Restrictive covenants—unnecessary harm

Minnesota needs to ban noncompetes in physician employment agreements.

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As Minnesota’s largest health care organizations become ever more dominant in both rural and urban parts of the state, restrictive covenants (noncompetes)* in physician employment agreements become increasingly punitive to doctors and the patients they serve.

The American Medical Association, in its recently adopted “AMA Principles for Physician Employment”† correctly asserts that a “physician’s paramount responsibility is to his or her patients” and discourages physicians from entering into restrictive covenants that would keep patients from seeing their physicians upon termination of employment. Discouragement, however, is not enough.† Common sense dictates that there can be no justifiable reason for restrictive covenants that deny patients access to “their” physicians or deny physicians the right to practice where they want and for whom they want. In the interest of the doctor-patient relationship, restrictive covenants in physician employment agreements in Minnesota should be banned. In doing so, Minnesota would follow states such as North Dakota, Hawaii and Massachusetts that correctly found that the public interest outweighed any potential harm to private interests when restrictive covenants for physicians were banned.§

Restrictive covenants in Minnesota—the status quo

The majority of health care institutions and physician groups in Minnesota impose noncompetes on their employed physicians. By doing so, they seek to keep physicians from continuing to practice in a geographic area** because of the alleged economic harm that the employer might incur if the physician were to “compete” with it. These restrictive covenants a) define the geographic boundary that the physician cannot practice in, b) state a time (at least a year) during which the prohibition applies and c) state the scope of competitive activities the physician cannot engage in. Some restrictive covenants contain a buyout clause (liquidated damages) that waives the restrictive covenant, but at a very hefty price.

Courts in Minnesota and elsewhere have adopted a rule-of-reason analysis in determining the issue of the enforceability of noncompetes. This analysis generally seeks to answer the following questions:

• Is the restriction reasonably necessary for the protection of the employer’s business?
• Is the restriction unreasonably restrictive of the employee’s rights?
• Is the restriction prejudicial to the public interest?

* Although the terms “restrictive covenant” and “noncompete” are used interchangeably, from a public policy perspective, it is probably better to focus on the issue of competition and the rhetorical questions of how one physician can really be a threat from a competitive perspective and, even if he or she were, what that means in the context of whether the proper focus should be on patient freedom of choice.

† In the AMA’s November 13, 2012, press release, an AMA board member is quoted as saying that “[t]he guidelines reinforce that patients’ welfare must take priority in any situation where the interests of physicians and employers conflict.” However by continuing its longstanding policy of not taking a hard-line stance on the issue of restrictive covenants, the AMA’s equivocation undermines the basic premise of responsibility to patients upon which the principles are based.

‡ North Dakota and Hawaii ban restrictive covenants as restraints of trade regardless of profession, while the Massachusetts statute is specific to physicians.

§ Examples of geographic restrictions in Minnesota include being prohibited from practicing in the seven-county metro area (2,972 square miles) or practicing within x miles of any of the employer’s clinics or hospitals.
It is this last part of the analysis that has long been the reason why lawyers cannot be bound to noncompetes. And this is the reason why physicians should be treated no differently.

Physicians and lawyers should be treated the same

In an insightful law review article “Physician Restrictive Covenants: The Neglect of Incumbent Patient Interests,” Professor S. Elizabeth Wilborn Malloy notes that it is the third prong of the rule-of-reason analysis that the courts have often neglected and that it is at the patient level that the traditional analysis over the reasonableness of noncompetes generally comes up short. Professor Malloy’s analysis is as follows:

Applying the rule-of-reason test, courts have only rarely invalidated physician restrictive covenants solely out of concern for the public welfare. This approach does not respect the unique role a physician can play in the community. Some factors courts have downplayed or ignored are the physician’s ability to provide optimal care and the patient’s ability to choose their physician freely. Surprisingly, nearly identical considerations have been applied by most courts to limit or completely bar the enforceability of attorney restrictive covenants. This strangely disparate treatment of two professional groups exists despite the fact that the physician-patient relationship is at least as important from a public policy standpoint as that of attorney and client.

(Emphasis added – Id at 192-193.)

As noted by Professor Malloy, the disconnect between prohibiting restrictive covenants for attorneys while allowing them for physicians is profound. Surely, by any measure, interference in the physician-patient relationship is as prejudicial to the public interest as interference with the attorney-client relationship.

In 2005, the Tennessee Supreme Court addressed the issue of the double standard head on in Murfreesboro Medical Clinic, P.A. v. Udom, 166 S.W.3d 674 (TN, 2005). The Court noted:

In analyzing this issue, 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 the patient or client that goes well beyond merely providing goods or services. These relationships are “consensual, highly fiduciary and peculiarly dependent on the patient's or client's trust and confidence in the physician consulted or attorney retained.”

Karlin, 77 N.J. 408, 390 A.2d 1161, 1171 (Smith J, dissenting). In both contexts, restrictive covenants have a destructive impact on those relationships. The rules governing other businesses and trades are not relevant to either the legal or medical profession, as both often require the disclosure of private and confidential information such as, in the context of physician and patient, personal medical or family history. We agree with the dissent of Justice Smith in Shankman v. Coastal Psychiatric Assoc., 258 Ga. 294, 368 S.E.2d 753 (1988) in which he stated:

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 of confidence and the patient (client) does not wish to have that relationship involuntarily terminated. 368 S.E.2d at 754 (Smith J, dissenting).

The right of a person to choose the physician that he or she believes is best able to provide treatment is so fundamental that we can not allow it to be denied because of an employer’s restrictive covenant. (Murfreesboro Medical Clinic, P.A. v. Udom, 166 S.W.3d 674, 683 (TN, 2005)

The Court in its opinion held that covenants not to compete were unenforceable against physicians except for restrictions specifically provided for by statute as enacted by the Tennessee Legislature.††

Do no harm—really?

A restrictive covenant by its very nature punishes patients who depend on “their” physician and is antithetical to the ethical precept of “do no harm.” The reality is that restrictive covenants hurt every citizen in Minnesota. In other words, they hurt every patient. By restricting the power of the person trying to keep patients alive and healthy—their physician—many health care organizations in Minnesota are restricting patient choice for economic gain rather than continuity of care. Even assuming the worst-case scenario, in which an employed doctor leaves and sets up her practice across the street from her employer and her patients want to follow her, the greater harm from an ethical perspective must always be to deny those patients the right to continue with their physician based on a noncompete that is only designed to protect economic interests.

In addition to harm caused to patients, restrictive covenants harm the affected physicians, their families and their communities. This harm is especially great in rural Minnesota, where often restrictive covenants prohibit a physician from working within miles of any clinic or facility affiliated with the organization that employs them. For some organizations, that can be more than a third of the state. And in some cases, that can be surrounding states as well. The physician who wants to leave, for whatever reason, would likely have to move and leave his or her patients. If the patients were lucky, they would get a letter announcing that Dr. Smith has sought

†† Two years after the Tennessee Supreme Court’s ruling, the Tennessee Legislature effectively overturned the decision and now allows for noncompetes in a variety of circumstances, except for doctors who practice emergency medicine or radiology.
new opportunities without a forwarding address and contact information. If they were unlucky, there would be no letter and they would find out, to their surprise and consternation, that Dr. Smith was gone when they came in for or made their next appointment. The physician also would be forced to uproot her or his spouse and family to continue to practice and would have to leave behind the other roles in the community he or she played, for example serving on the school board or being active in service projects. In many cases, the physician’s spouse is also a physician, who would then also have to leave behind patients and other commitments.

Restrictive covenants harm competition.‡‡ In the age of health care reform, it makes no sense to hinder the small degree of competition that may be created by freeing physicians from noncompetes. Competition keeps organizations a little more honest. In rural areas, if there is only one option available for care, the price for that care will not be negotiable. It is best for the patient to be able to shop around. It is best for everyone if large health care organizations have to worry about their pricing and compete to keep their patients and employees happy.

In small towns where there is no competition, large organizations can limit access to care and charge as they wish for it. The patient may be charged excessively for a service that would cost less if another clinic could open up down the street. When there is only one health care organization available to provide care, that care does not have to be good, affordable or even friendly.

**Imposed conflict of interest**
The interests of physicians and their patients should never be in conflict. Yet restrictive covenants, by their very nature, create such a conflict since they may cause physicians to fear, whether unfounded or not, that if they advocate too strongly for patients and ruffle too many feathers, they will not only lose their job but also suffer even greater losses. A recent New York Times article on the bind physicians are placed in when they become employees of large organizations noted that “[d]octors at numerous hospitals said it was often difficult to criticize the policies instituted by hospitals or investor-owned physician groups because, as employees, they could easily be fired. “We all have families, and we have mortgages,” an emergency room physician was quoted as saying. “If you get fired, it looks bad and it’s hard to get another job.”

Physicians should not have to worry about being forced to move, pay liquidated damages or lose their means of making a living because they advocate for their patients. More importantly, patients should not have to entertain the thought that the care that is being provided or recommended is being influenced by a physician’s financial interest in keeping his or her job.”

**A call for legislative action**
On so many levels, the public interest makes clear the need for Minnesota to prohibit the imposition of restrictive covenants on physicians except in a very few well-defined situations. Common sense and the common good require that no patient should be denied the freedom to continue to see the physician to whom he or she may literally have entrusted their life because that physician no longer works for a particular employer.  

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**REFERENCES**


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‡‡ To restore competition for adult cardiology services, the Federal Trade Commission on November 30, 2012, approved a Consent Decree with Renown Health in Reno, Nevada, that required Renown to waive non-competes in employment agreements with up to 10 cardiologists who were part of group practices that Renown had acquired. This is the first time that the waiver of non-competes was part of health care-related FTC enforcement action (http://www.ftc.gov/opa/2012/12/renownhealth.shtm).

***As noted by the AMA in its Principles for Physician Employment: “Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.” The Association of American Medical Colleges Task Force on Financial Conflicts of Interest in Clinical Care issues a report in 2010 in which it noted: “The presence of individual or institutional financial interests in the patient care setting may create real or perceived bias in clinical decision making and may distort the values of medical professionalism.” Although the AAMC report was focused on relationships between physicians and the pharmaceutical, device and biotechnology industry, one may argue that a financial interest is a financial interest with the attendant conflicts and risks. (https://members.aamc.org/eveupload/in%20the%20Interest%20of%20Patients.pdf.)