RESTRICTIVE COVENANTS

MORE OR LESS ENFORCEABLE: NON-COMPETE PROVISIONS IN PHYSICIANS' EMPLOYMENT CONTRACTS

*By James P. Flynn**

Opinions in the health care industry are split. One segment looks at a growing trend, and likens it to a "disease . . . [l]ike a vicious, malignant cancer" that has "spread to every organ of the medical profession," noting that, if not stopped, this outbreak will soon become an epidemic."[1] Another sees in the same trend a development that has lead to a "positive impact on patient care" and that, without that trend, "younger, inexperienced doctors" will remain untrained and un-mentored.[2] How could they be looking at the same trend?

The fact is that they are each looking at the use of post-employment non-compete provisions in physician employment agreements. Dramatic tensions exist in the medical community over the appropriateness of post-employment restrictive covenant provisions in the employment agreements of physicians. When a member of that community looks at the sizeable investments of time, training and money that developing a young physician or enhancing the reputation of a more experienced practitioner will require from any employer, the medical community—be it a president looking at her hospital, dean looking at his medical school, or family doctor looking at her well-established practice—wants the right to protect itself *through* such covenants. But when other members of that same community—another hospital's chairman of the board bent on establishing a new program, a different medical school seeking a star faculty recruit, or a no-longer-neophyte physician looking to the freedom that she envisions in serving her present patients in "her own" practice—seek the economic enticements of new employment, the opportunity to create new programs, and the desire of patients and referral sources to follow specific doctors (or more frequently the desire of particular physi-

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1. Mike J. Wyatt, *Buy Out Or Get Out: Why Covenants Not To Compete In Surgeon Employment Contracts Are Truly Bad Medicine,*" 45 WASHBURN L.J. 715 (Spring 2006).

2. *Mohanty v. St. John Heart Clinic*, 866 N.E.2d 85, 95 (Ill. 2006).

cians to have patients and referrals follow them), the medical community seems bent on protecting itself *from* such covenants.

Courts throughout the country have wrestled with these competing visions, and this has led to somewhat of a patchwork of results, where such provisions are more or less enforceable depending on where one finds him or herself around the country. This article analyzes the state of the law, with a focus on the leading case of *The Community Hospital Group v. More*, decided by the New Jersey Supreme Court in 2005,[3] and the cases around the country that have addressed similar issues.

A *More* or Less Familiar Fact Pattern

Some background on the *More* case is important because it is a fact pattern not unlike that faced in many restrictive covenant cases involving physicians. The Community Hospital Group, Inc. t/a JFK Medical Center's New Jersey Neuroscience Institute (Institute), a not-for-profit teaching hospital, sought preliminary relief to prevent irreparable harm at the hands of one its former employees, Dr. Jay More (Dr. More), whom the Institute had trained, promoted within the profession as one of its leading neurosurgeons, and paid substantial compensation. As part of the JFK Medical Center, the Institute was founded in 1992 as a not-for-profit medical provider for the diagnosis and treatment of neurological diseases and neurosurgical conditions, services that were previously only available at large university teaching hospitals in major urban areas. Prior to 1992, New Jersey residents were forced to travel to New York or Philadelphia to receive the type of neurosurgical and neurological care that became available at the Institute. Clinical care, research and education form the core mission goals of the Institute.

In exchange for the Institute's investment, in three successive employment agreements, Dr. More promised not to perform surgical procedures within a defined geographic area from the Institute and for a fixed duration post-employment. On July 1, 1994, Dr. More commenced his employment with the Institute directly after completing his residency at Mt. Sinai Medical Center (Mt. Sinai) in New York City. Prior to joining the Institute in 1994, Dr. More did not have a practice or patient base and did not bring any patients with him. Prior to his employment with the Institute, Dr. More did not even have a New Jersey medical license, which was financed by the Institute.

During his employment, by his own sworn admission, Dr. More "'began to develop a patient referral base for the Institute.'"[4] Dr. More also admitted that both he and the Institute had a common goal of "growing the business" – which meant "'increas[ing] the number of patients

3. 183 N.J. 36 (2005).

4. Brief of Plaintiff-Appellant at 12 (*quoting* Dr. More's deposition), *The Community Hospital Group v. More*, No. AM-003861-02T3 (N.J. Super Ct. App. Div. May 9, 2003).

through both the office clinical setting as well as surgeries.'"[5] The Institute funded all of Dr. More's activities in this regard. Dr. More was well aware that by increasing the number of patients through the Institute's patient referral base, "'the more revenue would be generated to accomplish [the Institute's mission] goals.'"[6]

In exchange for his services and efforts, the Institute paid Dr. More a substantial salary and reimbursed him for all his business-related travel and entertainment expenses. Further, Dr. More also specifically admitted that during his employment, he was taught and mentored by the Institute's then-Director, Dr. Rosario Zappulla, and that this fact "certainly" enhanced his professional reputation. Nonetheless, the lower court refused to preliminarily enjoin Dr. More from joining a surgical practice located only five miles from the Institute, reasoning that the undeniable "economic" impact of Dr. More's siphoning of the Institute's patient-referral base and its ongoing patient relationships precluded a finding that the harm is "irreparable." Any significant siphoning of its patient base, such as through improper solicitation of its patient referral sources, would severely impair its ability to meet its core mission goals and threaten the Institute's sustainability.

Astonishingly, Dr. More admitted that between the date of his notice of resignation and his separation date, he created a list of the Institute's patients by name and address from documents he secretly removed from the Institute. Dr. More further admitted that he created a similar list from other documents he pilfered, identifying those physicians and physician groups that referred surgical cases to him while he was at the Institute. The Institute argued that Dr. More's surreptitious removal of patient and patient referral information violated his employment agreement.

Based on these facts, the Institute sought to enforce its agreement, and eventually prevailed on the issues of its enforceability.[7] But it was not easy, as the Federal Court denied a request for preliminary injunction and the intermediate Appellate Court denied leave to appeal.[8] Only after New Jersey's highest court granted such leave, and returned the case to the Appellate Division, did the Institute prevail.[9] The Supreme Court of New Jersey then affirmed, as modified, that result.[10] The modification related to the geographic scope of restriction, and provided that it could not be enforced so as to prevent Dr. More from providing emergency room care in an area claimed to have a shortage of neurosurgeons.[11]

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5. *Id.* at 12-13 (*quoting* Dr. More's deposition).

6. *Id* at 13 (*quoting* Dr. More's deposition).

7. 183 N.J. at 45, 59.

8. *Id.*

9. *Id.*

10. *Id.* at 36.

11. 183 N.J. at 48.

STATES *MORE* FRIENDLY TO SUCH AGREEMENTS

More confirmed that post-employment restrictive covenants involving physicians are enforceable and do not violate New Jersey public policy.[12] In fact, the Court specifically considered and rejected an argument that such agreements should be *per se* unenforceable simply because they apply to a physician.[13]

The *More* Court also rebuffed a challenge to the application of restrictive covenants to physicians on the theory that they were contrary to either law or ethics guidelines governing medical professionals.[14] As the Court noted, even the American Medical Association does not opine that all physician covenants are unenforceable, but states that they are "unethical" only "if they are excessive in geographic scope or duration in the circumstances[.]"[15] Moreover, contrary to arguments made by Dr. More, the Court held that New Jersey law does not limit enforceable restrictive covenants only to those instances where the employer is a doctor. In fact, in determining that post-employment restraints may be enforced against a doctor, the Court never made any mention of the business structure of the former employer seeking to enforce the restrictive covenants. As noted by Dr. Gizzi, the Institute's current Director, physicians practice medicine in a variety of ways – as a sole proprietor, a medical association, faculty groups at teaching hospitals or as direct employees of a hospital. Regardless of the form of the medical practice, *More* provides that restrictive covenants that are reasonable as to time and distance must be enforced.[16]

More re-affirmed the Court's earlier decision in *Karlin v. Weinberg*, where the same Court held that employers of physicians "have a legitimate interest in protecting [their] customer relationships."[17] The employer in *Karlin*, "by virtue of his efforts, expenditures and reputation, has developed a significant practice, and only if the restrictive covenant is given effect can he hope to protect in some measure his legitimate interest in preserving his ongoing relationship with his patients."[18] That a physician may incur some "adverse financial consequences as a result of enforcement of the covenant" cannot be the basis for denying an injunction since "a mere showing of personal hardship does not amount to an 'undue hardship' that would prevent enforcement of the covenant."[19] In-

12. *More*, 183 N.J. at 36; *Karlin v. Weinberg*, 77 N.J. 408, 417 (1978).

13. 183 N.J. at 54.

14. 183 N.J. at 56.

15. *Id.*

16. *See cases recognizing protectible interest of hospitals: Medical Educ. Assistance Corp. v. State ex rel. East Tennessee State University Quillen College of Medicine*, 19 S.W.3d 803 (Tenn.Ct.App. 1999); *Gillespie v. Carbondale and Marion Eye Centers, Ltd.*, 251 IllApp.3d 625, 622 N.E.2d 1267 (Ill.App. 5 Dist. 1993); *Reddy v. Community Health Foundation of Man*, 171 W.Va. 368 (W.Va. 1982).

17. *Karlin v. Weinberg*, 77 N.J. 408, 417 (1978).

18. *Id.*

19. *Id.* at 417, n.3 (internal citations omitted).

deed, "where the breach results from the desire of an employee to end his relationship with his employer rather than from any wrongdoing by the employer, a court should be hesitant to find undue hardship on the employee, he in effect having brought that hardship on himself."[20]

One of the questions under *Karlin* and *More* is whether agreements impose a limitation in any way on a patient's ability to obtain treatment from a particular doctor. The "covenant in the present case does not contain a blanket prohibition requiring the covenantor to end his relationship with his patients."

> While it is true that if the covenant is ultimately found enforceable some patients may have to travel a greater distance to [the doctor's] new office (and conceivably some a shorter distance) than they traveled to his former office, no patient will, by force of law, automatically be deprived of continuing his ongoing relationship with his physician.[21]

If one contends that enforcement of his restraints "would limit the right of potential patients in the [restricted] area to avail themselves of [his] services, it can be argued with at least equal conviction that this would afford countless other people in other areas [ ] the opportunity to have a [neurosurgeon] in their areas."[22] Thus, a patient accessibility argument fails since it would not "outweigh [a state's] law's interest in upholding and protecting freedom to contract and to enforce contractual rights and obligations."[23] Indeed, a covenant is narrowly tailored if patients routinely travel greater distance than the protected area to seek specialized care, such as for neurosurgical treatment.[24]

Many institutions, especially teaching hospitals, rely upon restrictive covenants with their physician-employees to protect their ongoing patient relationships, their patient referral base and their substantial investments in newly licensed physicians. A significant geographic restrictive covenant is necessary to protect the relationships with referral sources that refer patients to receive specialized care such as that provided by an institution since they do not have competency in neurosurgical sub-specialties. These specialists are in fact a pipeline of patients and a primary referral source of patients to such institutions.

Like New Jersey, the majority of states enforce restrictive covenants involving physicians. As noted in cases from many of these jurisdictions, there is nothing particularly unique about physicians that makes cove-

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20. 77 N.J. at 423-24.

21. *Karlin*, 77 N.J. at 417.

22. *Rash v. Toccoa Clinic Med. Assoc.*, 253 Ga. 323, 326, 320 S.E.2d 170, 173-4 (1984).

23. *Id.*

24. *See Keeley v. Cardiovascular Surgical Associates. P.C.,* 236 Ga. App. 26, 510, S.E.2d 880 (1999) (upholding a 75-mile restricted territory for a cardiovascular surgeon based on finding that the employer-practice group "had a substantial patient base and a network of referring patients throughout the 75-mile radius"); *Silvens, Asher, Sher & McLaren v Batchu*, 16 S.W.3d 340, 344 (Mo. 2000) (upholding 75-mile restricted area for neurologist).

nants not to compete involving them more or less enforceable than those involving other types of employees:

> Covenants restricting a professional, and in particular a physician, from competing with a former employer or associate are common and generally acceptable (citations omitted). As with all restrictive covenants, if they are reasonable as to time and area, necessary to protect legitimate interests, not harmful to the public, and not unduly burdensome, they will be enforced (citations omitted).[25]

Absent a statute to the contrary, covenants not to compete covering physicians have generally not been found to be *per se* unenforceable. Rather, the overwhelming majority of state courts have ruled that such covenants are enforceable, if they contain reasonable temporal and geographical limitations.[26] Further, covenants involving physicians have been uniformly enforced on behalf of hospital-employers.[27]

Most courts have rejected arguments that physicians should be treated differently than other types of employees.[28] For example, in *Concord Orthopedics Professional Association v. Forbes*,[29] the New Hampshire Supreme Court specifically held that the traditional test of reasonableness sufficiently protects the public interest, and there was no reason to enunciate a new test applicable to physicians.[30] Similarly, in *Raymundo v. Hammond Clinic Ass'n*,[31] the Indiana Supreme Court noted the lack of "cogent argument or authority as to why a physician's agreement not to compete should be treated differently, as a matter of public policy, than that of

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25. *Gelder Medical Group v. Webber*, 41 N.Y. 680, 683, 363 N.E.2d 573, 576 (1977).

26. *See, e.g., Phoenix Orthopedic Surgeons, Ltd., v. Peairs*, 164 Ariz. 54, 60-61, 790 P.2d 752, 758-59 (1989); *Rash v. Toccoa Clinic Med. Assoc.*, 253 Ga. 323, 320 S.E.2d 170, 173-74 (1984); *Prairie Eye Center, Ltd. v. Butler*, 305 Ill. App. 3d 442, 445-449, 713 N.E.2d 610, 613-616 (1999); *Raymundo v. Hammond Clinic Ass'n*, 449 N.E.2d 276, 279 (Ind. 1983); *Weber v. Tilman*, 259 Kan. 457, 469-475, 913 P.2d 84, 93-96 (1996); *Wilson v. Gamble*, 180 Miss. 499, 510-12, 177 So. 363, 365-66 (1937); *Silvers, Asher, Sher & McLaren, M.D.s Neurology, P.C., v. Batchu*, 16 S.W.3d 340, 345 (Mo. 2000); *Concord Orthopedics Professional Association v. Forbes*, 142 N.H. 440, 442-43, 702 A.2d 1273, 1275 (1997); *Gelder Medical Group v. Webber*, 41 N.Y. 2d 680, 683, 363 N.E.2d 573, 576 (1977); *Iredell Digestive Disease Clinic, P.A. v. Petrozza*, 92 N.C. App. 21, 27-28, 373 S.E. 2d 449, 453 (1988); *Williams v. Hobbs*, 9 Ohio App. 3d 331, 333, 460 N.E.2d 287, 290 (1983); *Lifesource Institute of Fertility and Endocrinology v. Gianfortoni*, 18 Va. Cir. 330, 334-35 (Henrico County 1989*); Gant v. Hygeia Facilities Foundation, Inc.*, 181 W. Va. 805, 807-08, 384 S.E.2d 842, 844-45 (1989); *Pollack v. Calimag*, 157 Wis.2d 222, 239, 458 N.W.2d 591, 599 (1990).

27. *See cases recognizing protectible interest of hospitals*: *Medical Educ. Assistance Corp. v. State ex rel. East Tennessee State University Quillen College of Medicine*, 19 S.W.3d 803 (Tenn.Ct.App. 1999); *Gillespie v. Carbondale and Marion Eye Centers, Ltd.*, 251 Ill. App.3d 625, 622 N.E.2d 1267 (Ill.App. 5 Dist. 1993); *Reddy v. Community Health Foundation of Man*, 171 W.Va. 368 (W.Va. 1982).

28. *See generally*, Ferdinand S. Tinio, Annotation, *Validity and Construction of Contractual Restrictions on Right of Medical Practitioner to Practice, Incident to Employment Agreement*, 62 ALR 3d 1024.

29. 142 N.H. 440, 702 A.2d 1273 (1997).

30. 142 N.H. at 443, 702 A.2d at 1275.

31. 449 N.E.2d 276 (Ind. 1983).

other business or professional people," and held that the argument that it was in the public interest for physicians to determine their own code of conduct and ethical standards "unpersuasive in the light of the public interest in the freedom of individuals to contract."[32] Shortly after *More*, Kansas also approved such covenants in the employment agreement of a surgeon, noting the protectible interest in referral relationships.[33] Since then, Michigan has also enforced such covenants, also relying on *More*.[34]

In Rash v. Toccoa Clinic Med. Assoc.,[35] the Georgia Supreme Court held that restrictive covenants, like such clauses in other employment contracts, will be upheld if they are sufficiently limited in time and territorial effect and are otherwise reasonable, considering the interests to be protected and the effects on both parties to the contract."[36] It then noted a long history of enforcing such provisions when they involved physicians.[37] The Court expressly rejected an argument that enforcement would be contrary to public policy because it would limit the right of potential patients in the restricted area to use the doctor's services, noting that it was equally true that the restrictions would afford countless other people in other areas the opportunity to have a physician in their area:

> If it be argued that the enforcement of this restrictive covenant would be contrary to public policy because it would limit the right of potential patients in the Demarest and Habersham County area to avail themselves of Dr. Rash's services, it can be argued with at least equal conviction that this would afford countless other people in other areas, both in and outside of the state, the opportunity to have a physician in their areas. There is no reason to conclude that the obstetrical and gynecological needs of persons within a 25-mile radius of Toccoa are any greater than in many other areas of this and other states, nor is there any reason to conclude that the need for the appellant's services, in the context of this case, is sufficient to outweigh the law's interest in upholding and protecting freedom to contract and to enforce contractual rights and obligations.[38]

The *Rash* Court further noted that the doctor "in executing the covenant in question, expressly agreed that the covenant was 'reasonable' and that breach of the covenant 'would work harm' to the partnership. It is the policy of this state to uphold and protect valid contractual rights and obligations."[39]

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32. 449 N.E.2d at 279.

33. *Idbeis v. Wichita Surgical Specialties, P.A.*, 112 P.3d 81, 88 (Kan. 2005).

34. *St. Clair Medical, P.C. v. Borgiel*, 715 N.W.2d 914, 919 (Mich. Ct. App. 2006).

35. 253 Ga. 322, 320 S.E.2d 170 (1984).

36. 253 Ga. at 323, 320 S.E.2d at 171.

37. 253 Ga. at 324, 320 S.E.2d at 172.

38. 253 Ga. at 326, 320 S.E.2d at 173-74.

39. 253 Ga. at 326, 320 S.E.2d at 174.

Many jurisdictions have also rejected arguments that the ethical opinions of the AMA or state medical societies foreclose enforcement.[40] In *Ladd v. Hikes*,[41] the Oregon Court of Appeals rejected reliance on a resolution of the Oregon Medical Association opposing restrictive covenants because it is a voluntary organization without public sanctions or authority. Likewise, the Arizona Court of Appeals in *Phoenix Orthopedic Surgeons, Ltd., v. Peairs*,[42] found unpersuasive a 1985 opinion of the Council on Ethical and Judicial Affairs of the AMA discouraging restrictive covenants. Consistent with this approach, the Court in *Lifesource Institute of Fertility and Endocrinology v. Gianfortoni*,[43] specifically rejected any reliance upon the same AMA ethical opinion, noting both that it did not provide the legal standard by which the court was bound and that "from the evidence in this case, it would appear that this statement is honored in the breach more often than in practice."[44] Indeed, the many judicial opinions already noted upholding such restrictive covenants demonstrates that they are indeed quite common and by no means contrary to public policy. Thus, as a general rule and in the absence of statutory restrictions, courts have routinely enforced restrictive covenants involving physicians, subject only to the usual test of reasonableness applicable to all such provisions.

More and *St. Clair* expressly rejected this contention, noting that medical ethics pronouncements essentially mirrored existing law:

> Defendant also argues that the covenant is unreasonable in light of the Principles of Medical Ethics issued by the American Medical Association, which provide:
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> > Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of the time or in a specified area upon termination of an employment partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. [AMA, E-9.02: *Restrictive Covenants and the Practice of Medicine.*]
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> We conclude that this standard merely reflects the common-law rule of reasonableness and states that restrictive covenants are

40. *More*, 183 N.J. at 56.

41. 55 Or. App. 801, 805-807, 639 P.2d 1307, 1309-1310 (1985).

42. 164 Ariz. 54, 60-61, 790 P.2d 752, 758-59 (1989).

43. 18 Va. Cir. 330 (Henrico County 1989).

44. 18 Va. Cir. at 335 (citing testimony by the defendant's medical management consultant that such restrictive covenants are *standard* in the medical profession and the defendant's own testimony that another physician group had asked him to sign such a covenant).

> unethical only if they are excessive in geographical scope or duration.[45]
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> *More* made this express:
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> Notably, the AMA, which governs the ethical standards of the medical profession, does not declare restrictive covenants *per se* unethical . . . Although the AMA discourages restrictive covenants between physicians, it only declares them unethical if "excessive in geographic scope or duration, or if they fail to make reasonable accommodation of patients' choice of physician." *Ibid*. That is essentially the same reasonableness standard we apply under *Karlin*: *See also* Derek W. Loeser, *The Legal, Ethical, and Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign,* 31 *J.L. Med. & Ethics* 283, 287 (2003) (noting that E-9.02 "has limited legal impact" because it "merely parrots the reasonableness standard applied by most courts"). Thus, the AMA's ethical rules are consistent with, and not contrary to, the *Karlin* analysis.[46]

Particularly instructive on these issues is the decision in *Silvers, Asher, Sher & McLaren, M.D.s Neurology, P.C., v. Batchu.*[47] Dr. Batchu, a neurologist, entered into a contract with the plaintiff partnership (Neurology P.C.) pursuant to which, among other things, he agreed that upon termination of his employment for any reason, he would not for two years handle any medical business or engage in the practice of neurology within 75 miles of Neurology P.C., or treat any individual who was a patient of Neurology P.C. at the time of his termination. The Missouri Court of Appeals found that Neurology P.C. had a protectible interest, noting that neurology is "a highly technical field," that the purpose of the agreement was to protect Neurology P.C.'s patient base, and that as Neurology drew patients from a five state area, a seventy-five mile radius was reasonable.[48] The appellate court also found the restriction on treating individuals who were patients at the time of his termination protected a legitimate interest and concern of Neurology P.C. in retaining its patient base.[49] Finally, it rejected the argument that such a restriction was contrary to public policy:

> [P]ublic policy approves employment contracts containing restrictive covenants because the employer has a proprietary right in its stock of customers and their good will, and if the covenant is otherwise reasonable, the court will protect the asset against appropriation by an employee. In *Williman v. Beheler*, 499 S.W.2d 770, 777 (Mo. 1973), our Supreme Court, in upholding a restrictive covenant among doctors, rejected the notion that public policy should prevent the enforcement of restrictive covenants.

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45. *St. Clair*, 715 N.W.2d at 920-921.

46. *More*, 183 N.J. at 56-57.

47. 16 S.W.3d 340, 345 (Mo. 2000).

48. 16 S.W.3d at 344.

49. *Id.* at 345.

> The court noted that "there is a counterbalancing public policy which recognizes the interest of the public in protecting the freedom of persons to contract and in enforcing contractual rights and obligations."[50]

Therefore, the Court of Appeals enforced the restriction. Not all plaintiffs, even in *More*, were fortunate enough to have such a geographically extensive covenant enforced.

In the end, most courts have held that employers who employ physicians "have a legitimate interest in protecting [their] customer relationships."[51] Such employer, "by virtue of his efforts, expenditures and reputation, has developed a significant practice, and only if the restrictive covenant is given effect can he hope to protect in some measure his legitimate interest in preserving his ongoing relationship with his patients."[52] That a significant practice generates revenue, and that diversion of a segment of that practice will lessen the flow of that revenue stream, does not mean that a later monetary payment adequately remedies the harm done. A monetary payment cannot adequately compensate the loss of good will. And courts have consistently recognized in commercial "customer relations" cases that once a relationship is lost, it may never return. The referral relationship is built up over time based upon reputation, credibility, sustained results and trust. Moreover, there is no way to calculate presently the future harm resultant from lost relationships because eventually there is a house of cards effect that can threaten the very existence of a practice, particularly for an institution that requires not only a minimum number of patients to survive but a diverse number of cases to support its research and teaching goals. In recognizing expressly the protectible nature of these investments, *More* actually strengthened and expanded noncompetes by loosening any requirement that restrictions necessarily tie into confidential information.[53] In fact, as one commentator noted,

> [T]he Court in *More* has quietly but significantly expanded the circumstances in which restrictive covenants may be enforced.
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> Prior to *More*, it was well settled that there were three legitimate interests that could be protected through the enforcement of a restrictive covenant: (1) protection of the employer's trade secrets, (2) protection of the employer's confidential information, and (3) protection of the employer's customer relationships.
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> In identifying the legitimate interests that could be protected by the hospital through the enforcement of its restrictive covenant with *More*, however, the *More* court added two more legitimate

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50. *Id.*

51. *Karlin*, 77 N.J. at 417.

52. *Id.*

53. *More*, 183 N.J. at 57-58; Walsh, *If You Think More Is Less, Think Again: The Supreme Court Has Significantly Expanded The Circumstances In Which Restrictive Covenants May Be Enforced,* New Jersey Law Journal, April 11, 2005.

> interests: "protecting . . . referral bases" and "protecting investment in the training of a physician."
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> It has long been recognized that the protection of customer relationships is a legitimate interest. It is no a major analytical leap to extend that protection to people who refer customers to a particular business. Still, the *More* court's express recognition of the protection of referral relationships as a legitimate interest should be a comfort to business – particularly health-care providers – whose most vital relationships are with referral sources rather than with individual customers or patients.[54]

States That Are Not *More*, But Are Less Friendly to Non-Compete Provisions in Physician Employment Contract

Not all states allow for the enforcement of such covenants. In fact, Alabama, California, Colorado, Delaware, Florida, Louisiana, Massachusetts, Montana, North Dakota and Tennessee limit, or preclude, their enforceability.[55] A small handful of states have enacted statutes that prohibit covenants not to compete for physicians, either through a prohibition as to physicians in particular (Colorado, Delaware and Massachusetts),[56] through a prohibition applicable to various classes of professionals (Alabama),[57] or through general restrictions applicable to all covenants not to compete (California, North Dakota).[58] There are also a few jurisdictions, such as Tennessee, that have had courts refuse to enforce such covenants.[59] A more extended discussion of the Tennessee decision in *Murfreesboro* is appropriate to illustrate the legal arguments against enforcing such covenants.

Murfreesboro involved a private medical practice's effort to enforce an eighteen-month, twenty-five mile post-employment restriction on a departing physician.[60] The agreement also allowed the departing doctor to "buyout" the restriction for an amount equal to his last year's pay from the practice.[61] When the departing physician sought to commence employment as a hospital-based physician at an institution within the restricted geographic area, the practice filed suit.[62] On leave to appeal, the

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54. Walsh, *supra* note 53.

55. Wyatt, *supra* note 1 at 721, *fn.* 49-51.

56. *See* Colo. Rev. Stat. § 8-2-113 (3) (Bradford 1986) (but damages, including damages related to competition, still may be recovered); 6 Del. C. § 2707 (Michie Repl. 1993) (same); Mass. Gen. L. chapter 112, § 12X (Law. Coop. 1991).

57. *See* Ala. Code § 8-1-1 (Michie 1993).

58. *See* Cal. Bus & Prof. Code § 16601 (Bancroft-Whitney 1992) (but permitting such covenants if part of a partnership agreement's anticipation of dissolution of the partnership); N.D. Cent. Code §99-08-06 (Michie 1987).

59. *Murfreesboro Medical Clinic v. Udom*, 166 S.W.3d 674, 684 (Tenn. 2005).

60. 166 S.W.3d at 676.

61. *Id.*

62. *Id.* at 677-78.

intermediate appellate court and then Tennessee's highest court reversed the granting of preliminary relief.[63] The Tennessee Supreme Court, however, went on to address a broader question beyond the enforceability of the particular clause at issue, and asked here generally whether any "covenant[ ] not to compete are enforceable against physicians."[64] That court held that they are *per se* unenforceable.[65]

The Tennessee Court addressed virtually all the same arguments made in *More*, *Idbeis*, *Rash*, *St. Clair*, and other cases allowing enforcement of such provisions — and decided the other way.[66]

For example, on the issue of the competitive impact of covenants and patient freedom of choice, the Tennessee Court concluded that such restrictions were impossible to balance with such interests:

> Restrictive covenants in the medical profession raise concerns regarding the public good. Having a greater number of physicians practicing in a community benefits the public by providing greater access to health care. Increased competition for patients tends to improve quality of care and keep costs affordable. Furthermore, a person has a right to choose his or her physician and to continue an ongoing professional relationship with that physician. *See Med. Educ. Assistance Corp.*, 19 S.W.3d at 816; *see also* AMA Code of Medical Ethics § E-9.06 (1977). Enforcing covenants not to compete against physicians could impair or even deny this right altogether.[67]

Similarly, the *Murfreesboro* court read AMA ethical guidelines to be wholly antithetical to such covenants:

> Since 1980 the American Medical Association (AMA) has taken the position that physicians' non-compete agreements impact negatively on health care and are not in the public interest. *See* AMA Code of Medical Ethics § E-9.02 (1998). Although stopping short of completely prohibiting covenants not to compete, the AMA strongly discourages them. *Id.* The AMA has maintained the view for the past twenty-five years that non-compete agreements "restrict competition, disrupt continuity of care, and potentially deprive the public of medical services." *Id.* The AMA has also found that a person's right to choose a physician and free competition among physicians are "prerequisites of ethical practice." *Id.* at § E-9.06 . . .[68]

It is worth pointing out that the Tennessee Court does not, as *More* and *St. Clair* did, actually quote the entire applicable ethical guidelines.[69] Hence, it is unclear what the Tennessee Court thought the impact of the

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63. *Id.* at 678.
64. *Id.* at 678.
65. *Id.* at 683-84.
66. *Id.*
67. *Id.* at 679.
68. *Id.* at 679-680.
69. Compare *id.* at 679-681 with *More*, 183 N.J. at 56-57 and *St. Clair*, 715 N.W.2d at 520-21.

ethical guidelines conditional position only being triggered if such covenants "are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician."[70]

Further, the Tennessee Court accepted as valid the analogy of physicians to attorneys, and thereby involved the fairly consistent law that non-compete agreements involving attorneys are *per se* unlawful. [71]

This Tennessee decision is perhaps somewhat surprising because Tennessee, by statute, actually specifically allows non-compete agreements to be enforced against physicians when the employer is (a) a hospital or affiliate or (b) a faculty practice plan associated with a medical school.[72] Rather than reading that statute as reflecting a public policy of allowing such covenants, the Tennessee Court read it as reflecting specific exceptions to a contrary public policy.[73]

Conclusion: What Employers Can and Should Do, *More* or Less

As one can see, there is abundant case law, and even some statutory authority, supporting the enforcement of restrictive covenants in physician employment contracts. As an employer, one must understand that law and the facts on which it will depend. That is because the general notion that such provisions are enforceable in the abstract is not an assurance that any specific provision will be enforced in all respects as written.

So what should an employer do, other than seek the advice of experienced counsel?

First, an employer should know the law in the applicable jurisdiction, as that is the most basic starting point and one to which this article is directed.

Second, an employer should know who the employed physicians are, meaning who were they and what was their source of patients and referrals at the inception of their employment, and how has it grown or changed. These facts will help determine the value of the relationship in which the employer has invested.

Third, an employer should know how patient and referral solicitation by, and reputation enhancement of, individual physicians has been supported, and invested in, by the employer. This will become the proof of the employer's protectable interest.

Fourth, an employer should know where the patients that visit that doctor, and the sources of referrals to that doctor, are located, as the geographic scope of a restriction will be judged in large part on such facts.

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70. *St. Clair*, 715 N.W.2d at 510-21 (quoting AMA, E-9l02 Restrictive Covenants and the Practiced of Medicine).

71. 166 S.W.2d at 679, 683.

72. *Id.* at 681 (citing Tenn. Code Ann. § 63-6-204(d) and (e)).

73. 166 S.W.2d at 681-683.

Finally, an employer should know the employer's competitors in the area – whatever that area is and whatever form in which the employer operates in, be it as a professional practice, a hospital, a facility practice plan, or in some other form. It is these factors that will play into an assessment of the public interest.

It is the strength and flexibility of one's command of these factors that will determine whether an employer's non-compete provisions will have punch. Without such command, the chance to enforce a non-compete may just slip through an employer's fingers. In the end, command over these facts and these legal principles will allow a physician's employer to make its covenants more, rather than less, effective.