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JUDICIAL ENFORCEMENT OF COVENANTS NOT TO COMPETE BETWEEN PHYSICIANS: PROTECTING DOCTORS' INTERESTS AT PATIENTS' EXPENSE

Paula Berg

It is the signature of our age that no-one, without exception, can now determine his own life within even a moderately comprehensible framework, as was possible earlier in the assessment of market relationships. In principle everyone, however powerful, is an object.

THEODOR ADORNO, MINIMA MORALIA 37 (1974)

I. INTRODUCTION

Dr. Sandra Foote, an oncologist, terminated her employment with a Delaware medical group in 1984. At the time, Dr. Foote was administering chemotherapy to a number of cancer patients at Milford Hospital, where she was the only board-certified staff oncologist. Dr. Foote's employment contract

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2. Dickinson Medical Group v. Foote, No. 84C-JL-22, 1989 WL
contained a covenant not to compete which prohibited her from practicing medicine within a 30 mile radius of Milford or Dover, Delaware for three years after her termination. Since Milford Hospital was within the restricted area, the noncompete clause required that Dr. Foote immediately stop treating her hospitalized cancer patients, even though neither her former employer nor the hospital had another oncologist to take over treatment.

In 1991, a suburban New York City medical group terminated the employment of Dr. Joel Novendstern, an obstetrician and gynecologist. A noncompetition clause in Dr. Novendstern's employment contract barred him from practicing medicine in northern Westchester County for three years. This provision forced Dr. Novendstern's patients to choose between having him deliver their babies at a hospital which was inconveniently located outside the restricted area, or giving birth at a well-equipped, nearby hospital under the care of a less familiar doctor.

Covenants not to compete are common in physicians'
employment contracts and partnership agreements. Typically, these provisions bar a departing physician, whose employment or partnership relationship is terminated, from practicing medicine within a certain geographic region for a specified period of time. In most cases, the restriction explicitly or implicitly bars the physician from treating patients at hospitals located within the covenant area. Departing physicians are thus unable to treat patients

article to refer to provisions ancillary to employment contracts and partnership agreements whereby the covenantor agrees, upon the termination of employment or withdrawal from a partnership, not to practice medicine within a specified geographic area for a specified period of time. Noncompetition agreements incident to contracts for the sale of medical practices are beyond the scope of this article.

10. This article does not distinguish between restrictive covenants in physicians' employment contracts and in partnership agreements because both involve the primary focus of this critique, i.e., depriving patients of convenient access to the doctor of their choice. See infra notes 146-48 and accompanying text. This distinction, however, has an important legal significance. For example, a number of state statutes bar restrictive covenants only in employment contracts. See infra note 61.

11. See, e.g., Ballesteros v. Johnson, 812 S.W.2d 217, 220 (Mo. Ct. App. 1991) (covenant not to compete ancillary to employment contract specified seven hospitals at which the departing cardiologist could not practice within one year of terminating his employment).

12. Covenants not to compete between physicians typically state that the covenantor may not practice medicine or surgery within the restricted area. Such a broadly worded provision bars the practice of medicine in any capacity within the restricted area, even at hospitals located within the provision's geographic boundaries. For a more detailed discussion of the impact of noncompetition agreements on physicians' right to practice at hospitals, see infra notes 157-63 and accompanying text.

13. Physicians may not admit patients to a hospital or treat inpatients until they have been accepted as a member of the hospital's staff. The application process involves a review of medical school performance and clinical qualifications. Additionally, a hospital may deny admitting privileges to physicians if it has an exclusive contract with a medical group to provide practitioners of certain specialties, such as radiology, cardiac surgery or emergency room medicine. Courts have generally upheld hospitals' exclusive contracts for medical services in the face of challenges grounded in constitutional, statutory and common-law theories. See Andrew K. Dolan & Richard S. Ralston, Hospital Admitting Privileges and the Sherman Act, 19 Hous. L. Rev. 707, 732 (1981); Lawrence W. Kessenick & John E. Peer, Physicians' Access to the Hospital: An Overview, 14 U.S.F. L. Rev. 43, 70 (1979). See also Clark C. Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 Duke L.J. 1071, 1108 (1984); Sheree Lynn McCall, A Hospital's Liability for Denying, Suspending and Granting Staff Privileges, 32 Baylor L. Rev. 175 (1980).
requiring hospitalization until they are granted admitting privileges at a hospital outside of the covenant area.

The purpose of noncompetition agreements among physicians is to protect an economic interest of the covenantor by temporarily restricting a departing physician's right to establish a competitive medical practice. These provisions, which usually encompass the covenantor's service area, force departing physicians to relocate so that they can neither compete directly for new patients nor retain patients treated while associated with former employers or partners. The underlying assumption is that most of a departing physician's patients will choose to be treated by the employer or by the departing physician's replacement rather than to follow the physician to an inconvenient location outside the covenant area.

Courts do not analyze noncompetition agreements between physicians any differently than comparable provisions between commercial parties. If the underlying employment contract or partnership agreement is supported by consideration, courts apply the "rule of reason." Under this rule, noncompetition provisions are deemed reasonable and enforceable if they are

14. See, e.g., Freeman v. Duluth Clinic, Ltd., 334 N.E.2d 626, 630 (Minn. 1983) (declining to enforce covenant not to compete ancillary to employment contract which was executed after neurosurgeon began working for clinic, because covenant lacked consideration). See also Kari Family Clinic of Chiropractic v. Bohnen, 349 N.W.2d 868 (Minn. Ct. App. 1984). The requirement of consideration is not particularly problematic in the context of noncompetition clauses ancillary to partnership agreements, because all partners are equally benefitted and burdened by the provision and the parties' bargaining power is presumed to be equal. See, e.g., Bradford v. Billingson, 299 S.W.2d 601 (Ky. Ct. App. 1957); Glover v. Shirley, 155 S.W. 878 (Ky. 1913). However, analysis of the adequacy of consideration is considerably more complex in cases involving covenants not to compete ancillary to employment contracts, because only the employee is burdened and inequality often exists in bargaining power between the parties. The issue of adequate consideration is most difficult when a noncompetition clause is ancillary to an at-will employment agreement, because an employer may unilaterally terminate an employee after a period of weeks, while the employee may be required to forego employment in a certain area for a period of years. This difficulty also exists when employment agreements are signed after employment has commenced. For excellent discussions of this issue, see Jordan Liebman & Richard Nathan, The Enforceability of Post-Employment Noncompetition Agreements Formed After At-Will Employment Has Commenced: The "Afterthought" Agreement, 60 So. Cal. L. Rev. 1468 (1987); Kathryn J. Yates, Consideration For Employee Noncompetition Covenants In Employments At Will, 54 Fordham L. Rev. 1123 (1986).
no broader than necessary to protect a legitimate interest of the employer and are not unduly burdensome to the employee or harmful to the public. To remedy a breach of a restrictive covenant, courts usually grant an injunction barring the departing doctor from practicing medicine in the covenant area for a specific period of time.

Neither courts nor commentators have carefully considered the practical and jurisprudential ramifications of enforcing private contractual agreements that involuntarily terminate existing relationships between doctors and patients and restrict patients' choice of physicians. This article will examine current statutory and judicial treatment of covenants.


18. Only one law review article specifically addresses noncompetition agreements between physicians. See Edwin Merrick Dodd, Contracts Not to Practice Medicine, 23 B.U. L. REV. 305 (1943). Professor Dodd notes that noncompetition agreements ancillary to physicians' employment contracts and partnership agreements are usually enforced, but he declines comment. Id. at 318. Restrictive covenants among physicians have been the subject of a number of articles targeted at doctors. See Richard P. Bergen, More Restrictive Covenants, 220 JAMA 1533 (1972); Angela Roddy Holder, Restrictive Covenants Since 1967, 213 JAMA 1543 (1970); Richard P. Bergen, Practical Considerations on Restrictive Covenants, 203 JAMA 197 (1968); Veronica M. O'Hern, Public Policy on Restrictive Covenants, 202 JAMA 185 (1967); Veronica M. O'Hern, Covenants Restricting Medical Practice, 202 JAMA 210 (1967).

not to compete between physicians. It will examine the factors that courts consider, as well as those they do not consider, when determining whether noncompetition agreements between physicians are reasonable and enforceable. This article argues that application of the rule of reason to restrictive covenants between physicians is theoretically unsound and practically detrimental. Noncompetition agreements between physicians, like noncompetition agreements between attorneys, would be per se invalid.20

II. CURRENT TREATMENT OF RESTRICTIVE COVENANTS BETWEEN PHYSICIANS

A. The Position of the American Medical Association

For the past 60 years, the American Medical Association (AMA) has consistently taken the position that noncompetition agreements between physicians impact negatively on patient care. In June 1933, the AMA's House of Delegates approved a Judicial Council resolution which

19. Noncompetition agreements between attorneys are typically held per se unenforceable because they interfere with the lawyer-client relationship and restrict clients' choice of an attorney. See infra text accompanying notes 159-76.


21. The American Medical Association (AMA), which comprises physicians, osteopaths and medical students, is the largest medical and professional association in the world. Membership in the AMA is not a prerequisite to obtaining a medical license, board certification or hospital staff privileges. As of 1982, approximately 50 percent of all licensed physicians in the U.S. were members of the AMA. Most AMA members are in private practice. For a detailed description of the internal structure of the AMA, see In re American Medical Ass'n, 94 F.T.C. 701, 709-12 (1979).

22. The AMA is composed of state associations that elect representatives to the House of Delegates, the organization's primary governing body. The House of Delegates is authorized to amend the AMA's Constitution, Bylaws and Principles of Medical Ethics. Id. at 710-11.

23. Eight AMA committees, referred to as "Councils," are responsible for making policy recommendations to the entire body regarding specific subjects. The Judicial Council is responsible for interpreting and
declared that contractual provisions that interfered with reasonable competition among physicians or prevented the "free choice of a physician" were unethical. This resolution was the first AMA proclamation on contractual arrangements affecting competition among physicians or covenants not to compete. The 1933 resolution remained unchanged for nearly 30 years.

In 1960, however, the AMA's Judicial Council published an opinion that retreated from the 1933 resolution. Rather than focusing on the impact that covenants not to compete have on patients, the revision was primarily concerned with the limitations such agreements impose on physicians' employment mobility. The 1960 opinion stated that there is no ethical proscription against a "reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made and understood." The opinion, however, cautioned that it was still debatable whether such agreements are "advisable as being in the best interest of the public."

In 1971, at a meeting of the AMA's House of Delegates, the Indiana delegation introduced a resolution that unequivocally declared that restrictive covenants were unethical. The full body rejected the measure and instead formally adopted a substitute resolution that echoed the ambivalent position of the 1960 opinion. The House of Delegates called for the Judicial Council to review the issue "in light of current legal, ethical, socio-economic and professional developments within the practice of medicine."

One year later, the Judicial Council reported its findings, and it recommended banning restrictive covenants in all but exceptional circumstances. The Council explained that it

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27. Id.
28. Id.
31. Id.
32. AMERICAN MEDICAL ASSOCIATION, PROCEEDINGS OF THE HOUSE OF
recognizes social and professional conditions have changed over the years. While there may once have been some need for restrictive covenants in agreements between physicians, the Council believes that existing socio-economic conditions leave little or no justification for restrictive covenant arrangements. In the opinion of the Council, the use of restrictive covenants in an agreement between or among physicians should be entered into only under the most unusual circumstances and then only after those circumstances have been found by the local medical society to require the adoption of such a provision in order to protect the public and the profession in the particular situation.\textsuperscript{33}

The full body of the AMA, however, once again rejected an outright ban on restrictive covenants, and the matter was referred to the Judicial Council for further study.\textsuperscript{34}

In 1977, the Judicial Council published a new version of its Opinions and Reports.\textsuperscript{35} The revision was prompted by a 1975 Federal Trade Commission (FTC) complaint charging that certain of the AMA’s ethical prohibitions violated Section 5 of the Federal Trade Commission Act.\textsuperscript{36} While these Reports revised a number of ethical provisions, the provision on restrictive covenants remained unchanged from the 1960 Judicial Council’s Opinions and Reports.\textsuperscript{37}

\textsuperscript{33} Delegates, Reports of Standing Committees of the House of Delegates, Report of Judicial Council 124 (June 18-22, 1972). In formulating its recommendation, the Council considered, \textit{inter alia}, the comments of attorneys representing medical societies, the American Association of Medical Clinics, and the Medical Group Management Association. \textit{Id.}

\textsuperscript{34} \textit{Id.}

\textsuperscript{35} American Medical Association, Opinions and Reports of the Judicial Council (1977).

\textsuperscript{36} The complaint, which was filed by the FTC against the AMA, the Connecticut State Medical Society and the New Haven County Medical Association, in essence alleged that these organizations violated the Act by restraining doctors from advertising, soliciting patients, and entering into contractual arrangements with non-physicians. The complaint is described in detail in the FTC’s decision. See In re American Medical Ass’n, 94 F.T.C. 701 (1979), \textit{modified and enforced}, American Medical Ass’n v. Federal Trade Comm’n, 638 F.2d 443 (2d Cir. 1980), \textit{aff’d}, 455 U.S. 676 (1982). See also Anderson Letter, \textit{supra} note 25, at 2.

\textsuperscript{37} Compare American Medical Association, Opinions and Reports of the Judicial Council 25 (1960) with American Medical Association, Opinions and Reports of the Judicial Council \S 4.63
Finally, in 1980, the AMA House of Delegates adopted an opinion of the Judicial Council that declared that noncompetition agreements were not "in the public interest."\(^{38}\) While this amendment, which is currently in effect, clearly states that restrictive covenants between physicians are contrary to the public interest,\(^{39}\) it does not deem such agreements unethical. The Council was reluctant to adopt an outright ban on restrictive covenants\(^{40}\) because of the Federal Trade Commission's final order in *In re American Medical Ass'n.*\(^{41}\) This order, while not specifically pertaining to covenants not to compete, compelled the AMA to cease and desist from declaring certain contractual practices among physicians to be unethical.\(^{42}\) The Council believed that a declaration that noncompetition agreements were unethical might run afoul of the FTC decision.\(^{43}\) Ironically, an FTC order, which was intended to increase competition among physicians, has perhaps forever prevented the passage of an ethical proscription against anticompetition agreements.\(^{44}\)


\(^{40}\) Several other sections of the American Medical Association's CURRENT OPINIONS also disfavor noncompetition agreements between physicians. See, e.g., *id.* at § 6.11 (encouraging competition between doctors for ethical reasons, and to foster higher quality service); see also *id.* at § 9.06 (describing freedom to choose physicians as a right of every individual).

\(^{41}\) *Id.*

\(^{42}\) The FTC's final order required the AMA to cease and desist from restricting member doctors from: (1) advertising or publishing the price of medical services; (2) soliciting patients through advertising; (3) entering into contractual arrangements for medical services; (4) entering into contractual arrangements with entities that offer medical services to the public; and (5) entering into contractual arrangements with non-physicians affiliated with entities that provide medical services to the public. *Id.* at 441-42.


\(^{44}\) Within the AMA, national organizations representing group practices are among the opponents of a declaration that restrictive covenants are unethical. See Letter from Betty Jane Anderson, Special Counsel to AMA (Jan. 3, 1992).
B. Federal and State Statutes

Section 1 of the Sherman Antitrust Act prohibits "[e]very contract, combination ... or conspiracy in restraint of trade or commerce among the several states, or with foreign nations ... ."45 The plain language of the Sherman Act seems to apply to covenants not to compete ancillary to both employment contracts and partnership agreements.46 While a relatively small number of cases involving covenants not to compete between employers or partners have been brought under the Sherman Act, none of these cases involved physicians.47 No other federal antitrust law has been used to


Professor Sullivan correctly notes that the common law "rule of reason" for post-employment restraints overvalues the individual interests of the employer and employee, while failing to sufficiently consider the agreement's broader anticompetitive effects. He persuasively argues for application of federal antitrust principles, which would entail a more precise analysis of the restraint's impact upon the relevant market, because they would better assess the reasonableness of anticompetition agreements. Id. at 643.

47. See Milton Handler & Daniel E. Lazaroff, Restraint of Trade and the Restatement (Second) of Contracts, 57 N.Y.U. L. REV. 669, 751 n.380 (1982). Federal antitrust laws clearly apply to the medical profession. See Arizona County Medical Soc'y v. Maricopa, 457 U.S. 332, 349-50 (1982). It is unclear, however, whether the health care industry possesses the necessary conditions for an efficient free market, given the prevalence of third party payors and the inability of many patients, especially those suffering from emergency conditions, to rationally select among competing health care options. Moreover, there is considerable disagreement about the role and desirability of promoting competition among health care providers. For a variety of perspectives, see Timothy Stoltzfus Jost, The Necessary and Proper Role of Regulation to Assure the Quality of Health Care, 25 HOUS. L. REV. 525 (1988) (government regulation essential to maintain and promote quality health care); Arnold S. Relman, M.D., Practicing Medicine in the New Business Climate, 316 NEW ENG. J. MED. 1150 (1987) (greater physician self-restraint, not increased competition, needed to curb rising health care costs and preserve integrity of the medical profession); CLARK C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 81-82, 200-01, 354-56 (1982) (increasing competition among health care providers would increase quality of health care); James F. Blumstein & Frank A. Sloan, Redefining Government's Role in
challenge the legality of noncompetition agreements between physicians.48

Eight states, however, have invalidated noncompetition agreements between physicians either through direct legislation or judicial interpretation of state antitrust statutes. Colorado and Delaware are the only states that have enacted statutes specifically invalidating covenants not to compete between physicians.49

In 1982, Colorado amended its antitrust statute, which prohibited covenants not to compete in many types of employment contracts, to include a limitation on noncompetition agreements between physicians. Essentially, the Colorado statute maintains the legitimacy of non-compete provisions between physicians by permitting the recovery of monetary damages from a covenantor/doctor who causes the employment agreement to terminate by breaching the non-compete provision.50 This statute was adopted because the state legislature believed that restrictive covenants between physicians adversely affected patient care and the delivery of health care services.51

In 1983, Delaware adopted a statute that declared that covenants not to compete ancillary to employment, partnership, or corporate agreements, which restrict the right of a physician to practice medicine in a certain location for a

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Health Care: Is a Dose of Competition What the Doctor Should Order?, 34 VAND. L. REV. 849 (1981) (increased competition among health care providers would decrease overall costs, increase the information physicians convey to patients, and reduce unnecessary procedures).


49. See infra notes 50 & 52. For a listing of the states that have invalidated noncompetition agreements through judicial interpretation of state antitrust statutes, see infra notes 55-60.

50. COLO. REV. STAT. ANN. § 8-2-113(3) (West 1982).

51. See COLO. REP. HUME & COLO. SEN. SOASH, MEMORANDUM RE HOUSE BILL 1174, COLO. HOUSE OF REP. (1982). This memorandum stated that restrictive covenants between physicians are not in the public interest because they, inter alia, (1) are anti-competitive and inhibit free enterprise; (2) restrain trade and enable some medical organizations to engage in monopolistic practices, which increase the cost of medical care; (3) protect the business interests of the medical organization, while not protecting the health care needs of patients; (4) have a negative impact on patient care; and (5) sever the doctor-patient relationship. By not authorizing injunctive relief to remedy the breach of a restrictive covenant between physicians, this statute promotes continuity in the doctor-patient relationship.
certain period of time, are void.\textsuperscript{52} Like the Colorado measure, the Delaware law permits an action to recover damages related to termination of the underlying agreement, including damages associated with competition.\textsuperscript{53}

There is no written legislative history that reveals the intent of the Delaware statute. Evidence suggests, however, that the measure was passed in response to complaints to state legislators from a hospital that was threatened by the loss of its only staff oncologist because of a covenant not to compete.\textsuperscript{54}

The state antitrust statutes of Alabama,\textsuperscript{55} California,\textsuperscript{56} Florida,\textsuperscript{57} Louisiana,\textsuperscript{58} Montana\textsuperscript{59} and North Dakota\textsuperscript{60} expressly prohibit contractual restraints upon the practice of a "profession," and they have been held to render invalid all noncompetition agreements ancillary to employment contracts\textsuperscript{61} between physicians.\textsuperscript{62}

53. Id.
54. Interview with Bernard Brady, Legislative Aide to Delaware State Senator Thurman Adams (July 24, 1991). According to Mr. Brady, the bill, which was sponsored by Senator Adams, was drafted at the urging of representatives of Milford Hospital, located in southern Delaware. At the time, the hospital was involved in a dispute between Dr. Sandra Foote and her employer, the Dickinson Medical Group, over a covenant not to compete in the employment contract, culminating in four judicial opinions. See Dickinson Medical Group v. Foote, 1989 WL 100466 (Del. Super. Ct. July 31, 1989); Dickinson Medical Group v. Foote, No. 84C-JL-22, 1989 WL 40965 (Del. Super. Ct. March 23, 1989); Dickinson Medical Group v. Foote, 1987 WL 8665 (Del. Super. Ct. March 24, 1987); Dickinson Medical Group v. Foote, No. 834-K, 1984 WL 8208 (Del. Ch. May 10, 1984).
62. See, e.g., Odess v. Taylor, 211 So. 2d 805 (Ala. 1968) (covenant not to compete between physicians violated Alabama statute prohibiting contracts that restrain the practice of a profession); Bosley Medical Group
The state antitrust statutes of twenty-eight states\(^{63}\) and the District of Columbia\(^{64}\) do not expressly apply to professions, and instead only prohibit contractual restraints affecting business, trade and commerce.\(^{65}\) The enforceability of

\[\text{v. Abramson, 207 Cal. Rptr. 477 (Ct. App. 1984) (noncompetition agreement between plastic surgeon and medical corporation was void and unenforceable under California statute prohibiting contracts that restrain a person from engaging in a lawful profession); Bergh v. Stephens, 175 So. 2d 787 (Fla. Dist. Ct. App. 1965) (provision in employment contract barring plaintiff from practicing medicine for a period of five years was void and unenforceable under Florida statute prohibiting contracts restraining the free exercise of a lawful profession); Gauthier v. Magee, 141 So. 2d 837 (La. Ct. App. 1962) (provision of doctor's employment contract requiring the payment of $60,000 if he practiced medicine in the area within five years was illegal and unenforceable under Louisiana statute prohibiting all covenants not to compete incident to employment contracts); Western Montana Clinic v. Jacobson, 544 P.2d 807 (Mont. 1976) (court declared covenant not to compete incident to orthopedic surgeon's employment contract unenforceable because it violated Montana statute prohibiting contracts restraining the exercise of a lawful profession); Spectrum Emergency Care, Inc. v. St. Joseph's Hospital and Health Center, 479 N.W.2d 848 (N.D. 1992) (covenant not to compete in employment contract between corporation, which supplied emergency physicians' services to hospitals, and its physician employees violated antitrust statute and was void).}\]


\(64. \text{D.C. CODE ANN. § 28-4502 (1991).}\]

\(65. \text{See Bayly, Martin & Fay v. Pickard, 780 P.2d 1168 (Okla. 1989) (court held that antitrust statute, which declared that every contract restraining the lawful exercise of a profession, trade, or business was void, did not require application of per se rule and instead prohibits only unreasonable restrictions). See also People v. Roth, 420 N.E.2d 929, 930 (N.Y. 1981) (holding that state antitrust statute, which expressly applied}\)
noncompetition agreements between physicians in these jurisdictions is governed solely by the rule of reason. A number of states have, in fact, recently amended their state antitrust statutes to codify application of the common law rule of reason to covenants not to compete ancillary to all types of employment contracts.66

C. Common Law: The Rule of Reason

Under the common law, covenants not to compete ancillary to employment contracts and partnership agreements have traditionally been regarded as agreements in restraint of trade that contravene public policy favoring free competition.67 Yet, courts have recognized that noncompetition agreements are enforceable to prevent a departing employee from competing with a former employer if the employee has acquired an unfair competitive advantage over the employer as a consequence of the employment or partnership association.68 Noncompetition agreements are never justified to prevent fair competition by former employees. If they do nothing more than prevent fair competition, they are unreasonable contracts in restraint of free trade.69

only to “business,” “trade,” or “commerce” did not apply to physicians because they are professionals).


67. See, e.g., RESTATEMENT (SECOND) OF CONTRACTS § 186(1) & (2) (1981) (promises that limit competition or restrict promisor’s exercise of gainful occupation are restraints of trade).

68. See RESTATEMENT (SECOND) OF CONTRACTS § 188, cmt. (b) (1981); see also Blake, supra note 18, at 646-51.

69. See Duffner v. Alberty, 718 S.W.2d 111, 112 (Ark. Ct. App. 1986) (“[t]he law will not enforce a contract merely to prohibit ordinary competition”); Hoddeson v. Conroe Ear, Nose and Throat, Assoc., 751 S.W.2d 289, 290-291 (Tex. Ct. App. 1988) (“The covenant was solely to protect Appellee from competition . . . . ‘In the absence of special circumstances, a covenant which has as its sole purpose the elimination of competition is not reasonable.’”) (quoting Hospital Consultants, Inc. v. Potyka, 531 S.W.2d 657, 663 (Tex. Civ. App. 1975)). Some courts, however, exhibit a profound misunderstanding of the theoretical distinction between justified and unjustified noncompetition agreements. See, e.g., Lovelace Clinic v. Murphy, 417 P.2d 450, 453 (N.M. 1966). In Lovelace, the coventantor/physician argued that a noncompetition agreement was unenforceable because it was not reasonably related to
Courts developed the rule of reason in order to strike a balance between the opposing objectives of promoting free economic competition and protecting employers from unfair competition and upholding the freedom of contract. In most jurisdictions, a covenant not to compete is reasonable and enforceable if the level of restraint it imposes is neither greater than is required for the protection of a legitimate interest of the employer nor unduly hard on the employee or public.

1. Does the Covenantee Have a Protectible Interest?

Courts recognize that a medical employer has a legitimate interest warranting protection by a noncompetition agreement if a departing physician was provided with (a) patient contacts, (b) training or (c) confidential business information.

(a). Patient Contacts

In commercial cases, an employer's interest in retaining present customers may justify enforcement of a covenant not to compete. Thus, if employees have had substantial personal contact with clientele, courts usually enforce restrictive covenants to prevent these customers from severing their relationship with employers and becoming customers of departing employees.

the interests of the clinic, it was intended to restrict competition, and it was aimed at forcing employees to remain in the employ of the employer. The court responded by holding that "[t]hese are usually the main purposes of such covenants, and these are legitimate purposes, so long as the restrictions are reasonable." Id. See also Novendstern v. Mt. Kisco Medical Group, 576 N.Y.S.2d 329, 331 (App. Div. 1991) ("Established in 1947, the medical group developed and prospered as a result of the considerable time, money and efforts of its members. By including restrictive covenants in the employment contracts, the members were validly protecting their interest in their investments from competition."). See also Willman v. Beheler, 499 S.W.2d 770, 778 (Mo. 1973).

70. Blake, supra note 18, at 650-51.

71. RESTATEMENT (SECOND) OF CONTRACTS § 188(1) (1979). The geographical scope and duration of the restrictive covenant must also be reasonable. See infra notes 112-20 and accompanying text.

72. See, e.g., Young v. Mastrom, Inc., 392 S.E.2d 445, 449 (N.C. Ct. App. 1990) (customers are property of the employer and may be protected by a covenant not to compete); Arthur Murray Dance Studios, Inc. v. Witter, 105 N.E.2d 685, 706 (Ohio C.P. Cuyahoga County 1952) (covenant not to compete drafted to prevent customers from following departing employee is enforceable if there was significant personal relationship between employee and customers). See also Blake, supra note 18, at 657.

73. In cases in which employees' exposure to customers was "great,"
In the health care context, patients who have received ongoing treatment from a departing physician often wish to continue the relationship after the physician separates from an employer or partnership. Indeed, the most commonly asserted "protectible interest" in cases involving restrictive covenants between physicians is the need to prevent patients from following a departing physician.

*Mandeville v. Harman* was one of the first decisions to consider in detail whether covenantees/physicians could legitimately use noncompetition agreements to preserve their patient base. Dr. Mandeville, a physician with a well established practice in Newark, New Jersey, hired Dr. Harman to assist him with his large caseload. Their employment contract contained a covenant not to compete which provided that, upon the termination of Dr. Harman's employment, he could never practice medicine or surgery within Newark. After working for Dr. Mandeville for about one year, Dr. Harman violated the covenant by establishing a private practice in Newark.

After acknowledging that a covenant not to compete is a disfavored restraint on free trade, the court stated that such an agreement is enforceable only if it "afford[s] a fair protec-

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one study found that the enforcement rate of covenants not to compete was 83%. Peter J. Whitmore, *A Statistical Analysis of Noncompetition Clauses in Employment Contracts*, 15 J. CORP. L. 483, 505 (1990).

74. The risk to an employer of losing customers to a departing employee is a function of the closeness and duration of the employee's relationship with customers. This risk is greatest when an employee works closely with customers over a long period of time, especially if the employee's services are key to the transaction. See Blake, *supra* note 18, at 661.

Employers of physicians face a significant likelihood of losing patients to departing employee/physicians because the physician-patient relationship is uniquely intimate and often lasts for a considerable period of time. See, e.g., Karlin v. Weinberg, 390 A.2d 1161, 1164 (N.J. 1978) (60 patients followed departing dermatologist); Budoff v. Jenkins, 532 N.Y.S.2d 149, 151 (App. Div. 1988) (over 200 patients followed departing physician who specialized in treating women).


76. 7 A. 37 (N.J. Ch. 1886).

77. Id. at 38.
tion to the interest of the party in favor of whom it is given, and [is] not so large as to interfere with the interest of the public. Dr. Mandeville argued that the covenant was needed to protect the goodwill of his medical practice, which he had built up over a considerable period of years.

The court, however, did not recognize that Dr. Mandeville's goodwill was something that could be appropriated, fairly or unfairly, by Dr. Harman. Instead, the court noted that the peculiarly personal nature of Dr. Mandeville's relationship with his patients was not transferable to another. As such, Dr. Mandeville's relationship with patients was not an asset acquired by Dr. Harman during his prior employment which thereby entitled him to enforce a covenant not to compete. The court concluded that protection of a medical practice's patient base was not a sufficient interest to warrant judicial enforcement of a covenant not to compete.

The Mandeville approach, however, has not been widely followed. Rather, the dominant analytical model treats an employer/physician's relationship with patients as an asset that can be unfairly appropriated by the employee/physician, thus warranting protection by a covenant not to compete.

Granger v. Craven was an early case articulating the approach currently followed by a majority of state courts. Dr. Granger, who had a general medical practice in Rochester, Minnesota for 30 years, hired Dr. Craven to run the otolaryngology branch of his practice. The parties' employment contract, which was mutually terminable at will, provided that Dr. Craven could not practice medicine or surgery within a 20-mile radius of Rochester for a period of three years after the termination of his employment. After about two years, Dr. Craven severed the employment relationship and established a general medical practice in Rochester. While Dr. Craven did not actively solicit former patients, he placed an advertisement in a local

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78. Id. at 39.
79. Id. at 38.
80. Id. at 40-41. Mandeville may also reflect the view that if departing physicians' patients choose to follow them, they must have had no significant relationship with the employer/physician. Thus, the departing physician could not have appropriated an asset of the employer which justifies imposition of a restrictive covenant. See Blake, supra note 18, at 656.
81. 199 N.W. 10 (Minn. 1924).
82. Id. at 11.
newspaper announcing his intention to practice in the area.¹³

Unlike the court in *Mandeville*, the *Granger* court viewed a covenantee/doctor's relationship with patients as an asset that was susceptible to unfair appropriation by an employee. The court reasoned that, because of the unique nature of the doctor-patient relationship, the only reasonable protection for a professional about to employ another on such terms as to give the employee access to the acquaintance and confidence of his clients is to require the employee to enter into a covenant not to compete with the employer for a reasonable time after the relationship is terminated.¹⁴

The *Granger* court held that the covenant was reasonable because it did no more than was necessary to protect Dr. Granger's "hold" upon his patients and to prevent them from continuing treatment with Dr. Craven. It stated, "[c]ertainly a competent surgeon, particularly a specialist, may be presumed to acquire as firm a hold upon patients as the driver of a laundry wagon upon customers."¹⁵

Many state courts follow *Granger* in viewing patients as an asset belonging to a medical employer or partnership.¹⁶ From this premise, it follows that covenants not to compete are a logical and justified means of preventing the unjust enrichment of departing physicians who, in the absence of a noncompetition agreement, could deplete their former employers' patient base.¹⁷ Thus, courts typically enforce re-

83. *Id.*
84. *Id.* at 12.
85. *Id.* at 13.

Following this approach, in *Daniel Boone Clinic v. Dahhan*, 734 S.W.2d 488 (Ky. Ct. App. 1987), the court held that an employment contract between a departing physician and a clinic did not vest patients with any third party beneficiary rights which entitled them to notice of their physician's termination. The departing physician's employment contract included a restrictive covenant barring him from practicing within 50 miles of the employer for 18 months. Instead, the court recognized the existence of a contractual relationship between the clinic and the patients.

87. Unjust enrichment analysis seems to underlie most decisions
strictive covenants to prevent patients from following depart-
ing physicians and thereby reducing covenantees' patient bas-
es.88

(b). Training

Courts traditionally enforce restrictive covenants if employ-
ers have provided training to employees.88 The rationale is

enforcing noncompetition agreements to protect the employer's patient base. This was articulated in Granger v. Craven, 199 N.W. 10, 12 (Minn. 1924):

What one creates by his own labor is his. Public policy does not intend that another than the producer shall reap the fruits of labor. Rather it gives to him who labors the right by every legit-
imate means to protect the fruits of his labor and secure the enjoyment of them to himself.

See also Reddy v. Community Health Found. of Man, 298 S.E.2d 906, 916 (W. Va. 1982) ("The situations most likely to give rise to such an injury are those where the employer stands to lose his investment in employee training, have his trade secrets or customer lists converted by the employee, or have his market share threatened by the employee's risk-free entry into the employer's market.").


89. See Paul H. Rubin & Peter Shedd, Human Capital and Coven-
ants Not to Compete, 10 J. OF LEGIS. STUD. 93 (1981). This article em-
loys a useful framework for assessing if a post-employment restriction is a justified method for an employer to recapture an investment in employ-
ee training. Under this scheme, "general training" is defined as training that is useful in many firms, not only the firm that provides it. When an employer provides an employee with general training, the employee's overall value in the labor market is increased. "Specific training" consists of instruction in the employer's peculiar customs and practices and only increases an employee's productivity in the firm that provides it. It does not increase the employee's value to other employers. Id. at 93. Accord-
ingly, Rubin & Shedd argue that restrictive covenants are a valid means for employers to recapture investment in general training. Furthermore, judicial enforcement of restrictive covenants intended to recapture an investment in general training is macroeconomically sound, because it will encourage employers to provide general training to employees and thus increase the work force's skills and knowledge. Id. at 97. On the other hand, employers who provide specific training to employees do not increase the employees' value in the labor market and should not be entitled to judicial enforcement of a noncompetition agreement. Id. at 96.

In Reddy, 298 S.E.2d at 913, the court expressly adopted this
that restrictive covenants permit employers, who have invested in employee training and thereby increased employees' value in the labor market, to recapture their investment by temporarily restricting the employees' ability to use that training competitively after the employment relationship has been terminated.  

In general, courts have held that employer/physicians who provide training have a protectible interest warranting enforcement of a restrictive covenant. For example, in *Isuani v. Manske-Sheffield Radiology Group,* the court enforced a restrictive covenant after finding that a radiology group had paid for a departing physician's training in certain subspecialties, including magnetic resonance imaging (MRI) and diskograms.

A number of courts have denied enforcement of a restrictive covenant if the employer/physician did not pay for additional employee training but instead merely provided the new physician/employee with the opportunity to gain experience. New framework in a case involving physicians. In resolving disputes about restrictive covenants between physicians, the application of Rubin & Shedd's model is still troubling. While it enables physician/employers to recover their investment in general training, it nevertheless achieves this at the expense of patients.


91. *See, e.g., Duffner v. Albery,* 718 S.W.2d 111, 112 (Ark. Ct. App. 1986) ("the courts have found an interest sufficient to warrant enforcement of the covenant only in those cases where the covenantor provided special training, or made available trade secrets, confidential business information or customer lists . . ."); Hoddeson v. Conroe Ear, Nose and Throat Assoc., 751 S.W.2d 289, 290 (Tex. Ct. App. 1988) ("There are two competing interests in a covenant not to compete. The first, of course, is the protection of the investment made by employers in their employees, such as training."); *Reddy,* 298 S.E.2d at 913 ("Economic analysis compels the conclusion that restrictive covenants should be upheld where the employee has undergone certain types of training. Restrictive covenant protection is necessary, for example, to encourage efficient and extensive investment in 'human capital'.") (citations omitted).


93. *Id.* at 347-48.

94. *See, e.g., Darrow v. Kolczun,* No. 900A004759, 1991 WL 35120 at *2 (Ohio Ct. App. Mar. 6, 1991) (finding that the covenantor had acquired his skills through his education, not as a result of his association with orthopedic surgery group); *Lewis v. Surgery & Gynecology,* Inc., No. 90AP-300, 1991 WL 35010 at *4 (Ohio Ct. App. Mar. 12, 1991) (denying enforcement of restrictive covenant after finding that although the departing physician had completed his medical education immediately prior to
physicians, who had completed internships and residencies at considerable personal expense, were deemed fully trained when they arrived at their employers' doorsteps.

No court, however, has analyzed whether a post employment restriction is the least restrictive means for a physician/employer to recapture an investment in special training. This investment could be readily recaptured by a contractual provision requiring repayment of training expenses by the employee if the employment relationship is prematurely termi-

accepting employment by covenantee and became more skilled during the course of his employment, he was fully trained when he assumed the position); Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 130 (Wis. Ct. App. 1981) (noting that experience and skill gained by departing physician during his employment does not justify a post-employment restriction). But see Freudenthal v. Espey, 102 P. 280, 284 (Colo. 1909) ("It was certainly of great benefit to defendant, an inexperienced professional man, to be associated with a capable and efficient member of his own profession, long experienced, and enjoying an extensive practice."); Wilson v. Gamble, 177 So. 363 (Miss. 1937) (upholding validity of restrictive covenant between physicians, noting that covenantees were just beginning to practice, while the covenantors had been in practice for many years); Foltz v. Struxness, 215 P.2d 133, 135 (Kan. 1950) (upholding restrictive covenant and noting that covenantee was 69-years old and had many years of experience, while covenantor had only practiced for one year).


96. In 1990, the average cost of one year of medical school was $18,786 at a private institution and $14,932 at a public institution. AMERICAN MEDICAL COLLEGES, 1992-93 MEDICAL SCHOOL ADMISSION REQUIREMENTS 50 (1991). The average indebtedness of a medical school graduate in 1990 was $45,991. Id. at 49.

97. A more equitable approach is to deny enforcement of a restrictive covenant if the employer has only provided an opportunity for a new physician to gain experience. Given the extensive length of medical training, doctors are fully trained when they assume their first post-residency position. While it is certainly true that new doctors benefit from practicing with seasoned physicians, creating a rich learning environment for new physician/employees does not entail any economic expenditure by the employer and, therefore, should not justify the imposition of a post-employment restraint.
nated. This provision would fully compensate the employer for the training without impacting on the health care choices of the departing physician's existing or future patients.

(c). Confidential Business Information

Another ground for enforcing covenants not to compete is to protect employers from the competitive use of confidential information or trade secrets acquired by employees during the course of employment. The rationale is that employers have a legitimate interest in preventing employees from sharing confidential plans, processes or data with competitors, and it has proven quite a persuasive argument for commercial employers seeking enforcement of noncompetition agreements. This ground is sometimes asserted in cases involving noncompetition agreements between physicians. In some cases, departing physicians, who plan to continue treating patients acquired during the course of employment, leave with a list of patients' names and addresses. Additionally, some physicians, whose practice is dependent upon referrals from other physicians or hospitals, may leave with a list of referral sources, or at least knowledge of the identity of these sources. In such cases, employers argue that these lists constitute confidential business information which must be protected against competitive use by means of covenants not to compete.

Few courts, however, appear to have granted or denied enforcement based solely on this reason. One of several fac-


100. See, e.g., Dickinson Medical Group, at *1 (while employed by medical group, departing oncologist took original computer print-out of patients' names and addresses).

101. See, e.g., Dental East, P.C. v. Westercamp, 423 N.W.2d 553, 555
tors underlying a decision to enforce a covenant not to compete is whether a departing physician acquired a patient or referral list while employed by the covenantee.\textsuperscript{102}

2. Is the Covenant Broader Than Necessary to Protect Covenantee's Interest?

If a physician/covenantee is deemed to have an interest warranting protection, the court then decides whether the restrictive covenant extends beyond the bounds necessary to protect that interest.

(a) Nature of Covenantee's Medical Practice

Some courts have been careful to insure that a noncompetition agreement only prohibits the departing physician from practicing a medical specialty that is also practiced by the covenantee. Courts engaging in this type of analysis will enforce a covenant not to compete only to the extent that it bars a departing physician from practicing a specialty that directly competes with a former associate.\textsuperscript{103}

In \textit{Ellis v. McDaniel},\textsuperscript{104} a medical corporation sought enforcement of a covenant not to compete ancillary to an employment contract with Dr. Ellis, an orthopedic surgeon. The cove-

\textsuperscript{102} See, \textit{e.g.}, Total Health Physicians v. Barrientos, 502 N.E.2d 1240, 1242 (Ill. App. Ct. 1986) ("It is conceded that plaintiff furnished defendants with patient lists, referrals, confidential advertising and marketing techniques, office space, clinical facilities and supplies."); Middlesex Neurological Assoc. v. Cohen, 324 N.E.2d 911, 915 (Mass. App. Ct. 1975) (in determining whether restrictive covenant was reasonable, court considered that departing physician had acquired contacts with "the medical community from which a neurologist must derive patients by referral"); Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 130 (Wis. Ct. App. 1981) (court enforced restrictive covenant, noting that defendant copied employer's list of referral sources prior to terminating employment); Geocaris v. Surgical Consultants, Ltd., 302 N.W.2d 76, 78 (Wis. Ct. App. 1981) (by providing referral contacts, and by aiding development of his reputation among area physicians, a protectible right to reasonably prevent competition was acquired by covenantee).

\textsuperscript{103} See, \textit{e.g.}, Fumo v. Medical Group of Michigan City, Inc., 590 N.E.2d 1103, 1109 n.5 (Ind. Ct. App. 1992); Karlin v. Weinberg, 390 A.2d 1161, 1169 (N.J. 1978); Karpinski v. Ingrasci, 326 N.Y.S.2d 1, 6 (N.Y. 1971); Geocaris, 302 N.W.2d at 78.

\textsuperscript{104} 596 P.2d 222 (Nev. 1979).
nant provided that, upon the termination of his employment, Dr. Ellis would not "practice medicine" for two years within five miles of the town of Elko. After the employment contract expired, Dr. Ellis notified the clinic that he intended to establish an orthopedic surgery practice in Elko. The clinic immediately sought an injunction, which was granted by the trial court.

The Nevada Supreme Court carefully examined whether the clinic was justified in barring Dr. Ellis from practicing orthopedic surgery, even though no doctor on the clinic's staff practiced this specialty. The court concluded that this restraint was overly broad and upheld the lower court's ruling only to the extent that it prohibited Dr. Ellis from practicing areas of medicine that were actually practiced by doctors employed by the clinic.

The court in Isuani v. Manske-Sheffield Radiology Group further refined this approach. It held that a medical corporation that specialized in radiology could not restrain a departing radiologist from performing certain specific radiological procedures that were not offered by the corporation.

When a court determines that a covenant prohibits a departing physician from practicing specialties that are not directly competitive with the covenantee, the court will often limit the remedy to any overlapping areas of practice and will not entirely enforce the covenant. Departing physicians are thus permitted to practice medicine within the covenant area as long as the departing physician's specialty is not offered by former associates.

(b). Duration of Covenant

The duration of a restrictive covenant should be no longer than is necessary for employers to hire replacements and for replacements to have a reasonable opportunity to demonstrate

105. Id. at 223.
106. Id.
107. Id. at 224.
109. Id. at 352. Specifically, the court permitted the departing physician to continue performing "B" readings of X-rays, interventional radiology, arthrograms, angiography, angioplasty, diskograms, facet blocks and magnetic resonance imaging. Id.
110. See, e.g., Field Found., Ltd. v. Christensen, 309 N.W.2d at 133 (preventing doctor from performing abortions but allowing him to practice obstetrics and gynecology).
their effectiveness to customers. This is especially so if the purpose behind a restrictive covenant is to protect the covenantee's patient relationships. Among physicians, the duration of a restrictive covenant is reasonable to the extent that it provides physician/employers with a reasonable period of time to hire new doctors and gives those doctors sufficient time to demonstrate their competence to patients.

Courts often, however, do not engage in any fact-finding or theoretical analysis on the issue of whether the duration of a restrictive covenant between physicians is reasonable. Instead, most courts simply hold that covenants not to compete between physicians that last between two and five years are reasonable. Courts are not inclined, however, to enforce restrictive

111. See, e.g., Pollack v. Calimag, 458 N.W.2d 591, 599 (Wis. Ct. App. 1990) (noting that two-year restraints are generally found to be reasonable because they allow enough time to "obliterate in the minds of the . . . customers the identification" of the physician with the previous employer). In general, a covenant longer than the period needed for an employer to hire a replacement and to permit that replacement to prove her competency to customers would not serve its purpose of preventing unfair competition. If, after several years, a replacement cannot retain the departed employee's customers, then the customers clearly patronized the employer's establishment because of the former employee's personal qualities, not because of some quality of the employer. See Blake, supra note 18, at 677-78 (arguing that reasonable time restrictions depend on the nature of the customer relationship).

112. Some variation among courts exists as to where the duration inquiry fits into the overall reasonableness analysis. For example, some courts evaluate the reasonableness of the covenant's duration as part of an analysis of whether the covenant is no greater than is necessary to protect the covenantee. See, e.g., Karpinski v. Ingrasci, 320 N.Y.S.2d 1 (1971). For other courts, this inquiry is separate. See, e.g., Thompson v. Allain, 377 S.W.2d 465 (Mo. Ct. App. 1964); Lovelace Clinic v. Murphy, 417 P.2d 450 (N.M. 1966). Courts that fail to consider the nature of the employer's interest or the burden on the employee and public, but instead focus only on the reasonableness of the covenant's geographic scope and duration, are at the least precise end of the spectrum. These courts risk enforcing restrictive covenants that are normative in form but substantively unjustified. See, e.g., Vascular and Surgical Assocs., Ltd. v. Loiterman, 599 N.E.2d 1246 (Ill. App. Ct. 1992); Rash v. Toccoa Clinic Medical Assocs., 320 S.E.2d 170 (Ga. 1984); Thomson, 377 S.W.2d at 465. A more comprehensive approach is to assess the reasonableness of a restrictive covenant's duration as part of an inquiry into whether the provision is broader than necessary to protect a legitimate interest of the covenantee. Such an approach effectuates the purpose of imposing a time restriction, i.e., to give employers (or employee replacements) an opportunity to prove their competence to departing employees' customers.

113. See, e.g., Gelder Medical Group v. Webber, 394 N.Y.S.2d 867, 871
covenants between physicians that are unlimited in duration.\textsuperscript{114}

(c). Scope of Geographic Restriction\textsuperscript{118}

The geographic scope of a restrictive covenant that is designed to protect customer relations is reasonable if it encompasses the area from which the employer attracts customers.\textsuperscript{116} Therefore, courts typically enforce restrictive covenants between physicians if they correspond to the covenantee/physician’s service area.\textsuperscript{117} One court, for instance, has ruled that a geographic restriction is reasonable if it encompasses the area in which the covenantee markets its medical services to the public.\textsuperscript{118}

(d). Restrictions on Practicing at Hospitals

Noncompetition agreements between physicians often broadly state that covenantors may not “practice medicine or sur-

\begin{itemize}
  \item \textsuperscript{114} See, e.g., Rakestraw v. Lanier, 30 S.E. 735, 739 (Ga. 1898) (holding that restrictive covenant of unlimited duration was unreasonable and oppressive); Akhter v. Shah, 456 N.E.2d 232 (Ill. App. Ct. 1983) (holding that a noncompetition agreement between medical corporation and cardiologist employee that was unlimited in duration was unenforceable).
  \item \textsuperscript{115} The average mileage restriction for restrictive covenants that are enforced is 33.9 miles. Whitmore, supra note 73, at 511.
  \item \textsuperscript{116} See Blake, supra note 18, at 679-81.
  \item \textsuperscript{117} See, e.g., Gomez v. Chua Medical Corp., 510 N.E.2d 191, 193 (Ind. Ct. App. 1987) (upholding enforcement of restrictive covenant that barred surgeon from practicing within a 30-mile limit of his former employer’s office, because a substantial portion of patient base resided within the proscribed area); Fumo v. Medical Group of Michigan City, Inc., 590 N.E.2d 1103, 1109 (Ind. Ct. App. 1992) (ruling that 25-mile radius in restrictive covenant was not overbroad considering how far patients were willing to travel to obtain a particular service); Cogley Clinic v. Martini, 112 N.W.2d 678, 681 (Iowa 1962) (ruling a 25-mile limitation reasonable, considering that the clinic had 30,000 patients within its service area and attracted some patients from over 100 miles away); Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 132 (Wis. Ct. App. 1981) (ruling that a 50-mile restriction, from which 62 percent of the employer’s business originated, was reasonable and is not overbroad).
  \item \textsuperscript{118} See Pollack v. Calimag, 458 N.W.2d 591, 599 (Wis. Ct. App. 1990).
\end{itemize}
surgery" within a specified area for a certain period of time.\textsuperscript{119} Such a provision, which is limited by geography and duration, rather than function, implicitly bars departing doctors from practicing medicine at hospitals located within the covenant area.\textsuperscript{120} Cases are split in determining, however, whether a restrictive covenant is overly broad if it prevents departing physicians from practicing at hospitals that have certain equipment.\textsuperscript{121}

\begin{itemize}
\item \textsuperscript{120} No published case has rigorously analyzed whether restricting a departing physician's right to practice at hospitals within the covenant area goes beyond the bounds necessary to protect a covenantee's legitimate interest. On its face, such a restriction seems overly broad, because departing physicians who have relocated are prevented from treating certain patients who had no relationship with the covenantee. These patients include the departing physician's new patients as well as other physicians' hospitalized patients on whose cases the departing physician has consulted. Therefore, a general restriction prohibiting the "practice of medicine and surgery" within the covenant area unjustifiably burdens the covenantor's ability to compete with the covenantee. See infra text accompanying notes 151-61. For an example of a case that fails to fully analyze this issue by not identifying the employer interests at stake, see Fumo, 590 N.E.2d at 1109.
\item \textsuperscript{121} See, e.g., Retina Servs., Ltd. v. Garoon, 538 N.E.2d 651, 655 (Ill. App. Ct. 1989) (enforcing restrictive covenant that barred ophthalmologist from practicing at eight hospitals in Chicago which possessed equipment necessary to the practice of his subspecialty). Compare Ellis v. McDaniel, 596 P.2d 222, 225 (Nev. 1979) (denying enforcement of restrictive covenant to the extent that it barred orthopedic surgeon from practicing his specialty at the only hospital in a large area that was equipped to perform major surgical procedures). It is flawed, however, to consider this question as part of assessing whether the covenant goes beyond the bounds necessary to safeguard a protectible interest of the covenantee. Rather, the issue of whether a covenant is unreasonable when it prohibits a departing physician from practicing at a hospital that has special equipment should be part of determining either (1) the burden on the departing physician because she would be deprived of the right to perform certain procedures on patients in whom the covenantee has no interest, or (2) the harm to the public because the departed physician's new patients would be deprived of the right to have certain procedures performed on them by their physician.
\end{itemize}
3. Would Enforcement of the Covenant Unduly Burden the Covenantor?

After determining that a covenant is broader than necessary to protect a legitimate interest of the covenantee, courts then determine if the provision imposes an undue hardship on the covenantor. Covenantors usually argue that their personal circumstances make it particularly difficult to move their professional activities outside of the covenant area.122 However, this argument rarely persuades courts to deny enforcement of an otherwise reasonable restrictive covenant between commercial parties.123 Courts are not particularly sympathetic toward doctors who assert that a restrictive covenant is unenforceable because it imposes a unique personal hardship upon them,124 unless the hardship is quite severe.125

4. Would Enforcement of the Covenant Harm the Public?

Courts have recognized that restrictive covenants between physicians are injurious to the public if enforcement of the covenants will lead to a shortage of health care providers within the covenant areas.126 For example, in New Castle Orthope-

122. See Blake, supra note 18, at 684-86.
123. But see Whitmore, supra note 73, at 517 (noting a statistical correlation between the degree of harm to the employee and the likelihood that a restrictive covenant would be enforced).
125. See, e.g., Lewis v. Surgery & Gynecology, Inc., No. 90AP-300, 1991 WL 35010, at *4 (Ohio Ct. App. Mar. 12, 1991) (denying enforcement of noncompetition agreement between urological surgeon and professional corporation in part because surgeon's daughter, who suffered from a speech impairment, would be unduly harmed by transferring to a school outside of covenant area); Williams v. Hobbs, 460 N.E.2d 287, 290 (Ohio Ct. App. 1983) (denying enforcement of restrictive covenant in part because it would bar an osteopath from practicing at one of the few osteopathic hospitals in the state).
126. See Odess v. Taylor, 211 So. 2d 805, 810 (Ala. 1968); Fumo v. Medical Group of Michigan City, Inc., 590 N.E.2d 1103, 1109 (Ind. Ct.
dic Assoc. v. Burns, a physicians' association that specialized in orthopedic medicine sought enforcement of a restrictive covenant barring a departing physician from practicing this specialty within the county for two years. After finding that there was a shortage of orthopedic specialists in the county, the court held that the lower court erred in entering a preliminary injunction enforcing the covenant, because the public's interest in having a sufficient number of orthopedic surgeons outweighed its interest in promoting the freedom of contract.

Similarly, in Iredell Digestive Disease Clinic v. Petrozza, a North Carolina professional association of gastroenterologists sought enforcement of a restrictive covenant that barred a departing physician/employee from practicing for three years within 20 miles of the clinic's principal place of business, and within five miles of any hospital or office serviced by the corporation. The departing physician argued that the covenant was injurious to the public because it would result in a shortage of gastroenterologists in the area. In balancing the public interest in competition in the health care market against the public interest in freedom to contract, the court determined


Courts that examine the impact of restrictive covenants upon the physician services market as an aspect of "public harm" employ a rather crude analytical method. Generally, anticompetitive effects short of a complete monopoly of the health-care market by the employer are insufficient to invalidate a covenant not to compete. Professor Sullivan has persuasively criticized this approach. He argues that courts cannot adequately assess "public harm" without conducting the type of detailed market analysis that is used in federal antitrust litigation. See Sullivan, supra note 46, at 647-50.

128. Id. at 1384.
129. Id. at 1387.
131. Id. at 450-51.
132. Id. at 453. In support of his claim that the restrictive covenant was injurious to the public, Dr. Petrozza submitted affidavits from 41 local physicians stating that the loss of the defendant would give the plaintiff a monopoly on the practice of gastroenterology in the area and that one practitioner of this specialty was not sufficient to meet the community's need for these services. Id.
that the community's need for an adequate number of gastroenterologists outweighed the public interest in upholding a contract freely agreed to by private parties, and it held that the covenant was unenforceable. 133

Not all courts, however, have accepted the argument that noncompetition agreements between physicians are contrary to the public interest solely because they may lead to a shortage of physicians in the covenant area. 134 One court rejected this argument and explained that, while enforcement of the restrictive covenant would lead to a shortage of health care providers in the restricted area, it would result in an increase in health care providers in the area in which the departing physician established a new practice. 135 Thus, any harm to the public within the covenant area would be offset by a benefit to those who reside within the departing physician's new service area. 136

III. THE CONSEQUENCES OF ENFORCING RESTRICTIVE COVENANTS BETWEEN PHYSICIANS

When physicians comply with covenants not to compete, either voluntarily or as a consequence of judicial enforcement,

133. Id. at 455. See also Statesville Medical Group v. Dickey, 418 S.E.2d 256, 259-60 (N.C. Ct. App. 1992) (holding that covenant not to compete was unenforceable because it would give covenantee a monopoly over the practice of endocrinology in its service area and would require patients who wanted the services of a different endocrinologist to travel 45 minutes).


135. Willman v. Beheler, 499 S.W.2d at 777. The court also upheld the provision because of "a counterbalancing public policy . . . in enforcing contractual rights and obligations." Id.

136. Id. This analysis is peculiar on several levels. First, it completely ignores the hardship to patients who lose their doctor due to a noncompetition agreement and who will presumably find little comfort in knowing that patients in some other area can now benefit from their doctor's services. Second, on a larger scale, this analysis is sound only if the departing physician relocates to a geographic region which has a shortage of health care providers. Otherwise, the shortage of health care providers in the restricted area will not be offset by the lessening of a shortage of health care providers in the departed physician's new service area.
their patients must choose between establishing a relationship with a new physician or following their doctor outside of the covenant area. Even if existing patients desire to follow a departing physician to a less convenient location, their health, age, financial circumstances, or the quality of the hospital outside the covenant area may preclude this option. Whether it is sound from the standpoint of public policy and jurisprudence to enforce private contractual agreements that interfere with the doctor-patient relationship and restrict patients' choice of physicians will be examined in this section.

A. The Impact of Restrictive Covenants Between Physicians on the Quality of Health Care

1. Involuntary Termination of the Physician-Patient Relationship

The majority approach to noncompetition agreements between physicians, which weighs the economic interests of the parties, is contrary to medical research that demonstrates that continuity in the doctor-patient relationship fosters the delivery of quality health care and that the involuntary termination of this relationship may have lasting, negative effects on patients. 137

Long-term, continuous relationships between doctors and patients impact positively on many aspects of health care. 138 Patients who have permanent relationships with primary care physicians are less likely to seek treatment in hospital emergency rooms than patients who have no such relationship. 139

137. No empirical evidence exists that restrictive covenants are needed to protect physician/employers' economic interests. Indeed, one medical commentator has concluded that these provisions are usually not economically justified. Richard P. Bergen, Practical Considerations on Restrictive Covenants, 203 JAMA 197, 198 (1968).

138. See Ralph B. Freidin & Alan M. Lazerson, M.D., Terminating the Physician-Patient Relationship in Primary Care, 241 JAMA 819, 822 (1979) ("The physician-patient relationship is central to the process of primary care.").

Additionally, the hospital and intensive care stays of patients who have ongoing relationships with physicians are considerably shorter than the stays of patients who lack a permanent relationship with a physician.  

A longstanding, trusting relationship between doctor and patient often improves a physician's diagnostic abilities and increases the likelihood that the patient will comply with prescribed therapy. Providing continuity is particularly important to the treatment of certain patients and certain medical conditions. For example, continuous care is especially vital when treating children. Moreover, the development and maintenance of a strong "therapeutic alliance" between doctor and patient may be dispositive in determining if psychiatric treatment succeeds or fails. Given the centrality of the

(provider continuity in treating inner city families resulted in decreased hospitalizations, operations, hospital visits, and appointment breaking).

140. See Alpert et al., supra note 139, at 921; Wasson et al., supra note 139, at 2415-16. Wasson states that "the findings suggest that policies favoring improved outpatient provider continuity may result in significant financial savings." Id. at 2416.

141. See, e.g., Timothy E. Quill, Somatization Disorders: One of Medicine's Blind Spots, 254 JAMA 3075, 3078 (1985) (creation of long-term relationship between doctor and patient facilitates ability to recognize psychosomatic symptoms and treat patients accordingly); Jonathan T. Stewart, M.D., Huntington's Disease, 37 AM. FAM. PHYSICIAN 105, 112 (1988) (strong bond between physician, patient, and patient's family facilitates recognition of symptoms and treatment decisions for this progressive disease).

142. See, e.g., Arlene F. Frank, Ph.D. & John G. Gunderson, M.D., The Role of the Therapeutic Alliance in the Treatment of Schizophrenia, 47 ARCH. GEN. PSYCHIATRY 228, 232 (1990) (schizophrenic patients who had strong alliances with their psychiatrists were more likely to comply with medication regimen); Ramon Boza, M.D. et al., Patient Noncompliance and Overcompliance: Behavior Patterns Underlying a Patient's Failure to "Follow Doctor's Orders", 81 POSTGRADUATE MEDICINE 163, 168 (1987) (good rapport with physician may lead to greater patient compliance with treatment, such as taking medication); Freidin & Lazerson, supra note 138, at 820 (involuntary termination of the physician-patient relationship may lead to patients' erratic compliance with prescribed treatment).

143. See Marshall H. Becker, Ph.D. et al., Continuity of Pediatrician: New Support for An Old Shibboleth, 84 J. PEDIATRICS 599 (1974) (continuity in pediatric care yielded higher staff and patient satisfaction, greater ease in discussing behavioral problems, and better appointment Keeping); see also Alpert et al., supra note 139, at 921.

144. See Frank & Gunderson, supra note 142, at 235 (patients who formed strong alliances with their therapists more likely to remain in
therapist-patient relationship to psychotherapeutic treatment, it is particularly disturbing that courts uphold noncompetition agreements that involuntarily terminate this relationship.\(^{146}\)

Two studies have examined the impact upon patients of the involuntary termination of their relationship with a private primary care physician, and both found that this experience can be traumatic and long-lived.\(^{146}\) For example, patients who have suffered the involuntary loss of a physician need a considerable period of time to find a suitable replacement.\(^{147}\) Until a new primary care physician is found, patients tend to seek treatment for non-emergency conditions in their local hospital emergency rooms.\(^{148}\) Moreover, the negative impact of involuntarily losing a primary care physician does not end once a replacement is found. Patients need two to five years to feel

therapy, comply with medication regimen and achieve better outcomes); Elsa Marziali, D.S.W. et al., *Therapeutic Alliance Scales: Development and Relationship to Psychotherapy Outcome*, 138 AM. J. OF PSYCHIATRY 361, 363 (1981) (patients who developed positive relationships with therapist achieved greatest gains from psychotherapy).


146. See Toms, supra note 139, at 115, 117 (in-depth interviews were conducted with 30 blue-collar families to assess the effects of the retirement of their physician from his 20 year old private family practice); Keith Sinusas, M.D., *Patients' Attitudes Toward the Closing of a Medical Practice*, 28 J. FAM. PRAC. 561 (1989) (physician, who had a private family practice in a small town in rural Vermont for eight years, distributed questionnaires to 200 patients to determine their response to his impending retirement to assume a teaching position). While there has been a great deal of medical research on the impact of continuity in patient care, all but these two studies have examined this issue within the context of clinics, which are usually staffed by interns and residents, not private physicians. Since noncompetition agreements between physicians most often involve physicians in private practice, these two studies are the best available empirical information on the likely impact upon patients of losing a private physician due to compliance with a covenant not to compete.

147. Toms, supra note 139, at 115 (only one out of every six families was able to establish a reliable and permanent relationship with a new physician within six months of losing their primary care physician without experiencing "great difficulty").

148. See Wasson et al., supra note 139, at 2416; Toms, supra note 139, at 117.
confident that their new physician knows their medical problems well and more than five years to trust that their emotional problems are understood.\(^{149}\)

Patients who have received certain types of care are likely to experience increased hardship from the loss of their doctor. For example, mothers and their families appear to form a particularly strong bond with their obstetrician-gynecologist and may be particularly troubled by the loss of this relationship.\(^{150}\)

In sum, medical research on continuity and discontinuity in provider care has established that the involuntary loss of a primary care physician is a significant physical and psychological\(^{151}\) hardship and may be experienced by the patient for an extended period. Public policy, as effectuated through judicial decisions in cases involving noncompetition agreements between physicians, should foster provider continuity in health care, not undermine it.

2. The Impact of Restrictive Covenants on Hospitalized Patients

As previously noted, the language of most restrictive covenants requires departing physicians to cease the practice of medicine and surgery at all hospitals located within the restricted area.\(^{152}\) This aspect of restrictive covenants between physicians is rarely the subject of judicial consideration, even though it has far reaching consequences on the quality of health care and range of choices available to four categories of patients. First, departing physicians must cease treatment of their patients who are hospitalized at the time of the termina-

\(^{149}\) Sinusas, supra note 146, at 563. These findings suggest that those patients who have been under a departing physician's care for the longest period of time, who are most likely to be older patients, tend to suffer the greatest hardship from involuntary termination.

\(^{150}\) Id. at 564. But see Stephen P. Flynn, M.D., Continuity of Care During Pregnancy: The Effect of Provider Continuity on Outcome, 21 J. Fam. Prac. 375, 379-80 (1985) (finding that health care provider continuity had no effect on the health status and patient satisfaction of pregnant patients in a university-based practice, but noting that "continuity may improve this outcome in other settings, such as chronic illness, elderly patients, or private practice.").

\(^{151}\) See Peter R. Lichstein, M.D., The Resident Leaves the Patient: Another Look at the Doctor-Patient Relationship, 96 Annals Internal Med. 762, 762-63 (1982) (noting that patients commonly experience anger, guilt, anxiety, fear and depression after the termination of a relationship with clinic residents).

\(^{152}\) See supra text accompanying notes 119-21.
tion of employment.

Second, departing physicians must cease consulting on the cases of other physicians’ hospitalized patients, and performing emergency room services. As a result, these patients, in whom the covenantee has no arguable interest, lose the benefit of the departing physician’s expertise and experience as a consultant.

Third, departing physicians may not admit patients, who have chosen to follow them outside the restricted area, to hospitals within the covenant area for the duration of the restrictive covenant. These patients must, therefore, relinquish the opportunity to be treated at a hospital that is more likely to be convenient to their families and friends, and may be superior to hospitals located outside of the covenant area.

Finally, restrictive covenants impact on the new patients of the departed physician who has relocated outside of the covenant area. These patients must relinquish the opportunity to be treated at hospitals within the restricted area, even if they offer superior care to hospitals located outside of the covenant area.

In sum, restrictive covenants between physicians limit the range of hospital care choices available to several distinct groups of patients, some of whom have no prior relationship with the covenantee and in whom the covenantee has no argu-


154. This restriction is also overly broad because it affects patients with whom the employer had no relationship or interest. See supra note 120.

155. For purposes of marketing their services, hospitals are considered to have a service area extending 15 miles in all directions, because this is the distance that most doctors and patients are willing to travel. See Deborah W. Garnick et al., Appropriate Measures of Hospital Market Areas, 22 Health Services Research 69, 72 (1987).

156. The quality of care provided by hospitals in neighboring communities can vary a great deal. See Linda Sunshine & John W. Wright, The Best Hospitals in America 2 (1987) (“[t]he kind of treatment received from hospital to hospital, even in the same geographic area, is sometimes so dramatically different that choosing a particular hospital can literally determine your treatment.”).

157. This restriction is also overly broad because it affects patients with whom the employer had no relationship or interest. See supra notes 119-21 and accompanying text.
able interest. If a departing physician is the only practitioner of a certain specialty in a small hospital in an isolated area, a restrictive covenant may have devastating consequences for the doctor's private in-patients and for the community as a whole. 158 In the case of a large hospital in a metropolitan area, a physician's compliance with a noncompetition agreement results in discontinuity in the treatment of the departing physician's in-patients and the hospital's loss of an experienced member of its staff.

B. Jurisprudential Consequences

1. Inconsistency With Treatment of Restrictive Covenants Between Attorneys

Despite the AMA's declaration that restrictive covenants between physicians are not in the public interest, 159 and despite medical research demonstrating the importance of continuity in the doctor-patient relationship, 160 courts have been unwilling to hold these agreements contrary to public policy and hence per se unenforceable. 161 Yet, courts consistently invalidate noncompetition agreements between attorneys on the grounds that they inappropriately intrude upon the lawyer-client relationship and restrict the public's right to choose an attorney. 162 The inconsistent judicial treatment of restrictive


159. See supra text accompanying notes 21-44.

160. See supra text accompanying notes 138-51.

161. Two courts have concluded that covenants not to compete are not per se unenforceable after considering the argument in some detail. See Karlin v. Weinberg, 390 A.2d 1161 (N.J. 1978) and Ohio Urology, Inc. v. Poll, 594 N.E.2d 1027 (Ohio Ct. App. 1991). See also infra notes 172-94 and accompanying text. Several other courts have summarily dismissed the argument that noncompetition agreements between physicians are against public policy. See Phoenix Orthopedic Surgeons, Ltd. v. Peairs, 790 P.2d 752, 758 (Ariz. Ct. App. 1989); Raymundo v. Hammond Clinic Assn., 449 N.E.2d 276, 280-81 (Ind. 1983).

162. See, e.g., Cohen v. Lord, Day & Lord, 550 N.E.2d 410, 410-11 (N.Y. 1989) (holding that law firm's partnership agreement, which conditioned payment of withdrawing partner's uncollected revenues on his refraining from competing with former firm, was void as against public policy); In re Silverberg, 427 N.Y.S.2d 480, 480-81 (App. Div. 1980) (provision of partnership agreement, which amounted to covenant restricting practice of law, was void as against public policy); Gray v. Martin, 663 P.2d 1285, 1290-91 (Or. Ct. App. 1983) (provision of attorneys' partner-
covenants between these two types of professionals cannot be justified. Indeed, the philosophical and public policy underpinnings of the per se rule apply with greater force to restrictive covenants between physicians than to restrictive covenants between attorneys. Simply put, if the reasoning behind the per se rule for attorneys is valid, the reasoning applies even more strongly to physicians.

In 1969, the American Bar Association adopted a code of professional conduct, which included a specific disciplinary rule addressing restrictive covenants between attorneys. The rule stated that a "lawyer shall not be a party to or participate in a partnership or employment agreement with another lawyer that restricts the right of a lawyer to practice law after the termination of a relationship created by the agreement, except as a condition to payment of retirement benefits."166

_Dwyer v. Jung_166 was the first case to consider DR 2-108(A) in the course of analyzing whether to apply a per se or reasonableness rule to restrictive covenants between attorneys.167 In holding that restrictive covenants between attorneys were contrary to public policy and therefore invalid, the court explicitly adopted the view that a defining feature of professionalism

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ship agreement, which penalized attorney for entering into competitive practice, was contrary to public policy and void). _But cf._ Haight, Brown & Bonesteel v. Superior Court of Los Angeles County, 285 Cal. Rptr. 845 (Ct. App. 1991) (holding that California rule of professional conduct did not prohibit withdrawing partner from compensating former partner if he represented clients previously represented by firm).

163. Some commentators have criticized judicial acceptance of a _per se_ ban on anticompetition agreements between attorneys. _See_, _e.g._, Stephen E. Kalish, _Covenants Not to Compete and the Legal Profession_, 29 ST. LOUIS U. L.J. 423, 456-57 (1985) (calling for application of rule of reason, rather than _per se_ ban, to noncompetition agreements between attorneys to enable attorneys to protect themselves against unfair competition by departing partners).

164. For a detailed history of the American Bar Association's treatment of restrictive covenants between attorneys, _see id._ at 429-34.


167. In _Dwyer_, a partnership agreement included a dissolution provision that allocated clients among the partners and barred them from representing each other's clients for five years. After the partnership dissolved, one of the former partners charged two others with "attempting to pirate [his] clients and undermining his relationship with certain named insurance carriers." _Id._ at 499.
is an ethical obligation to place the needs and interests of the client above the needs and interests of the professional. The court stated:

Commercial standards may not be used to evaluate the reasonableness of lawyer restrictive covenants. Strong public policy considerations preclude their applicability. In that sense 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 . . . . No concept of the practice of law is more deeply rooted. The lawyer's function is to serve, but serve he must with fidelity, devotion and erudition in the highest tradition of his noble profession.  

While the Dwyer court relied on the Model Code in reaching its decision, it was not merely enforcing its requirements. Rather, the court looked to the Code as one of several sources of public policy. From these sources, the Dwyer court, along with most courts which have considered the issue, concluded

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168. Id. at 500. In Jacob v. Norris, McLaughlin & Marcus, 607 A.2d 142 (N.J. 1992), the New Jersey Supreme Court revisited the issue of the enforceability of covenants not to compete between attorneys. In holding that the provision violated public policy, the court reaffirmed the theoretical justification for applying a per se rule, stating that "Dwyer makes clear that the practice of law must be carefully governed by ethical considerations rather than by economic concerns that guide strictly commercial enterprises." 607 A.2d at 147.

169. The Dwyer court's view disfavoring noncompetition agreements between attorneys was also revealed by their criticism of Hicklin v. O'Brien, 138 N.E.2d 47 (Ill. Ct. App. 1956), which had upheld such an agreement. The Dwyer court stated that Hicklin "completely ignored the effect the covenant might have upon potential clients. The court there viewed the matter as a business proposition and failed to respect the underlying ethical considerations affecting the practice of law." Dwyer, 336 A.2d at 501.

170. The Dwyer court drew upon several sources in addition to the Code to ascertain public policy with respect to the restrictive covenants between attorneys. These sources included Drinker's treatise on Legal Ethics; observations attributed to Abraham Lincoln; and earlier cases expressing New Jersey policy. See 336 A.2d at 499-500.

Interestingly, the section of Drinker's treatise which was cited in Dwyer reflects the same perspective on the unique nature of a lawyer's relationships with clients and the impossibility of transferring a lawyer's goodwill as did an earlier opinion of the court which involved physicians. See Mandeville v. Harman, 7 A. 37, 40-41 (N.J. Ch. 1886).
that sound public policy requires application of a per se rule to
restrictive covenants between attorneys to uphold their duty to
public service and clients' rights to freely choose an attor-
ney.\footnote{171} The two courts that have sought to rationalize the applica-
tion of a per se rule to restrictive covenants between attorneys
and the rule of reason to restrictive covenants between physi-
cians have failed to provide a sufficient justification.

In \textit{Karlin v. Weinberg}, \footnote{172} Dr. Karlin hired Dr. Weinberg,
who had just completed his medical education, to assist him
with his dermatology practice. The parties' agreement specified
that Dr. Weinberg could not practice dermatology for a period
of five years within a 10-mile radius of Dr. Karlin's office after
terminating his employment.\footnote{173} After the parties terminated
their relationship, however, Dr. Weinberg established a derma-
tology practice several doors away from Dr. Karlin's office.\footnote{174} Dr. Karlin sought damages and injunctive relief.

Relying on \textit{Dwyer v. Jung}, the New Jersey Chancery Court
declared that restrictive covenants between doctors, like re-
strictive covenants between lawyers, were contrary to public
policy and invalid as a matter of law.\footnote{175} On appeal, however,
the New Jersey Appellate Division adopted the opposite view.
While endorsing the holding that restrictive covenants between
attorneys were contrary to public policy,\footnote{176} the court distin-

\footnote{171. \textit{See}, e.g., Cohen v. Lord, Day \& Lord, 550 N.E.2d 410 (N.Y.
1989); In re Silverberg, 427 N.Y.S.2d 480 (App. Div. 1980); Gray v. Mar-
Bonesteel v. Superior Court of Los Angeles County, 285 Cal. Rptr. 845
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\footnote{172. 390 A.2d 1161 (N.J. 1978).
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\footnote{173. \textit{Id.} at 1164.
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\footnote{174. \textit{Id.} The parties disagreed about whether their oral partnership
agreement incorporated the restrictive covenant that had been a part of
their earlier employment contract.
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\footnote{175. \textit{Id.} In the chancery court, Weinberg moved for partial summary
judgment dismissing Karlin's claim that he breached the restrictive cove-
nant. The motion was granted, with the court noting in an oral opinion
that restrictive covenants between physicians were per se unreasonable
and unenforceable. New Jersey's Appellate Division reversed the trial
court and ruled that such covenants were not per se invalid. Instead,
according to the appellate court, they were enforceable if the plaintiff had
a legitimate protectable interest to protect and the public was not
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\footnote{176. \textit{Id.} at 1167.
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guished Dwyer from Karlin on its facts. Specifically, the court noted differences in the scope of the covenants at issue in the two cases, and that, while it was constitutionally obligated to enforce the Code of Professional Responsibility's ban on restrictive covenants between attorneys, it had no such duty to enforce AMA guidelines. Therefore, rather than adopt a per se rule, the court opted for the rule of reason.

Ohio Urology, Inc. v. Poll is the only other reported decision that acknowledges and seeks to reconcile the inconsistency of applying a per se rule to restrictive covenants between attorneys and the rule of reason to covenants between physicians. Yet, like Karlin, this opinion manages to avoid the underlying theoretical issues.

Ohio Urology involved an employment contract between a urological surgeon and an Ohio medical corporation that specialized in urology. The employee/physician's two-year employment contract included a restrictive covenant barring him from

177. Id.

178. The restrictive covenant in Dwyer barred the partners from ever representing a client who had been designated as "belonging" to another partner. The covenant in Karlin, however, only barred Dr. Weinberg from continuing a relationship with former patients within a 10-mile radius of Dr. Karlin's office for a period of five years. In this regard, the court noted:

[w]hile it is true that if the covenant is ultimately found enforceable some patients may have to travel a greater distance to Dr. Weinberg's new office (and conceivably some a shorter distance) than they travelled to his former office, no patient will, by force of law, automatically be deprived of continuing his ongoing relationship with his physician. Consequently, Dwyer has no applicability where a restrictive covenant among physicians authorizes the maintenance of the relationship within certain geographical or time limitations.

Id.

179. At the time of the Karlin case, the AMA's 1977 version of the rule against restrictive covenants was in effect. See supra notes 35-37 and accompanying text. In 1980, the AMA revised its guidelines and declared that restrictive covenants between physicians were not in the public interest. See supra notes 38-39.

180. Karlin, 390 A.2d at 1169. Interestingly, the majority expressed concern that the restrictive covenant might prevent patients who wanted to continue treatment with the departing physician from doing so. This concern conflicts with the court's acceptance of the premise that restrictive covenants between physicians are a legitimate way for employer/physicians to interfere with patients' range of choices by making it inconvenient for them to follow the departing physician.

practicing urology within a five-mile radius of any of the corporation's offices for a period of two years. When a financial disagreement between the parties could not be resolved, the defendant terminated his employment and established a urology practice one block from one of plaintiff's offices. The corporation moved to enjoin the violation of the restrictive covenant.

The trial court held that the restrictive covenant was contrary to public policy and unenforceable, citing new AMA guidelines which stated that restrictive covenants between physicians were contrary to the public interest. According to the court, the state licensing statute, which empowered a state medical board to discipline doctors for violating the AMA's code of ethics, incorporated the AMA code into the state's public policy.

The appellate court did not analyze whether the theoretical underpinnings of the per se rule applied to restrictive covenants between physicians. Instead, it focused on linguistic differences between the AMA guidelines on restrictive covenants and comparable provisions in the ABA's Model Code. In remanding the case, the court instructed the trial court to apply the rule of reason.

Neither Karlin nor Ohio Urology thoughtfully considered whether as a matter of public policy a physician/employer's commercial risk of losing patients is more deserving of judicial protection than the doctor-patient relationship or a patient's ability to freely choose a physician. Instead, by adopting

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182. Id. at 1029.
183. Id. at 1030.
184. Id. The referee relied on the AMA's 1989 Current Opinions of the Council on Ethical and Judicial Affairs. Id.
185. Id.
186. Id. at 1030-31. Specifically, the court noted that the AMA rules merely "discourage" physicians from entering into restrictive covenants, while the Code of Professional Responsibility unequivocally bars attorneys from participating in noncompetition agreements. Id.
187. Id. at 1032.
188. In the course of considering the enforceability of restrictive covenants between doctors, some courts have expressed disdain at the spectacle of physicians battling over the right to profit from treating the ill. See, e.g., Novendstern v. Mt. Kisco Medical Group, No. 2537/91, slip op. at 2 (N.Y. Sup. Ct. July 16, 1991) ("Graced with the ability to practice medicine and honored with the privilege of licensure, these physicians now do battle over turf and money."); Dickinson Medical Group v. Foote, 1984 WL 8208, at *2 ("[A physician] is claiming, in essence, that [he]
the rule of reason, which derives primarily from commercial case law, both courts have elevated physicians' self-interest over the needs and interests of patients and the public. Yet, it is the professionals' duty to suppress self-interest that enables the formation and maintenance of fiduciary relationships with patient/clients, who typically lack the education and expertise needed to critique professional advice.\textsuperscript{189} The ability to trust professional advice and decision making turns upon whether patient/clients can assume that the "practitioner's self-interest is overbalanced by devotion to serving both the client's interest and the public good."\textsuperscript{190} Without this expectation, client/patients could never be sure if a lawyer was proposing litigation to increase attorneys' fees or whether a doctor was recommending surgery because it yielded the highest profits.\textsuperscript{191}

By focusing on tangential and inconsequential factual distinctions, both \textit{Karlin} and \textit{Ohio Urology} lost sight of the fundamental similarity between the destructive impact of restrictive covenants on relationships between lawyers and their clients and doctors and their patients, and the inappropriateness of applying commercial standards in both professional contexts.\textsuperscript{192} This myopic approach\textsuperscript{193} was the focus of an acromo-
nious dissent in *Karlin* by Justice Sullivan:

The art of healing the sick and the infirm is effected with a public interest. The restrictive covenant, which the Court is upholding in principle, does violence to the concept of the physician-patient relationship. A person requiring medical treatment and advice goes to the doctor of his or her choice. . . . The relationship is so personal and so sensitive, and the right of a patient to consult the physician of one's own choice so fundamental, that a restrictive covenant which substantially intrudes on that relationship and interferes with that fundamental right should be held contrary to public policy. This policy does not exist for the benefit of the physician consulted but rather to protect the patient's right to seek medical treatment from the doctor whom the patient believes is best able to treat him.  

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193. The New Jersey Supreme Court's recent opinion in *Jacob v. Norris, McLaughlin & Marcus*, 607 A.2d 142 (N.J. 1992), which reaffirms that covenants not to compete between attorneys violate public policy, hints that its myopia with respect to similar provisions between physicians has yet to be cured. During an eloquent, detailed discussion of the dangers that noncompetition agreements pose to the 'lawyer-client relationship and, more importantly, with clients' free choice of counsel,' *id.* at 148, the court makes a reference to some unstated distinction between restrictive covenants between attorneys and those between physicians. The *Jacob* court stated that by "distinguishing an employment agreement among physicians from one among attorneys, this Court, in *Karlin v. Weinberg* endorsed the principles enunciated in *Dwyer.*" *Id.* at 147 (citations omitted). This remark suggests that a majority of the New Jersey Supreme Court remains unconcerned by the dangers posed by noncompetition agreements between physicians to the doctor-patient relationship and patients' free choice of a physician. Indeed, noncompetition agreements between physicians arguably threaten harm to a range of patient needs and interests that are more serious than clients' needs and interests, which are primarily financial.

2. Inconsistency With Legal Doctrine Protecting Doctor-Patient Relationships

The majority approach to restrictive covenants between physicians places the relationship between physicians and patients on the same legal footing as the relationship between commercial sellers and customers. Yet, in other areas of the law, this relationship enjoys a unique status.

A majority of states have statutes that recognize a doctor-patient testimonial privilege. Under the privilege, physicians cannot be compelled to testify about information conveyed to them in confidence by patients. The doctor-patient privilege reflects the social valuation that preserving the integrity of the special relationship between a doctor and patient outweighs the value such evidence may have in a legal proceeding. The special status of the physician-patient relationship within the law of evidence is difficult to square with the majority approach to restrictive covenants between physi-


196. While a majority of states recognize some version of a doctor-patient testimonial privilege, it is often subject to a number of exceptions. Indeed, in some jurisdictions the exceptions seem to overtake the privilege. For example, California’s doctor-patient privilege statute lists 12 exceptions, including any civil action in which the patient’s condition is at issue, any criminal proceeding, any medical malpractice case, and any will contest. See Cal. Evid. Code §§ 996-1007 (West 1966 & Supp. 1992).

cians, which values protecting this bond less than preventing a decrease in physician/employers' incomes.

Tort law also recognizes the uniquely sensitive nature of the physician-patient relationship. Under the common law doctrine of patient abandonment, physicians who unilaterally terminate existing relationships with patients are liable for damages.\(^{198}\) Underlying the doctrine of patient abandonment is the recognition that patients can be injured merely from the involuntary termination of the physician-patient relationship.\(^{199}\) Physicians may also be sanctioned under disciplinary rules for abandoning a patient.\(^{200}\) The clear public policy objective of the tort of patient abandonment is to deter discontinuity in the doctor-patient relationship and to minimize the traumatic effects of terminating this relationship when it is necessary.

Finally, a number of states recognize the continuous treatment doctrine, under which the statute of limitations for filing a medical malpractice action is tolled while a patient is under a doctor's continuing care.\(^{201}\) This doctrine promotes continu-

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200. See, e.g., Burdge v. State Bd. of Medical Examiners, 403 S.E.2d 114, 116-17 (S.C. 1991) ("Burdge failed to inform his patients that he would not be able to deliver their babies. The failure to inform patients such as Ms. Couch deprived the patients of their right to choose their doctor.")


ity in the doctor-patient relationship by not requiring that patients summarily terminate this relationship and institute a malpractice action when they first doubt the adequacy of a physician's treatment.202

3. Inconsistency with Increasing Recognition of Patient's Right of Self-Determination

The majority approach to restrictive covenants between physicians, which recognizes that patients "belong" to physician/employers, is contrary to the current trend in the law of expanding patients' autonomy and rights of self-determination. These developments, which have revolutionized the practice of medicine over the past twenty-five years, have transformed the patient from a passive object of physicians' determinations into the ultimate decision makers about the health care they receive.203

This trend is reflected in a variety of judicial decisions and legislative enactments. For instance, under the doctrine of informed consent, patients must be informed of the material risks associated with alternative treatments so that they are able to make rational decisions about their health care.204 A


203. For excellent analyses of the impact of this legal trend upon the practice of medicine in the United States, see JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 104-65 (1984), and DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING 222-46 (1991).

physician's failure to fulfill this duty gives rise to a cause of action for negligence.\textsuperscript{205}

Increasing judicial recognition of a patient's right of self-determination is also evident in "right to die" cases. The United States Supreme Court has presumed that competent patients have a constitutionally protected liberty interest to refuse life-sustaining medical treatment\textsuperscript{206} and has recognized that incompetent patients also possess this interest.\textsuperscript{207} In addition, a number of state courts have ruled that competent and incompetent patients have a state based privacy right to have life-sustaining treatment withdrawn.\textsuperscript{208}

Recent federal and state legislative enactments similarly strengthen patients' autonomy and authority within the structure of the medical decision making. For example, the Medicaid Self-Determination Act, which applies to health care institutions that receive federal Medicaid and Medicare funding, requires that patients be informed of their rights under state law to accept or refuse medical treatment.\textsuperscript{209} A number of states have also enacted statutes that protect patients' rights.\textsuperscript{210} Additionally, a majority of states now recognize the

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\item \textsuperscript{205} See 2 LOUISELL & WILLIAMS, supra note 199, ¶ 22.04 at 22-14 (1987). A physician may be liable for battery if a patient fails to entirely consent to treatment. Id. at 22-12.
\item \textsuperscript{206} See Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990).
\item \textsuperscript{207} Id. at 280. While acknowledging that patients have a liberty interest in refusing life sustaining medical treatment, the Court also recognized that states have a competing interest in preserving life, which justifies the imposition of evidentiary standards that must be satisfied before treatment is terminated. Id. at 281-83.
\item \textsuperscript{209} See 42 U.S.C.A. § 1395cc(f) (West 1992).
\item \textsuperscript{210} See, e.g., ALASKA STAT. § 47.30.825 (1990) (giving patients right to be informed about treatment and to participate in medical decision making); GA. CODE ANN. § 31-8-103-121 (1991) (guaranteeing rights of elderly and indigent patients at long-term care facilities); N.J. STAT. ANN. § 30:13-5 (West 1981) (giving nursing home patients the right to control various aspects of their lives and treatment); N.Y. PUB. HEALTH LAW § 2803-C (McKinney 1985) (giving patients right to access information re-
validity of living wills, which articulate a patient’s wishes with respect to the continuation of life-sustaining treatment, and durable powers of attorney, which appoint a third party to make medical decisions if the signatory becomes unable to express her wishes.211

In the face of these developments, which have significantly enlarged patients’ rights and ability to self-determine health care, the majority approach to restrictive covenants between physicians anachronistically persists in viewing patients as passive objects whose right to choose a physician without interference is less deserving of legal protection than the preservation of physician/employers’ right to contract and their financial interest.

IV. CONCLUSION

At best, noncompetition agreements between physicians inconvenience patients and interfere with their access to health care by the physician of their choice in a conveniently located hospital. At worst, these agreements may completely supplant a patient’s choice to maintain a relationship with a departing physician if, for example, the patient is hospitalized, is too sick to travel to a new office in a distant location, or because the quality of care offered by hospitals outside of the covenant area is unacceptable.

Medical research demonstrates that continuity in the physician-patient relationship yields medical and financial benefits and that the involuntary termination of this relationship can be harmful to patients and costly to society as a whole. In recognition of this, the doctor-patient relationship has long enjoyed a special status within disparate bodies of law. Judicial treatment of restrictive covenants should similarly protect this relationship by holding that such provisions are contrary to public policy and unenforceable. Such an approach will promote the public service function of the medical profession and foster patients’ right to choose the physician they prefer and trust.