The Council was reluctant to adopt an outright ban on restrictive covenants because of the FTC’s final order in In re American Medical Ass’n . . . [which] compelled the AMA to cease and desist from
Meanwhile, courts are known to rule against non-compete agreements when such an agreement will seemingly hurt the public interest.\textsuperscript{307} When courts analyze the public interest, they typically take a forest analysis over a tree analysis; meaning courts look at the public at large, rather than each individual patient.\textsuperscript{308} When non-competes are upheld by courts, it is usually because the courts find “the employer has a rational interest in preventing the employee from appropriating the customer base and using the contacts the employee doctor developed during her employment.”\textsuperscript{309}

By allowing non-compete agreements to remain in physician employment contracts, however, the AMA “prevents many doctors from competing with practices with which they were previously affiliated.” This results in “doctors [being] forced to remain with existing practices longer than they otherwise would, and, when they depart, they often must leave the geographic location.”\textsuperscript{310} In other words, it is acting as a restraint of trade, and in doing so, the AMA is demonstrating its preference for trade over the unique physician relationship.\textsuperscript{311} One example of a case in which a physician made this very argument is \textit{Community Hospital Group Inc. v. More}.\textsuperscript{312}

In \textit{Community Hospital Group Inc. v. More}, Dr. Jay More, a neurosurgeon, was employed by Community Hospital Group, and had a non-compete agreement in his declaring certain contractual practices among physicians to be unethical. The Council believed that a declaration that noncompetition agreements were unethical might run afoul of the FTC decision”).\textsuperscript{307} Id. (“Courts have struck non-competes in contexts where the community needs the physician. This question depends on whether there are sufficient practitioners in the area.”).

\textsuperscript{308} Id.
\textsuperscript{309} Id.
\textsuperscript{310} Steinbuch, \textit{supra} note 37, at 1054 (“As a consequence of the AMA’s failure to prohibit this rational but predatory behavior by existing medical practices, the AMA reinforces the oligopolistic status quo. This reduces both compensation and access for patients.”).
\textsuperscript{311} Id. at 1053.
employment contract. It was later discovered, after Dr. More gave his notice of resignation that became effective on July 17, 2002, that there was a discrepancy among the non-competes contained in the employment contract. The hospital argued that the one-year referenced in the 1995 and 1999 agreements was a typographical error, while Dr. More contended that the two employment agreements were not for a period of two years. The court, however, “note[d] that all three agreements contained additional restraints for periods of two years on any attempts by defendant to acquire plaintiff’s patients, referrals, or staff for his subsequent practice.”

During his time working for Community Hospital, Dr. More’s “practice grew from no patient surgeries to between thirty-five to forty surgeries.” It was noted that after his employment at Community Hospital, “the number of surgeries he performed increased annually . . . at least until September 11, 2001.” In May 2002, Dr. More discussed possible employment with Neurosurgical Associates at Park Avenue (NAPA). He was employed by NAPA on July 22, 2002. Additionally, he obtained privileges at Somerset Medical Center (SMC).

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313 Id. (“Plaintiff hired defendant as a neurosurgeon immediately upon the completion of his residency at Mt. Sinai Hospital in New York. Defendant did not bring with him to this position any practice or patient base . . . Each of the three employment agreements [that transpired between the two parties] contained post-employment restrictive covenants which prohibited defendant from certain medical practice within a thirty-mile radius of plaintiff [hospital].”).
314 Id. at 91.
315 Id. (The 1994 agreement stated that the duration of the restrictions respecting new employment was for ‘two (2) years’ after termination. The 1995 and 1999 agreements stated that the duration of the restriction was for a period of one (2) years [sic].”).
316 Id.
317 Id.
318 Id. at 92.
319 Id.
320 Id. at 93 (NAPA is “located approximately five miles from plaintiff.”).
321 Id.
322 Id. (SMC is “a 355 bed medical center in Somerville, which is located within the thirty-mile radius. SMC provides a variety of emergency, medical/surgical and rehabilitative services in the central New Jersey area. Affiliated with the University of Medicine and Dentistry of New Jersey, SMC serves as a
Community Hospital brought suit claiming that the non-compete was reasonable as Community Hospital, “serves patients residing in or received from a referral base located throughout the thirty-mile area.”\textsuperscript{323} Community Hospital argued that there were other hospitals that were outside of the thirty-mile radius that had neurosurgical patients, and therefore a need for a neurosurgeon.\textsuperscript{324}

While the trial and appeal predominantly dealt with the issue of whether a preliminary injunction should have been granted, what is noteworthy about this case is the discussion pertaining to the issue of reasonable/unreasonable geographic scope. Dr. More argued that:

he resides in Scotch Plains, with his wife and three children and, with the exception of times he resided in other areas in connection with, for example, his education and medical training, he has lived in Union County all his life, as has his wife. His children attend public schools there and participate in soccer, baseball and hockey leagues, Cub Scouts, and summer day camp. He and his wife actively participate in and volunteer for scouting, athletics and community center activities. He has numerous family members and childhood friends residing in Union and Middlesex Counties and he feels it would be [extremely] disruptive, on a personal level, for both him and his family if they were forced to relocate their residence.\textsuperscript{325}

\textsuperscript{323} Id.
\textsuperscript{324} Id.
\textsuperscript{325} Id. at 103.
Despite the upheaval that resulted from the non-compete in Dr. More’s employment contracts with Community Hospital, the court was not persuaded by his argument.\footnote{Id.} Specifically, the court held that, “’personal hardship, without more,’ will not constitute undue hardship thereby preventing enforcement of the covenant.”\footnote{Id. at 104.} What the court failed to appreciate, and perhaps Dr. More failed to argue, is that the patients he came to care for were also being ‘punished’ by the thirty-mile radius restriction.

Stemming off of that is the problem that patients “are [being] forced into existing practices and are not offered the opportunity, when [their] doctors leave their employing practices, to stay with [the] doctors with whom they have developed relationships.”\footnote{Steinbuch, supra note 37, at 1055.} The physician-patient relationship is a deeply intimate and personal. It takes certain patients time to develop comfort in the personal issues that may need to be addressed. To have such a relationship be interrupted by a third party (ie. the employer) seems unnecessarily cruel and potentially hazardous for a client during a delicate time.

In the event a patient is unable to travel to his or her previous physician’s new location, not only has the patient’s top choice for provider care been taken away, but such an intrusion into this private relationship causes the additional hardship for the patient in the form of having to start from scratch in finding a new physician that they are comfortable visiting for treatment and that participates with said insurance provider.
VIII. The Significance of Continuity of Care

One of the main reasons the court in *Murfreesboro* held the non-compete in Dr. Udom’s employment contract void was because it disrupted the continuity of patient care. Continuity of patient care has been shown to be a vital factor in patients receiving quality care. Continuity of care is so important a factor in patient care that the CEJA has gone so far as to emphasize its relevance, stating that,

The patient has a right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. [Additionally] the physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

The gravity of continuity of patient care has also been demonstrated in numerous studies. In a study done by the University of Michigan Health System, researchers examined the impact continuity of care has on patient outcomes. Researchers utilized “articles limited to the English language and human subjects, published from January 1, 1966, to January 1, 2002, using Medline, the Educational Resources Information Center

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329 Id. at 683-84.
330 Cabana, *supra* note 100, at 979 (Dec. 2004) (“Based on our study criteria, our analysis suggests an association between SCOC and patient satisfaction, as well as improved process of care and patient outcomes.”).
331 Loeser, *supra* note 33, at 286-87 (Additionally, the CEJA went on to stress that, “The practice of medicine and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative care of patients and alleviate suffering. The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self interest and above obligations to other groups, and to advocate for their patients’ welfare.”).
332 Id.
The researchers looked at “(1) the process of care; (2) the outcome; (3) satisfaction; and (4) cost of care.”

Additionally, the studies utilized by these researchers were required to “(1) measure the SCOC at the provider level; (2) determine SCOC over a time frame longer than one visit; (3) be applied consistently to all patients; and (4) account for the possibility of more than one provider during the observed time period.” The researchers came across “5,087 candidate titles in [their] original search. [They] excluded 4,891 titles after examination of the bibliographical citation, which left 196 articles.”

In regard to the four previously mentioned areas these researchers were looking at, the researchers found no studies that demonstrated a link between SCOC and poor quality of care. Looking at cost, the researchers found “two cross-sectional studies that examined factors associated with cost of care.” They found “a consistent association between SCOC and patient satisfaction, based on the results of 4 studies.” Overall, the researchers found that “increased SCOC [did] not have any negative effects on quality of care . . . in many cases, increased SCOC heighten[ed] patient satisfaction, decrease[d]...

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333 Id. at 975 (The researchers also “excluded articles in which a significant percentage of providers were physicians in training.” The focus was on “sustained continuity of care (SCOC) in the outpatient setting.” They also excluded “articles that analyzed inpatient or chronic care facility settings, or transitions to or from an outpatient setting.”).
334 Id. at 976 (“Process of care refers to differences in the receipt of care by patients. Outcome is any change in the health status of the patient. Satisfaction is an individual’s emotional or cognitive evaluation of the structure, process, or outcome of health care. Cost of care encompasses direct and indirect costs to patient, payer, and society.”).
335 Id.
336 Id. at 977 (“After examining the full text of these remaining articles, 18 fulfilled [their] criteria.”).
337 Id.
338 Id.
339 Id. (“Three cross-sectional studies in different settings found a positive association between increased SCOC and patient satisfaction. However, all 3 studies used subjective methods to determine SCOC. One study that used quantitative methods to measure SCOC did not find a statistically significant association with patient satisfaction.”).
hospitalizations and emergency department visits, and improve[d] receipt of preventative services.”

In regard to patients who suffered from chronic conditions, the researchers found that “the association between SCOC and quality of care appear[ed] to be most consistent.” The reason behind this consistency was believed to be due to:

improved care [evolving] throughout the course of a long-term relationship. The time frame for most studies in [this] analysis was limited, with the longest being only 2 years. It is possible that the benefits of SCOC do not become manifest until a much longer time period or after many visits with the same primary care provider.

This study is only one example demonstrating the link between quality patient care and continuity of patient care.

In a second study, a group of 3,918 Norwegian patients were asked by researchers to complete a questionnaire about how satisfied the patients were with their physicians’ consultations. In regard to measuring the continuity of care, “[it] was recorded on two dimensions. Longitudinal care was noted as the duration of the relationship (time since first encounter with this specific doctor) and intensity (the number of encounters with the doctor during the previous 12 months).” Patients were asked to respond to 10 questions

\[340\] Id. at 978.
\[341\] Id.
\[342\] Id.
\[343\] Per Hjortdahl & Even Laerum, Continuity of Care in General Practice: Effect on Patient Satisfaction, BMJ Vol. 34: 1287, 1287 (May 1992) available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1881840/pdf/bmj00073-0037.pdf (“Each questionnaire and doctor’s recording were given similar numbers, and basic information about the non-responders could be obtained from the doctors’ recordings. The participating physicians were not informed about either the content of the envelope they gave to the patients or the nature of the questionnaire.”).
\[344\] Id. at 1287-88 (“In Norway, where patients are free to change primary care physicians at will, the relationship that may develop is generally unspoken and frequently unconscious. ‘Continuity of care’ is an expression not well understood by the layman. During the pilot phase of the project it was found that the common phrase ‘having a personal doctor’ best captured the qualitative dimension of continuity of care.
pertaining to their satisfaction with consultations.\textsuperscript{345} Possible responses included: very great, great, fair, somewhat, slight, and no satisfaction, as well as a separate category of uncertain.\textsuperscript{346} There were a total of “133 participating physicians [who] recorded 3,918 out of a possible 3,990 consultations.”\textsuperscript{347}

A total of 1,652 patients (54\%) put down that their treating physician was their regular physician; 1,032 (34\%) patients put down that their physician took care of some of their needs; finally, 357 patients (12\%) felt they had no relationship with their physician.\textsuperscript{348} Researchers found that “an overall personal patient-doctor relationship increased the odds of the patient being satisfied with the consultation sevenfold as compared with consultations where no such relationships existed.”\textsuperscript{349} The researchers also found no “significant relation between the doctor’s availability, as measured by hours of curative practice a week, and patient satisfaction with the consultation.”\textsuperscript{350} These researchers concluded that, “continuity of care and satisfaction are bidirectionally

\textsuperscript{345} Id.
\textsuperscript{346} Id. at 1288.
\textsuperscript{347} Id. (“In all, 3,044 (78\%) of the questionnaires were returned. No significant differences were observed in age, sex, or morbidity pattern between responders and non-responders. There was, however, a higher proportion of new patients among the non-responders (15\% v. 9\%, \textit{p}<0·004). The mean age of respondents was 39 (range 0-98) years and among participating physicians 38 (30-70) years. The doctors had been in general practice in the same geographical area for an average of seven (0-40) years. They did a mean of 27 (12-45) hours of clinical work a week.”).
\textsuperscript{348} Id. (“A total of 241 (8\%) of the patients met a new doctor, while 1,032 (34\%) had known him or her more than five years. Slightly less than half (1462; 48\%) of the patients had three or fewer consultations, while 352 (12\%) had 11 or more with the present doctor during the previous 12 months.”).
\textsuperscript{349} Id.
\textsuperscript{350} Id. (“A doctor spending 40 hours a week at the office with curative work had an 82\% increased chance of having patients satisfied with the consultation as compared with the consultation as compared with a doctor working only 20 curative hours a week. There was a trend, though not significant, for patients to be less satisfied with unscheduled and emergency appointments as compared with those scheduled, and to be more satisfied with consultations arising from chronic problems than those arising from new ones.”).
related.” Aside from continuity being linked to patient satisfaction, patient satisfaction, in turn, “predicts what patients will do next time they need health services.”

In a third study, a different set of researchers discovered that continuity of patient care resulted in patients having more trust in their physicians. Researchers hypothesized that continuity of care resulted in an “increased knowledge and trust [that] may make it easier for the physician to manage medical problems in the office or over the phone, thereby avoiding hospitalization or emergency department visits.”

The study went on to explain that in the United Kingdom, “the ability to choose a personal physician has been more limited [than it is in the United States].” Despite a lack of choice in choosing a practitioner, patients in the UK surprisingly do not have a high rate of continuity. Researchers explain that, “although patients are registered with a named GP, the way it works in most practices is that the patient mostly sees the GP in the practice who is available.” This setup is in stark contrast to the one in the United States, where “the patient has a better ability to choose and change doctors, and there is competition for patients.” Thus, researchers compared the setup in the UK to that of

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351 Id. at 1289.
352 Id. (These researchers believe that, “if patient satisfaction is accepted as an integral part of quality health care, reinforcing personal care may be one way of increasing this quality.”).
353 Denis Pereira Gray, et al., Continuity of Care and Trust in One’s Physician: Evidence from Primary Care in the United States and the United Kingdom, 33 FAMILY MED. 22, 27 (2001).
354 Id.
355 Id. at 23 (“In the UK, the patient registers with a general practitioner (GP). Registration is a form of contract, which means the GPs are paid for having the patient registered with them. The patient can choose with whom to register, but, in practice, the degree of choice is often limited. Thus, within a practice of six doctors, four may have as many patients as they can handle, and only two doctors will be taking on new patients. Also, there is no real competition among GPs, and, therefore, changing among GPs is rare.”).
356 Id.
357 Id. (“However, some GPs arrange their practices according to ‘personal lists,’ a system that attempts to steer patients to the physician to whom they are assigned.”).
358 Id.
the one in the US in order to analyze the relationship between continuity of care and trust in one’s doctor.\textsuperscript{359}

Researchers questioned patients eighteen years of age and older that visited several different ambulatory practices.\textsuperscript{360} The patients were provided with a two-part questionnaire, which contained questions that had to be completed prior to their appointment.\textsuperscript{361} Additionally, there were a few questions that had to be answered after the patients’ visits with their respective physicians.\textsuperscript{362} All of the questionnaires were anonymous.\textsuperscript{363}

In regard to source of care, patients “were asked whether they had a usual source of care prior to the diagnosis for which they were seeing the physician on the day of the survey.”\textsuperscript{364} In regard to continuity of care, patients were asked “if the doctor the patients were seeing [ ] was the doctor they usually [saw].”\textsuperscript{365} Another way researchers analyzed each patients’ view on continuity of care “was [to look at the] concentration of care with a single provider, calculated as a ratio of visits to the usual provider divided by the total number of visits to all providers in a defined period of time.”\textsuperscript{366}

\textsuperscript{359} Id.
\textsuperscript{360} Id. (“The participating practices were a family residency and a faculty practice 17 miles apart in Charleston, SC, a family practice in Lexington, KY, three general practices (one solo, two group) in Leicester, UK, and a general practice center in Exeter, UK.”).
\textsuperscript{361} Id.
\textsuperscript{362} Id.
\textsuperscript{363} Id.
\textsuperscript{364} Id. (“The questions included, ‘Is there one particular place that you go if you are sick or need advice about your health?’ and ‘Is there a regular doctor you usually see at this place?’”).
\textsuperscript{365} Id.
\textsuperscript{366} Id. (“The proportion of encounters to the regular doctor represented an indicator of continuity of care. This proportion [was] termed the usual provider continuity (UPC). The respondents . . . were asked to report all the encounters they had with the health care system in the past year (ambulatory visits, emergency department visits, hospital outpatient, hospital admissions, home visits) and how many were to their regular doctor, and [the researchers] calculated the UPC.”).
also analyzed continuity of care by studying “the longitudinality of the relationship with the regular provider.”\footnote{367}

Researchers also asked participating patients “how important it was to them that they see the same doctor every time they have a health problem.”\footnote{368} Finally, they measured the trust patients had in their physicians by using the “Trust Physician Scale.”\footnote{369} This scale “consist\[ed\] of 11 Likert-type items.”\footnote{370} The researchers explained that this scale was used to “demonstrate reliability and validity and is distinct from patient satisfaction with the physician.”\footnote{371}

Ultimately, researchers found that patients with continuity of care did have more trust in their treating physicians.\footnote{372} They believe this is important because “there is widespread agreement that trust between a patient and physician is important for high-quality health care.”\footnote{373}

It is easy to surmise from the aforementioned studies then that a lack of continuity in patient care can have dire consequences.\footnote{374} Such negative results stemming from discontinuity of care include “increased cost of care, decreased quality of care, and decreased patient satisfaction.”\footnote{375} If the AMA wants to provide patients with the best possible medical care it would behoove the AMA to remodel its guidelines after a model such as the ABA.

\footnote{367} \textit{Id.} (“The respondents were asked to assess the length of time of the relationship with the regular provider.”).

\footnote{368} \textit{Id.} (“The variable was scored on a 5-point Likert scale (1=not important at all, 5=very important.”).

\footnote{369} \textit{Id.}

\footnote{370} \textit{Id.}

\footnote{371} \textit{Id.} (“The scale is scored from 11 to 55; a higher score indicates greater trust in the regular doctor. Only individuals who completed all of the items in the trust scale had a score computed.”).

\footnote{372} \textit{Id.} at 27.

\footnote{373} \textit{Id.}

\footnote{374} Loeser, \textit{supra} note 33, at 287.

\footnote{375} \textit{Id.}
IX. Non-compete Agreements Protecting the Financial Interests of Employers

While physician-patient relationships are precariously balanced due to non-compete agreements, the employers who implement such provisions in these contracts only benefit from them.376 As previously mentioned, physicians are supposed to put their patients’ interests ahead of their own, however, non-compete agreements prevent physicians from doing so.377 Simultaneously, while physicians are struggling to provide adequate care and protection for their patients, their employers are enjoying the fullest protection possible towards their individual financial interests.378

This is extremely dangerous because, “in the medical context overzealousness in this pursuit raises ethical concerns that generally are not present, or at least not present to the same extent, in other fields.”379 In the business world, which many argue non-compete agreements should be limited to, customers’ health is not put at risk when a non-compete agreement is implemented.380 The same, however, cannot be said for non-compete provisions in physician employment contracts.381

In a survey entitled, “A National Survey of Board-Certified Emergency Physicians: Quality of Care and Practice Structure Issues,” “a list of 10,500 diplomates of the American Board of Emergency Medicine (ABEM) was obtained . . . 10% (1,050)

376 Id.
377 Id.
378 Id. (“[P]hysician noncompetition clauses potentially undermine [physicians protecting their clients] in large part, if not entirely, to protect the financial interests of employers.”).
379 Id.
380 Id. (“An anticompetitive practice, such as a noncompetition clause, may harm customers of a business financially, but it is the rare case that the actual health of the customer will be affected by the practice. This may not be the case in medicine. Thus, one may question the propriety of weighing employers’ financial interests over ‘customers’ interests in continuing to be treated by the departing physicians.’”).
were randomly selected] for the survey.” There were a total of three (3) mailings to the randomly selected participants with “the first mailing [] July, 1995. [The] second (October 1995) and third (January 1996).” There were 29 closed-ended questions, five of which were about “respondent background information and current employment status, 2 related to financial issues, 11 to society policies, 9 to practice structure and experience, and 2 to quality of care.”

In regard to the financial questions, “75% of respondents [] felt financially exploited, at some point in their career, by the holder of the emergency department contract.” Additionally, “ten percent felt financially exploited as hospital employees and 8% by democratic partnerships.” While the survey does not specifically discuss participants blaming non-compete provisions for their antagonistic feelings towards finances and their employers, the survey does mention “unfair business practices,” which may easily include non-compete provisions.

While it is easy to understand why employers, in general, seek to have non-competition agreements in employment contracts, it does not seem as though having such restrictions in physician employment contracts, in the medical profession, coincides well with public policy.

383 Id. (“All responses received between July 1, 1995 and June 28, 1996 were included in the study.”).
384 Id.
385 Id. at 2 (“The vast majority (75%) of emergency physicians have at one point felt financially exploited by the owner of the emergency department contract, most commonly those owned by sole proprietors and multihospital contract companies. Considering nearly half of our respondents have considered leaving their employer because of unfair business practices . . . ”).
386 Id.
387 Id.
X. Conclusion

In conclusion, it would behoove the AMA to model its guidelines pertaining to non-compete agreements after the guidelines implemented by the ABA. Physicians and patients both unnecessarily suffer from these restrictions that seemingly go against public policy. Because of the similarities between the legal and medical professions regarding public policy concerns, “it [is] difficult not to question the differing approaches.” Physicians suffer from non-competes in that they are forced out of the area in which they have patients who seek their services and risk losing such patients due to geographical location of their new place of employment. The physicians are also afforded lesser protection than their employers, already well-established practice. Patients suffer in that they may lose their physician whom they have developed a relationship with, as well as experience a disruption in continuity of care. Thus, “having a greater number of physicians practicing in a community benefits the public by providing greater access to health care” as well as “improv[ing] quality of care and keep[ing] costs affordable. The same is essentially true for the practice of law.”

The fact that the AMA ‘frowns upon’ such provisions, but does not go the distance to limit their implementation is not enough to prevent non-compete agreements in physician employment contracts from being contrary to public policy. The reasoning behind allowing an attorney greater leeway in employment because the attorney-client relationship has been deemed too important to allow a non-compete to interfere with that

389 Alina Klimkina, Are Noncompete Contracts Between Physicians Bad Medicine? Advocating in the Affirmative by Drawing a Public Policy Parallel to the Legal Profession, 98 K.Y. L. J. 131, 149 (2009-2010) (“A greater number of attorneys concentrated in an area means that representation is readily available; a greater number of attorneys in the same region results in a greater variety of available services.”).
relationship, while simultaneously allowing that interference to exist in the medical profession between a physician and a patient is a flawed reasoning. Meddling with patients’ free-will in who they decide to obtain medical care from blatantly goes against public policy.\textsuperscript{390}

To assume that all physicians were created equally is a misconception of the greatest proportions. Obstacles such as non-compete agreements in physician employment contracts need to cease interfering with the physician-patient relationship. Thus, unfortunately, until revisions are made to the AMA’s non-compete guidelines, such interferences will continue to take place and impede the practice of medicine:

Aside from caring for the sick, every physician takes on a greater responsibility, one which may force him or her to ‘treat with care in matters of life and death’ and stand by the loved ones of those who are dying. Those who choose to enter [the medical] profession take on ‘special obligations to all . . . fellow human beings, those sound of mind and body as well as the inform’ [which makes such] restrictions on the practice of those who willingly make this promise to every member of our society contrary to public policy, but to the covenant made by every physician in this country.\textsuperscript{391}

\textsuperscript{390} Id. at 151 ("'Prevent[ing] competitive use, for a time, of information or relationships which pertain peculiarly to the employer and which the employee acquired in the course of the employment' should not be a concern given weighty consideration in light of the patients’ interests at stake. Despite the freedom to contract, contracts among physicians affect the public to a much greater extent than contracts which deal with an ordinary employer-employee relationship.").

\textsuperscript{391} Id. at 153.