Regulate Physician Restrictive Covenants to Improve Healthcare

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REGULATE PHYSICIAN RESTRICTIVE COVENANTS TO IMPROVE HEALTHCARE

Judy Ann Clausen

ABSTRACT

The U.S. healthcare reform agenda seeks to expand patient choice and access, improve quality, and control costs. This Article argues these goals should govern enforceability of physician non-compete and non-solicitation agreements (restrictive covenants). Most jurisdictions apply a reasonableness test to assess the enforceability of physician restrictive covenants. Some jurisdictions hold physician non-competes per se invalid. Courts applying the reasonableness test often disrupt continuity of care and harm patients; continuity of care is key to patient health. Moreover, physicians departing a practice have an ethical obligation to notify patients of the physician's departure and how to transfer to the physician's new practice. Courts have heavily scrutinized a physician's notification to her patients to determine whether the physician crossed the nebulous line from fulfilling notification obligations to improper solicitation. Wary of liability for breach of a non-solicitation agreement, doctors will likely avoid fulfilling their obligations to notify patients, effectively preventing the patient from continuing treatment with her doctor. This Article articulates a model framework for evaluating restrictive covenants that protects patients and furthers healthcare reform goals. First, practices should be required to allow departing physicians to access patient info to fulfill patient notification obligations; courts should refuse to enforce non-solicitation agreements prohibiting physicians from soliciting their own patients. Otherwise, non-solicitation agreements potentially sever doctor-patient relationships. Next, courts should refuse to enforce restrictive covenants in a way that disrupts continuity of care or interferes with the doctor-patient relationship; courts should clarify that non-competes can only restrict the location where a physician practices and cannot prohibit a physician from treating her patients. Finally, states should enact transactional incentives to lower costs to patients and expand patient choice and access by making covenant enforcement turn on the extent to which the covenant supports healthcare reform goals. Current frameworks fail to incentivize providers to: (1) accept lower reimbursement coverage such as TRICARE, Medicare, and Medicaid and (2) reduce patient costs. This Article's model provides these incentives.

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TABLE OF CONTENTS

ABSTRACT ....................................................................................................................... 111
TABLE OF CONTENTS ...................................................................................................... 112
INTRODUCTION ............................................................................................................... 113
I. BACKGROUND – PHYSICIAN RESTRICTIVE COVENANTS ........................................ 114
   A. Non-Compete Agreements ....................................................................................... 115
   B. Non-Solicitation Agreements ................................................................................. 118
   C. Healthcare Reform Goals ....................................................................................... 120
      i. Maintain and Expand Patient Choice and Access .................................................. 120
      ii. Maintain and Improve Quality ............................................................................. 124
      iii. Contain and Reduce Costs .................................................................................. 125
      iv. Physician Restrictive Covenants Support or Undermine Healthcare Reform Goals................................................................................................................................. 126
         1. The Potential to Support Healthcare Reform Goals ........................................... 126
         2. The Potential to Undermine Healthcare Reform Goals ........................................ 127
II. THE EXTENT TO WHICH CONTEMPORARY FRAMEWORKS SUPPORT HEALTHCARE REFORM GOALS ............................................................................................................ 128
   A. Some Version of Reasonableness ........................................................................... 128
      i. Reasonableness with No Heightened Scrutiny ....................................................... 128
         1. Valid Consideration and Ancillary Nature of Covenant ...................................... 129
         2. Legitimate Business Interests ............................................................................. 130
         3. Undue Burden on Physician .............................................................................. 131
         4. Injury to the Public .............................................................................................. 132
         5. Reasonableness in Time, Place, and Activities ................................................... 133
      ii. Reasonableness with Strict Scrutiny .................................................................... 134
      iii. Blue Pencil Rule .................................................................................................. 135
      iv. Extent to Which the Reasonableness Approach Supports Healthcare Reform Goals ................................................................................................................................. 137
   B. Per Se Invalidity with Varying Allowance for Liquidated Damages ....................... 139
      i. Survey of Jurisdictions Adopting the Per Se Invalidity Approach ......................... 139
      ii. Extent to Which Per Se Invalidity Supports Healthcare Reform Goals ................ 143
III. MODEL FRAMEWORK FOR EVALUATING PHYSICIAN RESTRICTIVE COVENANTS ......................................................................................................................... 144
   A. The Unique Approach in Texas ............................................................................. 144
      i. The Texas Approach Better Supports Healthcare Reform Goals Than Other Contemporary Frameworks Do .................................................................................................................. 145
      ii. The Texas Approach Could Do More to Support Healthcare Reform Goals .......... 145
   B. Model Framework for Evaluating Physician Restrictive Covenants ...................... 146
      i. Refuse to enforce non-solicitation agreements prohibiting physicians from soliciting their own patients ............................................................................................................. 146
      ii. Clarify that restrictive covenants can only restrict the location where a physician practices ...................................................................................................................... 147
      iii. Prohibit injunctions for restrictive covenant breaches and enforce only liquidated damages provisions ................................................................. 148
      iv. Prohibit blue penciling over broad restrictive covenants ..................................... 148
      v. Enact transaction incentives to lower patient choice and access by making covenant enforcement turn on the extent to which the covenant furthers healthcare reform goals ............................................................................................................ 149
MODEL STATUTE ............................................................................................................ 149
CONCLUSION ................................................................................................................ 151
INTRODUCTION

For five years, Albert has received HIV treatment from Dr. Smith from Sunshine Medical. At Albert's most recent appointment, Dr. Smith informs Albert he will no longer be able to treat Albert because Dr. Smith is starting a new practice. Dr. Smith's contract with Sunshine Medical prohibits him from treating Sunshine Medical's patients after Dr. Smith departs the practice. Albert must search for a new physician. Switching doctors will negatively impact Albert's health.

Amelia, a Medicaid patient, has bipolar disorder. Amelia moves across the country and is unable to find a psychiatrist who accepts Medicaid anywhere within 200 miles of her home. Amelia cannot afford to pay out-of-pocket. Her prescriptions are running out. This Article addresses these common scenarios by crafting a model framework for regulating physician restrictive covenants that expands patient choice and access, improves quality, and controls healthcare costs.

Despite the American Medical Association’s (AMA) assertion that physician non-compete agreements are unethical if they fail to make reasonable accommodation of patients’ choice, patients often face disruption of care because of doctors' perceptions of their contractual obligations. Moreover, the AMA requires a physician departing a practice to notify her patients that the physician is leaving, the address of the new practice, and offer the patient the opportunity to have medical records forwarded to the new practice. Courts have, however, held physicians liable for breach of non-solicitation agreements and misappropriation of trade secrets when they attempt to fulfill their patient notification ethical obligations. Punishing doctors who cross the nebulous line from notifying to soliciting patients deters physicians from fulfilling ethical obligations, disrupts continuity of care, and potentially deprives patients of the choice to continue care with their physician.

States should adopt this Article’s model framework for assessing the validity of physician restrictive covenants to expand patient choice of providers and access to care. The Affordable Care Act (ACA) is under attack. Patients face increasing obstacles to access to care. In 2017, the number of adults with health insurance decreased. Even if the patient has coverage, that coverage may be simply a “card without care.” Physicians often turn away patients with lower reimbursement coverage such as TRICARE, Medicare, and Medicaid.

States have failed to adequately incentivize doctors to accept patients with lower reimbursement coverage. Modern frameworks for evaluating restrictive covenants ignore the covenant’s impact on the healthcare reform goals of expanding patient choice and access, improving quality, and controlling costs. Instead, most

2 Although the names have changed, these situations actually occurred.
3 See Michelle Andrews, Did Your Doctor ‘Ghost’ You? An Employment Contract May Be To Blame, KAISER HEALTH NEWS (Mar. 19, 2019), https://khn.org/news/did-your-doctor-ghost-you-an-employment-contract-may-be-to-blame/ [https://perma.cc/2RSW-VJV9] (asserting that the AMA does not “oppose restrictive covenants outright” but its policy notes that such covenants “can limit patients’ choices” and quoting Dr. Patrice Harris, the organization’s president-elect, as stating “[t]o the extent that these agreements disrupt continuity of care and disrupt patient choice, this is of great concern to the AMA”); see infra Section I.A.
4 See infra Section I.C.i.
jurisdictions apply some version of a reasonableness analysis. Some jurisdictions make physician non-competes per se invalid and vary in the degree to which they enforce liquidated damages clauses. The per se invalidity approach often undermines practices' attempts to control costs. The contemporary frameworks fail to incentivize doctors to accept lower reimbursement coverage and often disrupt continuity of care and therefore undermine quality of care. The time is ripe for legislative reform; in a recent report evaluating how best to promote patient choice and competition in healthcare, the Trump administration advised states to examine non-competes' impact on patient access and physician supply.

To expand patient choice and access, improve quality, and control costs, this Article sets forth the following model framework for evaluating physician restrictive covenants.

First, states should require group practices to allow departing physicians to access patient information to fulfill patient notification responsibilities and refuse to enforce non-solicitation agreements prohibiting a physician from soliciting her own patients.

Second, states should refuse to enforce restrictive covenants in a way that disrupts continuity of care or interferes with the doctor-patient relationship. States should clarify restrictive covenants can only restrict the location where a physician treats patients and cannot prohibit a physician from treating patients.

Third, states should prohibit injunctions for breaches of physician restrictive covenants and enforce only liquidated damages provisions.

Fourth, states should prohibit courts from rewriting overly broad restrictive covenants. Otherwise, covenant holders have every incentive to draft overreaching covenants with the knowledge the court will salvage the covenant to make it reasonable.

Finally, states should enact transactional incentives for physicians to: (1) accept lower reimbursement coverage, thereby expanding patient choice and access, and (2) reduce costs to patients. Covenant enforcement should turn on the extent to which the covenant furthers healthcare reform goals of expanding patient choice and access, improving quality, and controlling costs.

I. BACKGROUND – PHYSICIAN RESTRICTIVE COVENANTS

This Section provides background. Section I(A) explores physician non-competes and illustrates that courts have enforced non-competes to disrupt continuity of care and interfere with the doctor-patient relationship. Section I(B) explores physician non-solicitation agreements and illustrates that physicians departing practices have ethical obligations to notify patients. However, if a court later determines the doctor has crossed the line from notification to solicitation, the doctor may be liable for breach of a non-solicitation agreement and misappropriation

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of trade secrets. Section I(C) explores the healthcare reform goals of: (i) maintaining and expanding patient choice and access, (ii) maintaining and improving quality of care, and (iii) containing and reducing costs. Section I(C)(4) explains physician restrictive covenants have the potential to either support or undermine these goals.

A. Non-Compete Agreements

A physician non-compete is a provision “ancillary” to an “employment contract[] [or] partnership agreement[]” in which the covenantor physician agrees to refrain from practicing within a designated “geographic area for a specified period of time” after termination of employment or withdrawal from the practice. The AMA “strongly disfavors [but does not prohibit] post-employment” physician non-competes. First, the AMA regards physician non-competes “as unethical if they restrict a patient’s choice of physician.” Moreover, the AMA posits that physician non-competes “restrict competition, disrupt continuity of care, and potentially deprive the public of medical services.” The AMA “discourages any agreement which restricts the” physician from practicing “for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement.” According to the AMA, physician non-competes “are unethical if they are excessive in geographic scope or duration . . . or if they fail to make reasonable accommodation of patients’ choice of physician.”

Despite the AMA’s negative stance, physician non-competes are common and enforceable in most jurisdictions, unlike lawyer non-competes. A recent survey of nearly 2,000 primary care physicians determined that roughly 45% of the physicians were bound by non-competes. Scholars argue physician non-competes should be unenforceable just like lawyer non-competes; the doctor-patient relationship is as vital and sensitive as the lawyer-client relationship. The New Jersey Hospital Association, however, argued that physician non-competes are different than lawyer

9 Id.
10 Id. at 896.
11 Id.
12 Id.; see also Malloy, supra note 5, at 207 (asserting that the AMA guidelines “state that once [the] physician-patient relationship is formed, the physician has a legal and ethical duty to continue providing care as long as the patient needs” the care); Robert Steinbuch, Why Doctors Shouldn’t Practice Law: The American Medical Association’s Misdiagnosis of Physician Non-Compete Clauses, 74 MO. L. REV. 1051, 1054–55 (2009) (asserting that the AMA has failed to protect patients and has allowed predatory behavior by existing medical practices and so should adopt rules prohibiting non-competes similar to those adopted by the American Bar Association); Restrictive Covenants, AM. MED. ASS’N, https://www.ama-assn.org/delivering-care/ethics/restrictive-covenants [https://perma.cc/Z7BM-QD5S].
14 Andrews, supra note 3.
non-competes.\textsuperscript{16} A lawyer non-compete prohibits the lawyer "from having any relationship with a client."\textsuperscript{17} A physician non-compete, however, "only restricts the location where the physician can have a relationship with the patient" and does not prohibit the physician from treating patients.\textsuperscript{18}

Although supporters of physician non-competes may argue that physician non-competes do not prohibit a physician from treating patients and only limit the location in which the physician treats patients,\textsuperscript{19} this is not true in every case. Courts have enforced physician non-competes which disrupt continuity of care, interfere with the doctor-patient relationship, and prevent a doctor from treating a patient.\textsuperscript{20}

Moreover, courts and legislatures have provided insufficient and inconsistent guidance.\textsuperscript{21} Doctors and practice groups may not realize that they should avoid forming non-competes prohibiting doctors from treating patients and should only form non-competes limiting the location in which doctors can practice. For this reason, practice groups are likely forming non-competes prohibiting physicians from treating their patients after they depart practices. If these departing physicians comply with their contractual obligations, patients will suffer.

For example, in \textit{Dental East, P.C. v. Westercamp}, the court enforced a restrictive covenant that essentially prohibited a dentist from: (1) treating his patients for two years after terminating his employment and (2) notifying his patients of his departure from the practice.\textsuperscript{22} To comply with the covenant the court deemed enforceable, the dentist would have to: (1) disrupt his patients' continuity of care and (2) shirk patient notification obligations. The covenant was between a professional corporation owned by a dentist and another dentist and stated that the professional corporation owned all patient records.\textsuperscript{23} For two years after the dentist's departure from the practice, the covenant prohibited the dentist: (1) from practicing within twenty miles of the professional corporation and (2) from contacting or informing any patient of the professional corporation, including the departing dentist's patients.\textsuperscript{24} This combination of obligations essentially prohibited the dentist from treating his own patients for two years. The dentist terminated his employment and practiced dentistry within one mile of the professional corporation.\textsuperscript{25} Accordingly, the professional corporation filed suit to enforce the covenant.\textsuperscript{26} Despite the fact that the trial court determined the covenant was "unduly restrictive and unenforceable," the appellate court held the covenant was enforceable and reasonable.\textsuperscript{27} The appellate court reached this conclusion, in part, because the covenant did not penalize the dentist for

\begin{itemize}
\item \textsuperscript{16} \textit{Cmty. Hosp. Grp.}, 869 A.2d at 893.
\item \textsuperscript{17} \textit{Id.}
\item \textsuperscript{18} \textit{Id.}
\item \textsuperscript{19} See \textit{id.} at 894.
\item \textsuperscript{20} See \textit{supra} text accompanying notes 22-39.
\item \textsuperscript{21} See \textit{supra} text accompanying notes 22-39; see \textit{supra} Section II.B.
\item \textsuperscript{22} \textit{Dental East, P.C. v. Westercamp}, 423 N.W.2d 553, 554-55 (Iowa Ct. App. 1988).
\item \textsuperscript{23} \textit{id.} at 554.
\item \textsuperscript{24} \textit{Id.}
\item \textsuperscript{25} \textit{Id.}
\item \textsuperscript{26} \textit{Id.}
\item \textsuperscript{27} \textit{id.} at 554-55.
\end{itemize}
“performing dental services on persons who had not been patients.” Instead, the covenant required the dentist to pay “40% of whatever production done” for services performed on persons who had been patients of record of the professional corporation, even though these patients had presumably been the departing dentist’s patients. Therefore, the court enforced a restrictive covenant that prohibited a dentist from treating his own patients and even from notifying his own patients of his departure; the court sent the message to doctors that courts will enforce non-competes that essentially sever the doctor-patient relationship.

In Valley Medical Specialists v. Farber, the restrictive covenant prohibited the physician from treating his patients and went further than limiting the location in which the physician could treat patients. For three years after leaving the practice, the covenant prohibited the physician from providing “medical care . . . for any person or persons who were patients” of the practice while the physician worked for the practice. Even though the Court declined to enforce the covenant, the covenant demonstrates that practices do, in fact, ask physicians to enter non-competes which prohibit physicians from treating their own patients when the physician leaves the original practice.

In Prairie Eye Center, Ltd. v. Butler, the court stated it was bound to enforce the physician non-compete, despite the court’s acknowledgment that the public policy concerns were not different between the rights of clients to keep and choose their lawyers and the rights of patients to keep and choose their doctors. The departing physician argued the non-compete was unenforceable, especially as to patients the physician brought to the covenant holder’s practice, and that the covenant holder had no protectable interest in those patients. The departing physician argued a covenant-holder practice only had a protectable interest in patients when an established practice hired a new physician who gained the practice’s patient base. His case was different—he had an established practice and brought his patients to the covenant holder. Finding that practices have a protectable interest in the patients of their physicians, the court rejected the departing physician’s argument. The covenant holder did not need to present evidence of a protectable interest in the departing physician’s patients that the physician had brought to the covenant holder’s practice because these were the patients for whom the covenant holder negotiated. The court upheld the award of damages and injunctive relief, barring the departing physician from practicing for an additional two-year term, pursuant to the non-compete’s extension for physician breach. Physicians can reasonably infer from

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28 Id. at 555.
29 Id. at 554.
31 Id. at 1279.
32 Id. at 1286.
34 Id. at 421.
35 Id.
36 Id.
37 Id. at 421–22.
38 Id. at 422.
39 Id. at 423–24.
cases like Prairie Eye Center that courts will enforce non-competes that prohibit doctors from treating their patients, even patients the departing physician brought to the covenant-holder practice.

B. Non-Solicitation Agreements

In the healthcare context, a non-solicitation agreement is a contract prohibiting a physician from soliciting patients of a practice to join the physician in the physician’s new practice.40 Courts have looked to Black’s Law Dictionary to define “solicit,” which is defined as “[t]o appeal to (for something); . . . to ask earnestly; to ask for the purpose of receiving; to endeavor to obtain by asking or pleading; to entreat, implore, or importune; to make petition to; to plead for; to try to obtain.”41

There is a subtle distinction between solicitation and notification. A physician has an ethical responsibility to notify patients the physician has treated that the physician is departing a practice and to advise patients about the location of the new practice.42 The duties a physician departing a practice owes to her patients stem from the Hippocratic oath—“[t]he interest of the patient is paramount . . . everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient.”43 The AMA Code of Ethics states that patients’ best interests require a physician departing a practice to notify patients of the physician’s departure and the address of the new practice and to offer patients the opportunity to have their medical records forwarded to the new practice.44 The group should not interfere with the departing physician’s discharge of these duties and, accordingly, should not withhold patient lists.45 Although the AMA requires patient notification, the AMA does not authorize the departing physician to solicit patients from the practice.46

Distinguishing between patient notification and solicitation is challenging.47 If a court determines the doctor has crossed the line from notification to solicitation, the court may hold the doctor liable for breaching a non-solicitation agreement and for misappropriation of trade secrets.48 This potential liability makes departing physicians wary of fulfilling ethical patient notification obligations; they fear a court

41 Id. at *8 (citing Aetna Bldg. Maint. Co. v. West, 246 P.2d 11, 15 (Cal. 1952)).
42 Id. at *5–6 (citing CODE OF MED. ETHICS §§ 7.01, 7.03 (AM. MED. ASS’N 1994)).
43 Id. at *5 (quoting CODE OF MED. ETHICS § 7.01 (AM. MED. ASS’N 1994)).
44 Id.
45 Id.
46 Id. at *6.
47 See, e.g., Dickinson Med. Grp., P.A. v. Foote, No. 834-K, 1984 WL 8208, at *3 (Del. Ch. May 10, 1984) (enjoining a doctor from using patient lists to contact patients even though the doctor believed she was only notifying patients of her upcoming departure from practice); Total Care Physicians, 2002 WL 31667901, at *7 (stating the propriety of physician’s communications with patients about upcoming departure from practice raised question of first impression in Delaware, with the exception of some guidance from the Foote case).
will later decide that communications the doctor perceived to be patient notification were, in fact, improper solicitation.49

For example, in Dickinson Medical Group, P.A. v. Foote, the court held the departing physician liable for breach of non-solicitation agreement and for misappropriation of trade secrets when she used patient lists to contact patients.50 The departing physician used patient lists to notify her patients of her departure.51 The practice sued her for breach of non-solicitation agreement and misappropriation of trade secrets.52 The physician argued that she had the ethical responsibility to notify patients that she was leaving the practice, and that she should be authorized to use patient lists to contact her patients to fulfill these obligations.53 The practice argued that the physician breached the non-solicitation agreement and misappropriated trade secrets by surreptitiously removing confidential medical records to assist in starting her new practice.54 The court ruled in favor of the practice, enjoining the departing physician from using the lists to contact patients she had treated.55 The court was concerned the physician would solicit her patients from her former practice, in breach of the non-solicitation agreement, and irreparably harm the former practice.56 Although the court acknowledged a departing physician’s patient notification obligations, the court enjoined the physician from using patient lists to notify patients herself.57

Similarly, in Total Care Physicians v. O’Hara, the court held a physician liable for misappropriating trade secrets and breaching a non-solicitation agreement because the court determined the physician used patient information to solicit his patients from the practice he was departing.58 The departing physician believed he was fulfilling his ethical obligations to notify patients of his departure.59 The court scrutinized every word of the physician’s letter to his patients from the practice he departed.60 Based on a review of the AMA standards and corresponding Delaware public policy and case law, the court concluded that a proper communication should notify the patient of (1) the physician’s departure, (2) the location of the physician’s new practice, and (3) the means by which the patient can transfer medical records to the new practice, if the patient chooses.61

The court emphasized that notification letters “should not . . . encourage” the physician’s patients to transfer care.62 The court acknowledged that the departing physician properly (1) announced his departure and (2) advised patients on how to

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49 See, e.g., id. at *2.
50 Id. at *1, *3.
51 Id. at *1.
52 Id.
53 Id. at *2.
54 Id. at *1–2.
55 Id. at *3.
56 Id.
57 Id. at *2–3.
59 Id. at *2.
60 Id. at *3, *9.
61 Id. at *9.
62 Id.
Because the departing physician “tout[ed]” the “quality of care” and facilities offered at the new practice, however, the letter was an improper solicitation. Even though the court recognized that the doctor could properly use patient lists to notify patients, the doctor could not use patient lists to solicit patients. The court held that the departing physician misappropriated trade secrets contained in the patient lists and breached the non-solicitation agreement when the physician solicited patients.

Punishing doctors who cross the line from notification to solicitation of patients deters physicians from fulfilling ethical obligations, disrupts continuity of care, and potentially deprives patients of choice of providers. Physicians, afraid of liability for misappropriation of trade secrets and breach of non-solicitation agreements, will refrain from contacting their patients. A patient who never learns (1) her doctor is leaving the practice, (2) her doctor’s new address, (3) how to transfer records to her doctor, and (4) that she can choose to continue treatment with her doctor will likely experience disruption of care. Disruption of continuity of care leads to poorer health outcomes. Worried about suits brought by a former practice, doctors may refrain from treating their patients from the former practice. Even though this more cautious approach may insulate the doctor from suits from the former practice, the approach breaches ethical obligations to patients, disrupts continuity of care, and deprives patients of the ability to continue treatment with their doctors.

C. Healthcare Reform Goals

This Section explores three interrelated healthcare reform goals and explains that physician restrictive covenants can support or undermine these goals.

i. Maintain and Expand Patient Choice and Access

The rate of adults without health insurance rose in 2017 as the Trump administration tried to repeal and replace the Affordable Care Act (ACA). In the current political climate, the long-term future of the ACA is uncertain. The percentage of adults in the United States (U.S.) without health insurance may continue to rise. Without coverage, these individuals face tremendous obstacles to accessing care. Without either private health insurance or coverage from a governmental program, individuals must pay out-of-pocket for medical care. With

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63 Id.
64 Id.
65 Id. at *3, *5.
66 Id. at *1, *9, *11.
69 See id. ("Amid the uncertainty, several major insurers have already announced they are abandoning some health exchanges for 2018 plans, implying coverage options could dwindle further, and premiums could rise even higher across the U.S.").
an ever-growing percentage of the population paying out-of-pocket for care, controlling costs becomes even more important for the healthcare consumer.

Even individuals with health coverage, such as military families, often face barriers to access to care because providers refuse to accept the coverage. 70 TRICARE is the Department of Defense’s healthcare program covering approximately 9.4 million active duty military members and their families, National Guard/Reserve members and their families, retirees, survivors, and some former spouses. 71 A Government Accountability Office (GAO) study found that civilian providers too often turn away TRICARE patients, causing a “potential problem with (beneficiaries) getting access to care.” 72 According to the study, private doctors turn away TRICARE patients because the doctors are dissatisfied with reimbursement amounts. 73 Moreover, “[t]he number of private doctors accepting [] TRICARE patients is trending downwards.” 74 The study indicated that only about 39% of civilian mental health providers accepted TRICARE patients. 75 In California and Texas, nearly all providers accepted new patients, but less than half accepted TRICARE patients. 76

Similarly, the number of physicians dropping Medicare patients has been steadily rising. 77 Medicare is a government-funded health insurance program “for senior citizens, young people with certain disabilities, and patients with end-stage renal disease.” 78 A 2018 report revealed that many doctors have opted out of Medicare and will likely opt out in increasing rates in the future. 79 Doctors cite low reimbursement rates and burdensome paperwork and reporting requirements as reasons for opting out. 80 Recent studies indicated that 22,000 doctors no longer accept Medicare patients. 81 While most doctors continue to treat current Medicare patients, some have decided not to accept new Medicare patients. 82 Therefore, the access to healthcare

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72 Zoroya, supra note 70 (quoting Debra Draper, the director of a study conducted by the GAO); see also U.S. Gov’t Accountability Office, GAO-13-364, DEFENSE HEALTH CARE: TRICARE MULTIYEAR SURVEYS INDICATE PROBLEMS WITH ACCESS TO CARE FOR NONENROLLED BENEFICIARIES 3, 17 (2013) [hereinafter DEFENSE HEALTH CARE].

73 DEFENSE HEALTH CARE, supra note 72, at 31–32, 38, 41; Zoroya, supra note 70.

74 Zoroya, supra note 70.

75 DEFENSE HEALTH CARE, supra note 72, at 29.

76 Zoroya, supra note 70.


78 Id.


80 Id.

81 Wright, supra note 77.

82 Kane, supra note 79 (click to slide 27).
problem will likely worsen in the future, especially because the large baby boomer generation is becoming Medicare eligible.83 Doctors opting out of Medicare has been a consistent trend; in 2012, the number of doctors treating Medicare patients was falling and had nearly tripled from 2009.84

In addition, Seema Verma, an administrator for the Centers for Medicare and Medicaid Services, described the “dismally low” physician acceptance rate of Medicaid patients as a “card without care.”85 In 2013, the percentage of physicians accepting new Medicaid patients was 68.9%, nearly 20% lower than acceptance rates for Medicare and privately insured patients.86 Health and Human Services Secretary Tom Price indicated that “one out of every three physicians in this nation aren’t seeing Medicaid patients.”87 Medicaid “has nearly 69 million enrollees” and “is operated with state and federal matching funds.”88 The ACA Medicaid expansion, which 31 states and the District of Columbia implemented, expanded coverage outside of traditional enrollees to low-income families, pregnant women, children, people with disabilities, and elderly people.89 Now, “all individuals under age 65 who earn up to 13 percent of the federal poverty level” are eligible for Medicaid in states that have implemented the ACA expansion.90

To maximize profits and ease administrative burdens, many doctors prioritize privately insured patients over Medicaid patients.91 Physician Medicaid participation rates vary by specialty.92 In some specialties, there is a crisis.93 For example, more than half of psychiatrists will not accept new Medicaid patients.94 Lower Medicaid reimbursement rates are correlated with lower physician participation rates for Medicaid “as compared with Medicare or private insurance.”95 States vary widely in reimbursement rates, and the higher the state reimbursement rate, the more likely doctors in that state participate in Medicaid.96 Medicaid’s paperwork burden, payment delays, and the “high clinical burden” of Medicaid patients, who tend to have more health problems than privately insured patients, also

87 Id.
88 Id.
89 Id.
90 Id.
91 Id.
92 Id.
93 Id.
94 Id.
95 Id.
96 Id.
influence doctors to opt out of Medicaid. 97
In addition to providers refusing to accept their coverage, many patients’
geographic location causes barriers to access. For example, a shortage of primary
physicians in rural communities negatively impacts the health and life
expectancy of rural patients. 98 A 2017 GAO report indicated that “physician
maldistribution significantly impacts rural communities.” 99 “The patient-to-primary
care physician ratio in rural areas is only 39.8 physicians per 100,000 people,
compared to 53.3 physicians per 100,000 [people] in urban areas.” 100 “[A]n increase
of one primary care physician per 10,000 people is associated with an average”
of nearly 50 “fewer deaths per 100,000 [people] per year.” 101 A Centers for Disease
Control and Prevention study revealed that limited access to primary care physicians
is one of the factors contributing to reduced lifespans of rural patients. 102 A
longitudinal study illustrated that a patient’s zip code may have an equivalent impact
on that patient’s health and life expectancy as the patient’s genetic code. 103
Finally, provider shortage is an “escalating crisis” in some medical specialties. 104
Even though this shortage disproportionately impacts rural patients, all patients face
barriers to access to specialty care. 105 For example, nationally, there is a growing

97 Encouraging Healthy Communities: Perspective from the U.S. Surgeon General: Hearing Before S. Comm.
99 Hearing, supra note 98, at 2.
100 Id. at 1.
103 See David Levine, What’s the Answer to the Shortage of Mental Health Care Providers?, U.S.
shortage of mental healthcare providers. According to a projection, there will be a shortage of 250,000 mental healthcare providers in 2025. The shortage "is most acute in rural areas" as mental health providers, like other healthcare providers, "tend to cluster in urban areas." More than half of U.S. counties have zero psychiatrists" and "about 111 million people live in 'mental health professional shortage' areas." The mental healthcare professional shortage causes two thirds of primary care doctors to face "difficulty referring patients for mental health care," twice that of other specialties.

ii. Maintain and Improve Quality

Studies indicate continuity of care improves quality of care. Moreover, "involuntary termination" of the doctor-patient relationship may potentially have a long-lasting negative impact on patients. Continuity of care is care given by a single doctor over a period of time to a patient that builds an evolving relationship between the doctor and patient. The key relationship for continuity of care is that between doctor and patient, not that between clinic and patient. Patients who have continuity of care tend to be more satisfied with their care, and satisfied patients tend to comply with instructions from their doctors. Compliance with doctors’ instructions is key to positive healthcare outcomes. Moreover, patients with


Id.
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long-term relationships with their physicians tend to better use preventative services and screenings, such as colonoscopies and mammograms, which are key to improving the health and longevity of patients.

iii. Contain and Reduce Costs

The U.S. healthcare system is the most expensive in the world. Other comparably wealthy countries spend about as much per person on healthcare as the United States does. In 2017, U.S. healthcare spending per person was 28% higher than Switzerland, "the next highest per capita spender." Since the 1980s, healthcare spending grew at a greater percentage of the overall U.S. economy than healthcare spending of comparably wealthy nations. For instance, in 2017, the U.S. spent 17% of its gross domestic product (GDP) on healthcare; "the next highest comparable country (Switzerland) devoted [only] 12% of its GDP." Healthcare spending through public funds in the United States is more commensurate with public spending in comparably wealthy countries than is private spending. Therefore, individual U.S. citizens pay more of their own funds for healthcare than people do in comparably wealthy nations.

Barriers to access and disruption in continuity of care exacerbate the bloated costs of U.S. health care. High-quality primary care helps reduce per capita costs. Patients who have "a usual source of care" incur lower healthcare costs because they are healthier, use fewer healthcare resources, and resolve healthcare needs in a cost-efficient manner. In contrast, patients "without a usual source of care" do not receive timely, necessary intervention and more frequently visit emergency rooms and have unnecessary tests and procedures, making the U.S. healthcare system overly expensive. Patients with "a usual source of care" also benefit from better coordination amongst providers; this coordination improves health outcomes and reduces costs.

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118 Id. at 205–06 (citing studies indicating that continuity of care was linked to patients using "preventative services, such as breast and cervical cancer screening ... and vaccination [of] children").
120 Sawyer & Cox, supra note 119.
121 Id.
122 Id.
123 Id.
124 Id.
125 See id.
126 See supra Section I.C.i.
127 Hearing, supra note 98, at 1.
128 Id. at 2.
129 Id.
130 Id.
iv. Physician Restrictive Covenants Support or Undermine Healthcare Reform Goals

1. The Potential to Support Healthcare Reform Goals

Physician restrictive covenants have the potential to help control costs to patients. In fact, the Medical Society of New Jersey argued that physician non-competes "serve the legitimate purpose[s] of encouraging investment in new physicians" and "protecting the established physicians" when hiring. If covenant holders cannot protect that investment, they may be forced to raise costs to patients to recoup the loss. Moreover, they may be forced to decline lower reimbursement coverage as a result of the un-recouped investment in the departing physician. Therefore, all-out prohibition on physician restrictive covenants could lead to: (1) increased costs to patients, and (2) barriers to access to patients with lower reimbursement coverage such as Medicaid, Medicare, and TRICARE. Regulation of physician restrictive covenants, however, must ensure patients realize the cost savings and increased access that restrictive covenants have the potential to support. If the framework for evaluating the physician restrictive covenant fails to incentivize providers to: (1) control costs to patients and (2) accept lower reimbursement coverage such as Medicaid, Medicare, and TRICARE, restrictive covenants will not support the healthcare reform goals. Amelia, a patient in need of a psychiatrist who accepts Medicaid, will not realize the potential for restrictive covenants to increase access to Medicaid patients unless states incentivize doctors to accept Medicaid.

One proponent of physician non-competes argued that physician "[n]oncompetes are good for the patients because they help to provide stability within a practice and ensure continuity of care," presumably because non-competes incentivize contractually bound physicians to remain with their current practices and deter them from relocating. Conversely, if a physician really wants to leave a practice, a physician restrictive covenant has the potential to incentivize the physician to practice in an underserved area, such as a rural area. For example, Amelia has

132 See infra Section II.B.
133 See infra Section II.B.ii.
134 See infra Section II.B.ii.
135 See infra Section II.B.ii.
136 See infra Section III.B.v.
137 See infra Section III.B.v.
138 See infra Section III.B.v.
139 Andrews, supra note 3.
140 Kevin D. Koons, Physician Employee Non-Compete Agreements on the Examining Table: The Need to Better Protect Patients’ and the Public’s Interests in Indiana, 6 Ind. Health L. Rev. 253, 259–60 (2009) (“If a physician is already located in an adequately served area, enforcing his non-compete agreement could force him to move into a medically underserved area.”).
moved to a geographic area in which there is a shortage of psychiatrists. A non-compete could incentivize a psychiatrist leaving a practice in New York City to relocate to this underserved geographic area. For patients like Amelia who live in underserved areas to realize the potential for restrictive covenants to incentivize providers to move to underserved areas, there must be transactional incentives for doctors to move to underserved areas. Current frameworks for evaluating restrictive covenants fail to adequately consider the restrictive covenant’s impact on access to care for patients in underserved geographic areas. Patients like Amelia who live in underserved areas will only realize increased access to care if the framework for evaluating restrictive covenants considers the extent to which the covenant encourages physicians to practice in underserved geographic areas.

2. The Potential to Undermine Healthcare Reform Goals

Physician non-competes undermine the healthcare reform goal of improving quality of care when the non-compete disrupts continuity of care and interferes with an ongoing doctor-patient relationship. Patients without long-term relationships with their doctors have shorter lifespans and are less healthy. When a non-compete disrupts continuity of care, the non-compete undermines quality. For example, Albert may have a reduced life expectancy because Dr. Smith’s non-compete disrupted continuity of care and essentially severed the long-term doctor-patient relationship.

Similarly, if courts enforce non-competes to interfere with ongoing doctor-patient relationships, costs to patients will increase. Patients with poor health caused by disruption in continuity of care will inevitably incur greater costs; these patients will need more care because they will be less healthy. Moreover, patients without continuity of care are more likely to visit the emergency room, incurring greater costs.

Finally, courts that punish a physician for crossing the nebulous line from fulfilling ethical obligations to notify patients of the physician’s departure to soliciting patients undermine the health care reform goals of: (1) improving quality, (2) preserving patient choice and access, and (3) controlling costs. A patient who never learns her doctor is leaving the practice will suffer a disruption of care; in effect, the patient will be prevented from continuing to receive treatment from her doctor. Disruption of care undermines quality because patients without an ongoing doctor-patient relationship are less healthy. Interpreting a non-solicitation clause to prohibit a physician from contacting her own patients after leaving a practice not only undermines quality and patient choice and access, but also inevitably increases patient costs. Without continuity of care, patients incur increased costs because of more frequent emergency room visits and poorer health outcomes, resulting in an increased need for costly care.

141 id. at 271 ("[R]estrictive covenants may help disperse and decentralize physicians by encouraging them to move to rural or medically underserved areas, depending on the facts of the case.").
II. THE EXTENT TO WHICH CONTEMPORARY FRAMEWORKS SUPPORT HEALTHCARE REFORM GOALS

States have adopted two main approaches to determining the enforceability of covenants restricting physicians. First, most jurisdictions apply some version of the reasonableness test.\textsuperscript{142} Second, other jurisdictions make physician non-competes per se invalid, with varying allowance for liquidated damages clauses.\textsuperscript{143} Neither of these approaches adequately supports all healthcare reform goals.\textsuperscript{144}

A. Some Version of Reasonableness

“The overwhelming majority of [] states apply some type of reasonableness test” to assess the validity of covenants restricting physicians.\textsuperscript{145} States adopting the reasonableness test adopt one of two approaches. First, states apply the same reasonableness test to physician restrictive covenants as they apply to covenants in any other commercial context.\textsuperscript{146} Second, other states apply the reasonableness test with heightened scrutiny, given the public policy concerns implicated in physician restrictive covenants.\textsuperscript{147}

This Section explores: (1) reasonableness with no heightened scrutiny, (2) reasonableness with strict scrutiny, and (3) the blue pencil rule whereby courts enforce only a reasonable version of an overbroad covenant. This Section also evaluates the extent to which the reasonableness approach supports healthcare reform and concludes the approach does not adequately support healthcare reform goals. Rather, the approach undermines quality by interrupting continuity of care, increasing costs to patients, and limiting patient choice and access. Moreover, the reasonableness approach fails to encourage providers to contain costs and accept lower reimbursement coverage.

i. Reasonableness with No Heightened Scrutiny

States adopting the “reasonableness” approach with no heightened scrutiny expressly recognize the validity of restrictive covenants in medical practices.\textsuperscript{148} In “reasonableness” jurisdictions, courts begin with the presumption that contracts are

\textsuperscript{142} See infra Section II.A.
\textsuperscript{143} See infra Section II.B.
\textsuperscript{144} See infra Sections II.A.iv, II.B.ii.
\textsuperscript{145} See generally Ferdinand S. Tinio, Annotation, Validity and Construction of Contractual Restrictions on Right of Medical Practitioner to Practice, Incident to Employment Agreement, 62 A.L.R.3d 1014 (2018) (surveying a multitude of cases throughout the nation applying the reasonableness to physician restrictive covenants).
\textsuperscript{146} See infra Section II.A.i.
\textsuperscript{147} See infra Section II.A.ii.
The party challenging a contract shoulders the burden of proving the contract is illegal or violates public policy. When it is reasonably possible to uphold a contract, the court must do so. In "reasonableness" jurisdictions, the most important public policy is freedom of contract; courts should avoid interfering with freedom of contract. Public policy requires courts to avoid seeking loopholes to defeat the contract's purpose. Parties have broad discretion to agree to terms in contracts, even when the contracts contain restrictive covenants.

Courts adopting the reasonableness approach evaluate physician non-competes no differently than other non-competes. Typically, reasonableness jurisdictions use the following framework to evaluate the validity of physician non-competes. Like other contracts, the "covenant must be supported by [adequate] consideration." Next, the covenant "must be ancillary to the contract."

Then, courts consider the following. First, the covenant must support one or more legitimate business interests and must not be solely to avoid competition. Second, courts consider whether the covenant imposes an undue burden on the physician covenantor. Third, courts consider whether the covenant injures the public. Finally, courts consider whether the covenant's temporal, geographic, and activities scope is reasonable, considering the particular circumstances. Below, this Section explores how various courts have applied this framework and evaluates the extent to which this framework furthers healthcare reform goals.

I. Valid Consideration and Ancillary Nature of Covenant

In reasonableness jurisdictions, covenant holders have easily proven that the non-compete was supported by valid consideration and was ancillary to the overarching contract. For example, courts have found adequate consideration for

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150 Wichita Clinic, 185 P.3d at 951.

151 Id.


153 Wichita Clinic, 185 P.3d at 957 (quoting Weber v. Tillman, 913 P.2d 84, 89 (Kan. 1996)).

154 Id. at 951.

155 See, e.g., Varney Bus. Servs., Inc. v. Pottroff, 59 P.3d 1003, 1015 (Kan. 2002) (applying the same test applied in physician non-compete cases in the context of an accounting business); Wichita Clinic, 185 P.3d at 951–52 (analyzing a physician non-compete under the same test as other non-competes).

156 Wichita Clinic, 185 P.3d at 951.

157 Id.

158 Weber, 913 P.2d at 89; Wichita Clinic, 185 P.3d at 951–52.

159 Weber, 913 P.2d at 90–91; Wichita Clinic, 185 P.3d at 951, 955.

160 Weber, 913 P.2d at 90, 93–96; Wichita Clinic, 185 P.3d at 951, 955–56.

161 Wichita Clinic, 185 P.3d at 951, 954; see also Weber, 913 P.2d at 90.

162 See, e.g., Wichita Clinic, 185 P.3d at 951–52; Zellner v. Stephen D. Conrad, M.D., P.C., 183 A.D.2d 250, 253–57 (N.Y. App. Div. 1992) (holding that the trial court properly enforced the non-compete in an ophthalmologist's contract with a medical corporation covenant holder where the clause was supported by adequate consideration through the corporation's continued employment of the ophthalmologist upon execution of the contract); Ladd v. Hikes, 639 P.2d 1307, 1309–10 (Or. Ct. App. 1982) (holding that the trial court erred in denying an injunction for a medical associate's breach of a non-compete where the associate "walked into a ready-made practice at a guaranteed salary without the
a restrictive covenant in an employment agreement when the physician-employee promised to furnish medical services for the employer covenant holder, and the covenant holder promised to pay the physician. Moreover, courts have concluded that a restrictive covenant was ancillary to an employment contract where the covenant holder agreed to employ the physician in exchange for the physician’s agreement to the restrictive covenant. Because the overarching purpose was to protect against unfair competition, courts have found the restrictive covenant was ancillary to the overarching employment contract.

2. Legitimate Business Interests

To be valid, the restrictive covenant must support one or more legitimate business interests. If the only “purpose is to avoid ordinary competition,” the restrictive covenant is unenforceable. Courts have found that covenant holders have legitimate business interests to protect the following: the patient base, training of physicians, trade secrets, confidential business information, goodwill, reputation, and patient referral sources. Courts adopting the reasonableness approach have determined that patient referral sources were a legitimate business interest because the relationships a covenant holder developed during the departing physician’s employment belong to the covenant holder employer, not the departing physician.

Reasonableness courts have recognized patient base as a legitimate business interest and have enforced covenants to disrupt the doctor-patient relationship. Despite the importance of continuity of care, courts have found longer-term doctor-patient relationships, such as relationships between family practice doctors and patients, provide even more support for covenant enforcement. For example, in *Wichita Clinic, P.A. v. Louis*, the court held that the loss of family practice patients, where there is a longer-term relationship, was an even more legitimate business interest supporting covenant enforcement than in specialties, such as heart surgery,
where patients are transient. The court concluded that the clinic had legitimate business interests in its patient base, referral sources, and goodwill to support non-compete enforcement. Recognizing this valid interest, the clinic director testified that the non-compete’s purpose was to protect the clinic from doctors leaving and taking patients. The court enforced the non-compete and disrupted the long-term relationships the doctor had with her family practice patients.

3. Undue Burden on Physician

Even though many courts in reasonableness jurisdictions ostensibly consider the burden imposed on the physician, this factor rarely justifies refusal to enforce the covenant. For example, in Wichita Clinic, the appellate court determined that the covenant did not impose an undue burden on the physician, despite the lower court’s finding that the covenant unduly burdened the physician because of its three-year term even though “most restrictive covenants were only for [two] years.” The covenant gave the doctor the option to pay liquidated damages and continue practicing in the covered area or refrain from practicing in the covered area for three years. The appellate court decided that the covenant was not unduly burdensome because the “covenant did not entirely prevent [the doctor] from practicing as a family practice physician.”

Moreover, some jurisdictions statutorily prohibit courts from considering the burden imposed on the physician. In Florida, for instance, courts cannot refuse to enforce a covenant based on the burden on the physician. Florida’s restrictive covenant statute states, “[i]n determining the enforceability of a restrictive covenant, a court: [s]hall not consider any individualized economic or other hardship that might be caused to the person against whom enforcement is sought.”

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172 Id.
173 Id. at 954.
174 Id.
175 Id. at 949.
176 See, e.g., id. at 951, 955. See also Koons, supra note 140 (“Although the traditional formulation of the rule [of reason] requires courts to consider all three factors (i.e., employer’s interests, hardship on the employee, and injury to the public), most courts consider only whether the covenant seeks to protect some legitimate business interest, almost to the exclusion of the other two factors.”); Malloy, supra note 5 (stating “[w]hen considering the reasonableness of the physician restrictive covenant, courts fail to recognize that most physicians are relatively immobile in terms of state licensing and practice area” and that “[c]ourts often opine that physicians are not restricted from practicing all medicine, only that which they were practicing for the contracted employer”; see also id. at 196 n.35 (“To show a restrictive covenant is unduly burdensome, a physician must show the agreement imposes some severe and unique personal hardship.” (citing Lewis v. Surgery & Gynecology, Inc., No. 90AP-300, 1991 WL 35010, at *4 (Ohio Ct. App. Mar. 12, 1991) as an example of such rare, special hardship where a court found restrictive covenant enforcement would impose undue burden on the physician by forcing her to relocate her developmentally disabled child from her special school)).
177 Id. at 955.
178 Id. at 952.
179 Id.
180 See FLA. STAT. § 542.335(1)(g)(1) (West 2018).
181 Id.
Although courts in reasonableness jurisdictions ostensibly consider injury to the public, they often ignore the negative impact covenant enforcement has on continuity of care. For example, in *Wichita Clinic*, the court found that the three year non-compete did not unduly injure the public because: 

"(1) there were a number of family practice physicians in the covered area; (2) the covenant holder Clinic would have absorbed the physician’s patients, and (3) the patients were not prevented from having quality medical care." The physician could not continue to treat her patients unless she violated the restrictive covenant the court determined was enforceable.

Despite the importance of long-term relationships between family practice doctors and patients, courts like *Wichita Clinic* are more likely to enforce covenants against family practice doctors than those against specialists; the covenant holder clinic has a stronger business interest in the long-term relationships family practice doctors have with their patients. Moreover, there is often no shortage of family practice doctors in a given geographic area. Allowing covenant enforcement to sever the long-term doctor-patient relationship between family practice doctors and patients, however, disrupts continuity of care and negatively impacts quality of care. This is one reason why the AMA has stated that non-competes can disrupt continuity of care and should be unenforceable if they fail to make reasonable accommodation of patients’ choice of physician.

Courts have ignored the negative impact disrupting the doctor-patient relationship has on quality of care, instead focusing only on whether there is a shortage of doctors in the relevant practice area in the covered area. Therefore, it is often more difficult to enforce non-competes against specialists for which there is a shortage in the covered area. Even if there is a shortage of specialists in the area, however, courts have still enforced restrictive covenants limiting the physician’s ability to practice in the area. For example, in *Foltz v. Struxness*, the court enforced

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182 Klimkina, *supra* note 15, at 147–48, 154 (arguing that “when restrictive covenants are upheld [against] physicians, the patients take the hardest hit”).

183 *Wichita Clinic*, 185 P.3d at 952, 955 (agreeing with the above-mentioned trial court’s findings as to injury to the public and reevaluating the issue of whether the restrictive covenant was unreasonable and unenforceable).

184 See id. at 962–63.

185 Id. at 953–54.

186 See id. at 954 (recognizing the practice area as “competitive”); id. at 955–56 (comparing the case to one in which the noncompete was upheld on the basis that there were a sufficient number of doctors in the area).


189 See, *e.g.*, *Wichita Clinic*, 185 P.3d at 955–56 (concluding that patients would not be prevented from receiving quality care if a physician were unable to practice in a particular area).

190 See Berg, *supra* note 7, at 29–30 (asserting courts have recognized restrictive covenants concerning physicians injure the public if covenant enforcement will lead to a shortage of relevant specialty physicians and citing Iredell Digestive Disease Clinic v. Petrozza, 373 S.E.2d 449 (N.C. Ct. App. 1988) in which the court found the covenant unenforceable after determining that the community’s need for a sufficient number of gastroenterologists outweighed freedom of contract); Andrews, *supra* note 3 (stating that courts may consider whether enforcing a non-compete would produce “a physician shortage in a particular region or specialty”).
the non-compete based on the trial court’s finding that the covered area was “no more in need of further doctors and surgeons than many other [similar] communities.”

5. Reasonableness in Time, Place, and Activities

Reasonableness courts have enforced covenants that were quite broad in temporal, geographic, and activities scopes. As to temporal scope, most courts hold as reasonable physician restrictive covenants lasting between two and five years but decline to enforce restrictive covenants that are unlimited. Generally, to be reasonable, the covenant should be no longer than necessary for the employer to hire a replacement and for that person “to have a reasonable opportunity to demonstrate” her effectiveness to patients. Courts have, however, allowed for covenants of a longer duration. For example, in *Foltz*, the court upheld a non-compete that restricted the physician from practicing medicine within 100 miles of the covenant holder clinic for ten years from the date the agreement was signed. When the physician terminated his employment, there were over eight years remaining on the covenant. Although 100 miles from the clinic was overly broad, the court excused the covenant holder’s overreaching. Instead, the court fulfilled its duty to uphold the principle of freedom of contract, rewrote the covenant to reduce the radius to five miles, and upheld the covenant.

In reasonableness jurisdictions, physician non-competes need be no narrower than non-competes outside the healthcare sector. For example, one appellate court overturned a lower court’s finding that the three-year covenant scope was overly broad. The appellate court found that although two years was common for non-competes generally, a covenant running beyond two years was not necessarily unreasonable. The appellate court failed to recognize that two years was standard outside of the healthcare context where public policy issues like continuity of care and patient choice were not implicated. Despite the policy issues in the healthcare context and the lower court’s temporally overbroad finding, the appellate court found the three-year covenant reasonable. The appellate court took seriously its burden to avoid “seeking loopholes . . . [to] defeat[] the contract’s intended purpose.”

Reasonableness courts enforce covenants with broad geographic coverage as well. For example, one court cited precedent upholding geographically broad

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193 *Id.* at 24–25.
194 *Foltz*, 215 P.2d at 135, 140.
195 *Id.* at 135–36 (explaining the physician entered the ten-year covenant on December 29, 1947 and left on March 2, 1949).
196 See *id.* at 137–38.
197 See *id.* at 137.
199 *Id.* at 954–55.
200 *Id.* at 955.
201 *Id.*
202 *Id.* at 951.
203 See, e.g., *id.* at 955 (citing *E. Distrib. Co. v. Flynn*, 567 P.2d 1371 (Kan. 1977)).
covenants outside the healthcare sector to conclude the physician covenant was geographically reasonable.\textsuperscript{204} The court failed to recognize that public policy considerations such as patient choice, continuity of care, and quality of care warrant stricter scrutiny of the geographic scope of physician covenants. In reasonableness jurisdictions, the covenant’s protection need only be “coextensive with the area from which the [c]linic drew most of its patients.”\textsuperscript{205}

ii. Reasonableness with Strict Scrutiny

Several state courts have developed an intermediate approach, applying the traditional framework but more strictly scrutinizing physician restrictive covenants.\textsuperscript{206} Strict scrutiny gives greater attention to public policy concerns, such as continuity of care, quality of care, and patient choice.\textsuperscript{207} Courts applying strict scrutiny apply a more exacting review for the analysis of all the elements of the traditional framework.\textsuperscript{208} Such courts strictly scrutinize whether the restrictive covenant truly serves an employer’s identified legitimate interests.\textsuperscript{209} Moreover, courts strictly scrutinize whether the covenant is “narrowly tailored to achieve” the asserted interests.\textsuperscript{210} Finally, courts strictly scrutinize whether covenant enforcement would negatively impact public interests, especially noneconomic interests, such as the doctor-patient relationship and patient access to care.\textsuperscript{211} With strict scrutiny, employers shoulder a higher burden in justifying the restrictive covenant than employers should under the traditional framework applied in other economic sectors.\textsuperscript{212}

For example, in \textit{Valley Medical Specialists v. Farber}, the Arizona Supreme Court ruled that physician restrictive covenants should be “strictly construed in favor of professional mobility” and patient choice and access.\textsuperscript{213} The practice’s covenant with the “internist and pulmonologist who . . . treated AIDS and HIV-positive patients and performed brachytherapy” prohibited the physician from practicing for three years after termination of employment within a five-mile radius of any office of the covenant holder practice.\textsuperscript{214} Strict construction required the court to examine the

\textsuperscript{204} Id.
\textsuperscript{205} Id.
\textsuperscript{206} Koons, supra note 140, at 261–62.
\textsuperscript{207} See id.
\textsuperscript{208} Id. at 262.
\textsuperscript{209} Id.
\textsuperscript{210} Id.
\textsuperscript{211} Id.; see also Valley Med. Specialists v. Farber, 982 P.2d 1277, 1282–83, 1285 (Ariz. 1999); Iredell Digestive Disease Clinic, PA v. Petrozza, 373 S.E.2d 449, 453, 455 (N.C. Ct. App. 1988) (rejecting the per se rule, holding restrictive covenants unenforceable if it “create[s] a substantial question of potential harm to the public health,” and stating that the court was extremely hesitant to deny the patient her choice of physician); Ohio Urology, Inc. v. Poll, 594 N.E.2d 1027, 1031, 1033 (Ohio Ct. App. 1991) (adopting the position that physician non-competes were not per se unenforceable but stating that physician non-competes affected public interest more significantly than other non-competes).
\textsuperscript{212} Koons, supra note 140, at 262.
\textsuperscript{214} Id. at 1278–79.
interests of the practice, physician, patients, and public.\textsuperscript{215} The doctor-patient relationship and the patient’s freedom to choose her doctor heavily weighed against any interest the practice might have had in its patient base.\textsuperscript{216} The court acknowledged the practice had a protectable interest in referral sources but determined the covenant was unnecessarily broad to protect that interest.\textsuperscript{217} Pulmonology “require[d] contact with the treating physician [at least] once every six months,” making any timeframe over six months unnecessary to protect the practice’s interests.\textsuperscript{218} The court held that the activities scope was unreasonably broad because the covenant restricted all medical care and was not limited to the covenant holder’s specialties.\textsuperscript{219} As to the public’s interest, the court stated that even assuming other pulmonologists were available in the area, “court[s] must evaluate the extent to which enforcing the covenant would [preclude] patients from seeing the departing physician if they [wanted] to do so.”\textsuperscript{220} The court “conclud[ed] that patients’ right to see the doctor of their choice” warranted “substantial protection,” and the practice’s interests were “comparatively minimal.”\textsuperscript{221} The geographic scope of over 200 square miles was unnecessarily broad because it significantly inhibited patients’ ability to continue treatment with their physician.\textsuperscript{222} Therefore, the court held the covenant unenforceable and declined to rewrite the covenant to make it reasonable.\textsuperscript{223}

iii. Blue Pencil Rule

Courts adopting the reasonableness test often use equity powers to “blue pencil” a restrictive covenant and enforce only a reasonable version of an overbroad covenant.\textsuperscript{224} Generally, courts adopt one of two approaches. First, courts use the less flexible version of the blue pencil rule to scratch out grammatically severable portions of an overbroad covenant and enforce only the remaining portions. Second, courts adopt a more flexible approach and enforce only a reasonable version of an overbroad covenant, regardless of whether grammatical severance is possible.

Under the less flexible version, courts sever some words of the covenant and leave intact reasonable portions. For example, in Sharvelle, M.D., P.C. v. Magnante, the court used the blue pencil rule to enforce a limited version of the non-solicitation portion of a covenant but held the blue pencil rule did not support enforcing a limited version of the non-compete portion.\textsuperscript{225} The non-compete clause prohibited the ophthalmologist from practicing “health care of every nature and kind” in a specified

\textsuperscript{215} Id. at 1283.
\textsuperscript{216} Id. at 1284–85.
\textsuperscript{217} Id.
\textsuperscript{218} Id. at 1285 (citing and upholding the trial court’s findings).
\textsuperscript{219} Id. at 1285.
\textsuperscript{220} Id.
\textsuperscript{221} Id.
\textsuperscript{222} Id.
\textsuperscript{223} Id. at 1286.
\textsuperscript{224} Id. (discussing Arizona precedent of using the “blue pencil” approach, which entails the removal of “grammatically severable, unreasonable provisions” of a restrictive covenant).
geographic area for two years after leaving the clinic’s employment.\textsuperscript{226} The court ruled that if a covenant was clearly divisible into reasonable and unreasonable parts, the blue pencil rule allowed the court to enforce only the reasonable portions.\textsuperscript{227} The court stated that courts cannot add terms that were not originally part of the agreement but should make unreasonable restraints reasonable by “scratching out any offensive clauses to give effect to the parties’ intentions.”\textsuperscript{228} The court did not agree with the clinic’s argument that removing the phrase “of every nature and kind” would make the covenant reasonable.\textsuperscript{229} The evidence showed that the ophthalmologist practiced only eye-related health care.\textsuperscript{230} The court found that the term ‘healthcare’ “encompass[ed] the spectrum of medical practice, and the phrase ‘of every nature and kind’ [was] superfluous.”\textsuperscript{231} The court concluded that the clinic did not satisfy its burden to show the circumstances of the ophthalmologist’s employment supported the broad practice description and refused to use the blue pencil rule to enforce a limited version of the non-compete.\textsuperscript{232}

The \textit{Sharvelle} court, however, used the blue pencil rule to “scratch[] out [the] offensive clauses” and enforce the remainder of the non-solicitation clause.\textsuperscript{233} The non-solicitation clause prohibited the ophthalmologist from “soliciting ‘former, current or future’ patients or employees” of the clinic during the scope of the ophthalmologist’s employment and for two years after.\textsuperscript{234} The court held that the non-solicitation clause was overbroad but applied the blue-pencil rule to delete the terms “former” and “future” and enforce the remainder of the clause.\textsuperscript{235} Therefore, for two years after leaving the clinic, the clause prohibited the ophthalmologist from soliciting the clinic’s current patients or employees.\textsuperscript{236}

Under the more flexible version, courts enforce a limited version of the covenant, “regardless of whether a grammatical severance is possible.”\textsuperscript{237} For example, in \textit{Community Hospital Group, Inc. v. More}, the Supreme Court of New Jersey held that the geographic scope in a neurosurgeon’s non-compete injured the public and enforced a limited covenant, even though grammatical severance was impossible.\textsuperscript{238} The non-compete prohibited the neurosurgeon from practicing medicine within a thirty-mile radius of the hospital for two years after employment.\textsuperscript{239} The court considered whether there was a shortage of neurosurgeons in the area and examined whether enforcement would disrupt continuity of care.\textsuperscript{240} If enforcement restricted

\begin{flushleft}
\textsuperscript{226} \textit{Id.} at 434, 437.  \\
\textsuperscript{227} \textit{Id.} at 439.  \\
\textsuperscript{228} \textit{Id.} (quoting Burk v. Heritage Food Serv. Equip., 737 N.E.2d 803, 811 (Ind. Ct. App. 2000)).  \\
\textsuperscript{229} \textit{Id.}  \\
\textsuperscript{230} \textit{Id.} at 437–38.  \\
\textsuperscript{231} \textit{Id.} at 439.  \\
\textsuperscript{232} \textit{Id.} at 438–39.  \\
\textsuperscript{233} \textit{Id.} at 439–40.  \\
\textsuperscript{234} \textit{Id.} at 440.  \\
\textsuperscript{235} \textit{Id.}  \\
\textsuperscript{236} \textit{Id.}  \\
\textsuperscript{237} JOSEPH M. PERILLO, CONTRACTS 608–09 (7th ed. 2014).  \\
\textsuperscript{238} See \textit{Cmty. Hosp. Grp., Inc. v. More}, 869 A.2d 884, 900 (N.J. 2005); see also PERILLO, supra note 237, at 608 n.277.  \\
\textsuperscript{239} \textit{Cmty. Hosp. Grp., Inc.}, 869 A.2d at 887–88.  \\
\end{flushleft}
the neurosurgeon’s current patients from receiving treatment from the neurosurgeon at his new location, the geographic scope should be limited “in light of the number of patients who would be so restricted.” Enforcing the thirty-mile radius would injure the public because there was a shortage of neurosurgeons in the area. The geographic scope compromised the neurosurgeon’s ability to treat emergency room patients in a designated city as well as patients who could not travel beyond the thirty-mile radius. The court stated that “courts should not hesitate to partially enforce [] restrictive covenant[s].” Remanding, the court instructed the lower court “to determine the precise limits of the geographic” scope while: (1) avoiding exceeding thirteen miles and (2) excluding the designated city.

iv. Extent to Which the Reasonableness Approach Supports Healthcare Reform Goals

The reasonableness approach undermines patient choice and access because reasonableness courts often disrupt continuity of care. Because courts applying reasonableness treat physician restrictive covenants no differently than other restrictive covenants, these courts value freedom of contract over patient choice and access. Reasonableness courts recognize the patient base as a legitimate business interest and fail to give sufficient weight to continuity of care and the doctor-patient relationship. This is why courts such as the Dental East court enforced a covenant prohibiting a dentist from treating his own patients or even notifying his own patients of his departure, essentially severing the doctor-patient relationship.

Because the reasonableness approach disrupts continuity of care, the approach undermines quality of care. When courts enforce non-competes against family practice doctors because the covenant holder clinic has a strong interest in long-term patient relationships, like in Wichita Clinic, courts harm patients. Disrupting continuity of care, particularly for long-term conditions, shortens patients’ lifespans and produces poorer outcomes. Therefore, the reasonableness approach undermines quality.

Considering the reasonableness approach allows covenant holders to protect their investment in the physician, the reasonableness approach has the potential to contain

\[ \text{Id. at 898 (quoting Karlin v. Weinberg, 390 A.2d 1161, 1170 (N.J. 1978)).} \]
\[ \text{Id. at 899-900.} \]
\[ \text{Id. at 909.} \]
\[ \text{Id. at 906.} \]
\[ \text{See supra Section II.A.i.4.} \]
\[ \text{See supra Section II.A.i.2; see also Berg, supra note 7, at 48 (asserting that at best physician non-competes interfere with patient access to care by their physician of choice in a convenient location and at worst non-competes “completely supplant” the patient’s ability to maintain the doctor-patient relationship with the departing physician and that research indicates continuity of care yields benefits to patients and society and therefore physician non-competes should be unenforceable).} \]
\[ \text{See supra Section I.A.} \]
\[ \text{See supra Section I.C.ii.} \]
\[ \text{See supra Section II.A.i.4.} \]
\[ \text{See supra Section I.C.iv.2.} \]
patient costs.\textsuperscript{253} The reasonableness framework, however, fails to ensure that patients realize cost containment.\textsuperscript{254} Theoretically, a clinic’s ability to protect its investment ensures that the clinic can recoup unexpected losses when a physician leaves the clinic’s practice and sets up a competing practice.\textsuperscript{255} Even better, the clinic can enjoin the physician from setting up the competing practice.\textsuperscript{256} Protecting against unexpected economic losses could enable the clinic to: (1) control patient costs and (2) accept lower reimbursement coverage such as TRICARE, Medicaid, and Medicare. The reasonableness framework, however, fails to make covenant enforcement turn on the extent to which the covenant holder uses the covenant to protect its investment so that it can accept lower reimbursement coverage and contain patient costs. The reasonableness approach fails to contain costs for patients; reasonableness only contains costs for the covenant holder.

Reasonableness jurisdictions blue pencil restrictive covenants, undermining quality of care, patient choice and access, and cost containment;\textsuperscript{257} rewriting covenants encourages covenant holders to craft overreaching covenants.\textsuperscript{258} For every overreaching non-compete a physician contests, there are many more overreaching non-competes with which physicians comply.\textsuperscript{259} When the doctor-patient relationship and continuity of care are at stake, courts should not save covenant holders who draft overreaching covenants. Jurisdictions like Florida that mandate blue penciling\textsuperscript{260} encourage overreaching. This overreaching burdens departing physicians and adversely impacts patient choice and access and quality of care for patients like Albert who must search for a new physician because of his physician’s non-compete. Disruption of care will negatively impact Albert’s health.\textsuperscript{261} Moreover, overreaching covenants undermine competition in the healthcare marketplace, and competition helps control costs.\textsuperscript{262} Therefore, blue penciling undermines quality of care, patient choice and access, and cost containment.

Although strict scrutiny better protects patient choice and access and quality of care by placing higher value on these public policy issues, strict scrutiny is nothing

\begin{itemize}
\item \textsuperscript{253} See supra Sections I.C.iii, II.A.i.2.
\item \textsuperscript{254} See supra Section I.C.iv.2.
\item \textsuperscript{255} See Koons, supra note 140, at 270–71.
\item \textsuperscript{256} Id. at 286–87 (recognizing that injunctive relief will more significantly impact the public’s interest in having the physician’s services available and the patient’s interest in freely choosing a physician and that “courts should weigh a request for injunctive relief in favor of refusing [] enforce[ment] [of] a restrictive covenant,” but this is often not the case in reasonableness jurisdictions).
\item \textsuperscript{257} See supra Section II.A.iii.
\item \textsuperscript{258} Kenneth R. Swift, \textit{Void Agreements, Knocked-out Terms, and Blue Pencils: Judicial and Legislative Handling of Unreasonable Terms in Noncompete Agreements}, 24 HOFSTRA LAB. & EMP. L.J. 223, 254 (2007) (asserting that “the rewrit(ing) approach does nothing to discourage employers from seeking the broadest possible protections . . . because the employer can rely on the court to rein in any excesses”).
\item \textsuperscript{259} Id. at 246–47 (quoting Harlan M. Blake, \textit{Employee Agreements Not to Compete}, 73 HARV. L. REV. 625, 682 (1960).
\item \textsuperscript{260} FLA. STAT. ANN. § 542.335 (West 2019) ("[A] court shall modify the restraint and grant only the relief reasonably necessary to protect such interest or interests.").
\item \textsuperscript{261} See supra Section I.C.ii.
\item \textsuperscript{262} See Koons, supra note 140, at 262 (acknowledging the “importance of competition in physician services in times of skyrocketing health care costs”).
\end{itemize}
more than the reasonableness framework with a more exacting review. Therefore, 
strict scrutiny, like reasonableness, asks the wrong questions and fails to evaluate the 
covenant’s impact on healthcare reform goals. Strict scrutiny is not designed to 
support healthcare reform and therefore fails to: (1) adequately safeguard the 
doctor-patient relationship and continuity of care and (2) provide transactional 
incentives to contain costs to patients and expand access to underserved populations.

B. Per Se Invalidity with Varying Allowance for Liquidated Damages

This Section surveys jurisdictions adopting a per se invalidity approach to 
physician non-competes and analyzes the extent to which the per se invalidity 
approach supports or undermines healthcare reform goals. The Section posits that 
per se invalidity misses an opportunity to incentivize expansion of patient choice and 
access and cost containment.

i. Survey of Jurisdictions Adopting the Per Se Invalidity Approach

New Hampshire, Delaware, Colorado, and Massachusetts statutorily 
prohibit physician non-competes which restrict a physician’s right to practice in a 
designated geographic location for a specified period of time. These states prohibit 
enjoining the physician’s practice pursuant to a restrictive covenant. These states, 
however, vary in the extent to which they allow contractual provisions providing for 
damages from injury resulting from breach of a restrictive covenant.

Although the Delaware statute ostensibly prohibits non-competes which restrict 
the right of a physician to practice, the statute allows contractual provisions requiring 
a physician to pay damages reasonably related to the harm the covenant holder suffered because of the physician’s termination of the agreement, including 
“damages related to competition.” For example, in Palekar v. Batra, the court held 
that even though Delaware prohibits restrictive covenants from enjoining a physician 
from practicing medicine, “[l]iquidated damages provisions are presumptively 
valid.” The party challenging the liquidated damages provision shouldered the 
burden of proof.

To determine the validity of the liquidated damages provision, the Delaware 
court applied a two-part test. First, the damages must be “difficult to ascertain.” Second, the stipulated amount must either be a “reasonable estimate” of damages a 
breach would likely cause or be “reasonably proportionate” to damages the covenant

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263 See supra Section II.A.ii.
265 DEL. CODE ANN. tit. 6, § 2707 (2019).
266 COLO. REV. STAT. § 8-2-113 (2018).
267 MASS. GEN. LAWS ch. 112, § 12X (2019).
268 DEL. CODE ANN. tit. 6, § 2707 (2019).
270 Id. at *8.
271 Id. at *6.
holder actually suffered. When applying the first prong, the court deferred to the contract language. In Batra, the contract stated that “actual damages would be difficult to calculate.” Then, the contract required the physician to pay $200,000 in liquidated damages if the physician practiced within a twenty-mile radius of the covenant holder’s sites within two years of terminating his employment. The court refused to “look backward” to evaluate the amount of profits the physician “allegedly diverted from the practice” to create a more “certain and concrete amount of damages.” Harm resulting from lost patients was not amenable to precise estimation. Therefore, the court determined that the first prong—requiring damages to be difficult to ascertain—was met as a matter of law.

Applying the second prong, which requires the stipulated amount to be either a reasonable estimate or proportionate to damages actually suffered, the Delaware court held that the stipulated amount was reasonable as a matter of law. The physician argued that $200,000 in liquidated damages was unreasonable because the physician was extremely profitable when he worked for the covenant holder. Moreover, the physician urged the court to require the covenant holder to justify the $200,000 amount and explain how the practice suffered that amount in damages. The court rejected both of the physician’s arguments. First, the large revenue the physician brought to the practice actually supported the reasonableness of the $200,000 fixed amount. Second, even if the practice actually suffered far less damages than $200,000, the liquidated damages provision was valid because the fixed amount was a reasonable estimate at the time of the contract’s formation.

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273 Id. (quoting S.H. Deliveries, Inc., 1997 WL 817883, at *8).
274 Id. at *7.
275 Id.
276 Id. at *2.
277 Id. at *7.
279 Id.
280 Id.
281 Id.
282 Id.
283 Id. at *7–8.
284 Id. at *8.
285 Id.; In Christiana Medical Group, P.A. v. Ford, the court stated that liquidated damages were presumptively valid. Christina Med. Grp., P.A. v. Ford, No. 06C-07-033, 2008 WL 162829, at *4 (Del. Super. Ct. Jan. 16, 2008). To determine whether a clause was an invalid penalty or a valid liquidated damages clause, the court applied a two-part test. Id. First, at the time of contract formation, it must have been “difficult to ascertain” damages. Id. Second, the stipulated amount must be either a “reasonable estimate” of damages a breach would likely cause or be “reasonably proportionate” to damages the covenant holder actually suffered. Id. “If the amount is a reasonable estimate of the damages [the covenant holder would likely suffer], the provision is valid, even if the [designated amount is] substantially larger than the actual damages sustained.” Id. In Christiana Medical Group, the covenant required the physician to pay $100,000 in liquidated damages if the physician practiced in designated hospitals within one year of terminating employment. Id. at *1. The physician practiced in the designated hospitals within a year of terminating his employment. Id. at *1–2. The court could not determine as a matter of law whether the clause was valid but left that factual issue to the factfinder. Id. at *4.
The Colorado statute\textsuperscript{286} mirrors the Delaware statute.\textsuperscript{287} Just as in Delaware, Colorado invalidates physician non-competes that restrict physicians from practice but allows provisions requiring damages from a physician’s breach.\textsuperscript{288} Plaintiffs, however, shoulder a greater burden to justify liquidated damages in Colorado than they do in Delaware. For example, in \textit{Crocker v. Greater Colorado Anesthesia}, the court held that “\textit{[a]ny damages awarded . . . must be reasonably related to the injury actually suffered and not simply related to an injury prospectively estimated at the time of contract formation.}”\textsuperscript{289} Rather, courts could conduct the reasonableness assessment only upon an agreement’s termination.\textsuperscript{290} The damages amount had to be “reasonably related to ‘the injury suffered,’ in the past tense.”\textsuperscript{291} The agreement provided that if the physician competed with the covenant holder by practicing anesthesia within fifteen miles of the covenant holder’s hospital within two years of leaving the practice, the physician would be liable for liquidated damages as calculated by a specified formula.\textsuperscript{292} The covenant holder “did not present evidence of [] losses.”\textsuperscript{293} The \textit{Crocker} court found “no reasonable relationship” between the injury suffered and the $200,000 calculated under the formula.\textsuperscript{294} Further, the \textit{Crocker} court found the liquidated damages clause invalid because the covenant holder offered no evidence that the amount the formula produced was “reasonably related to [the] injury suffered.”\textsuperscript{295}

Therefore, even though Delaware and Colorado adopted the same statutory language, Delaware covenant holders stand a better chance of enforcing liquidated damages provisions. In Delaware, liquidated damages provisions are presumptively valid; courts defer to contract language stating damages were difficult to estimate. In Colorado, damages have to be reasonably related to the injury suffered, in the past tense. Covenant holders must present evidence to explain why the amount the clause fixed or produced through a specified formula reasonably related to the injury actually suffered.

In Massachusetts, it is extremely difficult for a covenant holder to enforce a contractual provision for damages suffered because of a physician’s breach of a non-compete. Massachusetts courts have refused to enforce contractual provisions for damages for competing with a covenant holder, even when the damages correspond to ascertainable debts incurred in setting up a practice.\textsuperscript{296} Unlike the Delaware and Colorado statutes, the Massachusetts law does not expressly allow contractual provisions requiring payment of damages for competition. Rather,
Massachusetts "prohibits the imposition of a covenant not to compete on a physician who leaves an established practice."297

For example, in *Falmouth Ob-Gyn Associates, Inc. v. Abisla*, the court held the "compensation for competition" clause violated Massachusetts physician non-compete law because it imposed the same "inhibitory effect" as that posed by an "absolute bar" on a physician's ability to practice.298 The covenant required the obstetrician to pay $250,000 in liquidated damages if he practiced within twenty-five miles of designated counties within two years of terminating employment.299 The employer argued that $250,000 represented a valid amount for liquidated damages, even though the figure did not correspond to ascertainable financial costs the employer actually incurred.300 The employer argued that Massachusetts law did not prohibit "compensation for competition" clauses because such clauses did not bar a physician’s practice; according to the employer, $250,000 reasonably approximated the employer's loss of goodwill "where actual damages [were] difficult to ascertain."301 The court rejected the employer's arguments.302 Even though a "compensation for competition" clause did not "absolute[ly] bar" the obstetrician's ability to practice, requiring liquidated damages imposed the same inhibitory effect.303

In *Parikh v. Franklin Medical Center*, the court held that "forfeiture" and "resignation" clauses "produce[d] ... an 'inhibitory effect' similar to [the] 'compensation' clause" in *Falmouth* and violated Massachusetts law.304 The partnership agreement’s "forfeiture" clause required the anesthesiologist leaving the practice to forfeit 10% of his partnership income to the other anesthesiologist if the departing anesthesiologist practiced in competition with the partnership in the designated county.305 The partnership agreement’s "resignation" clause required the departing anesthesiologist to resign his staff privileges at the designated county’s hospital if he terminated the partnership agreement.306 The court reasoned that whether a clause “demands compensation or shuts off a future source of income for choosing to compete, it clearly transgresses [section] 12X’s policy of putting public choice over freedom of contract."307

Finally, courts have interpreted Massachusetts law to void clauses allowing for damages corresponding to ascertainable debts incurred in setting up the departing physicians’ practice with the covenant holder.308 In *MetroWest Medical Group, Inc.*

298 *Falmouth Ob-Gyn Assocs., Inc.*, 629 N.E.2d at 293.
299 Id. at 292.
300 Id.
301 Id. at 292–93.
302 Id. at 293.
303 Id. at 399.
305 Id. at 408.
306 Id. (citing *Falmouth*, 629 N.E.2d at 294).
v. Mount Auburn Hospital, an “assumption of debt provision” obligated physicians leaving the covenant holder’s practice to repay a pro rata share of a $2.5 million loan the covenant holder made to the departing physicians, only if the departing physicians practiced within fifteen miles of the location of the covenant holder’s practice within three years of terminating their employment. The covenant holder argued that the provision was: (1) not a non-compete, (2) corresponded to ascertainable debts the covenant holder incurred in setting up the departing physicians’ practice, and (3) was distinguishable from the liquidated damages provisions that the Falmouth court “found to be void.” The court acknowledged that the departing physicians’ debt had more of a relationship to ascertainable debts incurred in setting up the practice and was unlike the liquidated damages clause in Falmouth. Nonetheless, the court concluded that the provision created an “inhibitory effect” on physicians choosing where to set up their new practices. Because the “restriction, in the form of a significant and inhibitory repayment obligation” was “tied only to geographic choice,” the provision violated Massachusetts law.

ii. Extent to Which Per Se Invalidity Supports Healthcare Reform Goals

Per se invalidity fails to control healthcare costs, regardless of whether covenant holders can collect liquidated damages, because per se invalidity does not consider the covenant’s impact on costs to patients. States like Massachusetts that prohibit physician non-competes, including damages corresponding to ascertainable debts incurred in setting up the departing physician’s practice with the covenant holder, contribute to rising costs for patients. For example, in MetroWest, the court invalidated the “assumption of debt provision” obligating the departing physicians to repay a pro rata share of the $2.5 million that the departing physicians borrowed from the covenant holder practice. Because the covenant holder could not recover on the loan, the covenant holder was likely forced to raise fees to patients to recover its loss. Similarly, the un-recouped expense could have deterred the covenant holder from accepting lower reimbursement coverage.

Merely enforcing liquidated damages clauses, however, does not necessarily help control patients’ costs and could result in raising patients’ costs in a given community. For example, Delaware courts enforce presumptively valid liquidated damages provisions, even if the damages do not correlate to losses the covenant holder actually suffered. Unlike the Massachusetts covenant holder in MetroWest, Delaware covenant holders need not raise fees to patients to recover losses suffered from un-recouped investment in physicians who leave to set up competing practices

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309 Id.
310 Id. at *3.
311 Id. at *4.
312 Id.
313 Id.
314 See supra Section II.B.i.
316 See supra Section II.B.i.
because covenant holders can protect their investment with liquidated damages clauses.\textsuperscript{317}

But states like Delaware fail to ensure patients realize cost containment because these states fail to incentivize practices to control patients’ costs and increase access to patients with lower reimbursement coverage. For example, the \textit{Palekar v. Batra} court enforced the $200,000 liquidated damages clause, even though the covenant holder may have actually suffered far less damages than $200,000.\textsuperscript{318} Such liquidated damages provisions have an inhibitory effect on a physician’s choice of where to practice.

The Delaware court failed to consider whether the departing physician intended to offer more affordable fee-for-service care to area patients than the covenant holder offered. The court also failed to evaluate whether the departing physician intended to accept lower reimbursement coverage. Such an inquiry was outside of the Delaware framework for evaluating physician non-competes. Liquidated damages clauses potentially inhibit departing physicians from setting up area practices offering more affordable care and accepting lower reimbursement coverage. Such competing practices not only bring more affordable care but increase competition in the community and drive down patient costs, incentivizing competing practices to reduce fees to attract patients.\textsuperscript{319} Blindly enforcing liquidated damages clauses, without considering whether covenant enforcement, in the circumstances, will preclude a doctor from setting up a competing practice offering more affordable care and expanding access to underserved populations, undermines healthcare reform goals.

\section*{III. Model Framework for Evaluating Physician Restrictive Covenants}

This Section sets forth a framework for evaluating physician restrictive covenants that supports the healthcare reform goals. Section III(A) describes Texas’s unique approach and posits that although Texas better supports healthcare reform goals than the other contemporary frameworks, Texas could do more. Section III(B) articulates the model framework and articulates model statutory language that provides transactional incentives to reduce patient costs and expand patient choice and access by making covenant enforcement turn on the extent to which the covenant furthers healthcare reform goals.

\textit{A. The Unique Approach in Texas}

A Texas statute attempts to ensure physician non-competes do not disrupt continuity of care.\textsuperscript{320} Under the Texas statute, a physician non-compete is

\textsuperscript{317} See supra Section II.B.i.


\textsuperscript{319} See Ohio Urology, Inc. v. Poll, 594 N.E.2d 1027, 1030–32 (Ohio Ct. App. 1991) (stating that restrictive covenants implicate public policy concerns such as the importance of competition in physician services, especially in times of skyrocketing health care costs for patients).

\textsuperscript{320} See TEX. BUS. & COM. CODE ANN. § 15.50 (West 2009).
unenforceable if it denies the covered physician access to a list of patients whom the physician has treated within one year of terminating employment with the covenant holder. Moreover, the non-compete must clarify that the physician is not prohibited from continuing care “to a specific patient... during the course of an acute illness even after the... [physician’s] employment [with the covenant holder] has been terminated.” Finally, the non-compete must allow “for a buy out of the covenant by the physician at a reasonable price.”

i. The Texas Approach Better Supports Healthcare Reform Goals than Other Contemporary Frameworks Do

The Texas statute better supports healthcare reform goals than other contemporary frameworks do. As compared to the reasonableness approach, in which courts enforce covenants to disrupt ongoing doctor-patient relationships, Texas attempts to safeguard continuity of care and protect quality by clarifying that a physician is not prohibited from continuing care to a patient during an acute illness, even after the physician’s employment has terminated. Texas’s attempt to protect the doctor-patient relationship preserves patient choice and access better than the reasonableness approach where courts like Wichita Clinic, P.A. v. Louis enforce non-competes even though enforcement results in disruption of the doctor-patient relationship. Moreover, Texas’s requirement for covenants to have buyout provisions, instead of authorizing injunctions, helps to ensure that physicians can practice in the covered area, if financially able, and therefore better protects patient choice and access.

Next, Texas helps control costs more than per se invalidity because Texas allows clinics to protect investment in new doctors. For example, unlike Massachusetts, Texas enforces damages clauses corresponding to ascertainable debts incurred in setting up the departing physician’s practice with the covenant holder. Because the covenant holder can recover on its investment, the covenant holder is not forced to raise fees to patients to recoup its investment in the departing physician.

ii. The Texas Approach Could Do More to Support Healthcare Reform Goals

The Texas approach, however, should do more to support healthcare reform goals. First, Texas fails to consider whether the covenant holder or the covered physician accepts lower reimbursement coverage such as TRICARE, Medicare, and Medicaid and misses an opportunity to expand patient choice and access.

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321 Id. § 15.50(b)(1)(A); see also Andrews, supra note 3 (asserting that, in Texas, “a non-compete [] must allow doctors to have access to a list of their patients in the past year and access to [those patients’] medical records”).
322 TEX. BUS. & COM. CODE ANN. § 15.50(b)(3) (emphasis added).
323 Id. § 15.50(b)(2).
324 Id. § 15.50(b)(3).
326 TEX. BUS. & COM. CODE ANN. § 15.50(b)(2).
327 See id. § 15.50.
Second, the Texas approach misses an opportunity to protect quality of care because it fails to prohibit a restrictive covenant from disrupting any doctor-patient relationship. The Texas statute only requires that a restrictive covenant provide that a "physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during the course of an acute illness," even after employment has ended. Continuity of care, however, is more critical for long-term illnesses and conditions such as diabetes, mental health issues, high cholesterol, and hypertension. The Texas statute fails to protect continuity of care and the doctor-patient relationship for these long-term conditions.

B. Model Framework for Evaluating Physician Restrictive Covenants

This Article recommends the following framework for determining the enforceability of physician restrictive covenants. Statutory language provides clarity and consistency and reflects the voice of the electorate. Therefore, the optimal approach is for the state legislature to adopt the framework below. Until that time, however, this framework should inform a court’s decision of whether to enforce a physician restrictive covenant.

i. Refuse to enforce non-solicitation agreements prohibiting physicians from soliciting their own patients.

To preserve patient choice and protect quality, states should incentivize doctors departing a practice to fulfill patient notification responsibilities; states should refuse to punish doctors for communication with their patients. Courts have held doctors liable for breach of non-solicitation agreements for attempting to fulfill patient notification responsibilities and crossing the line into solicitation. Holding doctors liable for solicitation when they cross the line between patient notification and solicitation deters doctors from fulfilling ethical obligations. To continue care with her doctor, a patient needs to know: (1) of her doctor’s departure from a practice, (2) the address of the doctor’s new practice, (3) of the her right to transfer her care to her doctor’s new practice, and (4) how to transfer. Failure to convey this information potentially deprives the patient of the choice to remain with her doctor and disrupts continuity of care.

To preserve patient choice and protect quality by avoiding disruption of continuity of care, courts should refuse to enforce non-solicitation agreements against physicians who contact their patients after departing a practice. No court should scrutinize a physician’s notification to her patients to determine if the

329 TEX. BUS. & COM. CODE ANN. § 15.50(b)(3); see also Andrews, supra note 3 ("Continuity of care is important, doctors say, especially for patients with ongoing medical issues.").
330 See supra Section I.C.ii.
331 TEX. BUS. & COM. CODE ANN. § 15.50(b)(2).
332 See supra Section I.B.
333 See supra Section I.B.
334 See supra Section I.B.
335 See supra Section I.B.
Physician restrictive covenant regulation should instead encourage physicians to support patients’ best interests by notifying patients when physicians depart. Doctors should be free to communicate with their patients, even if the doctor explains the benefits of transferring care to the doctor’s new practice. Refusing to punish doctors for communicating with their patients: (1) safeguards patient choice, (2) promotes quality of care by safeguarding continuity of care, and (3) conserves scarce judicial resources. Refraining from holding doctors liable for communicating with their patients avoids fact-intensive, expensive litigation requiring courts to scrutinize every word of a departing physician’s notification to her patients.

ii. Clarify that restrictive covenants can only restrict the location where a physician practices.

States should clarify that non-competes can only restrict the location where a physician treats his patients and cannot prohibit a physician from treating patients. Patients like Albert lose their doctors because of their doctors’ perceptions of contractual obligations. Thus, state statutes must clarify that non-competes can only restrict the location in which a physician practices medicine. For example, the Texas statute states that a non-compete must clarify “that the physician will not be prohibited from continuing care and treatment to a specific patient or patients during the course of an acute illness,” even after the physician’s employment with the covenant holder has terminated. The Texas statute fails to prevent restrictive covenants from disrupting the doctor-patient relationship in many situations. Continuity of care is even more critical for long-term illnesses and conditions. The Texas statute potentially allows non-compete enforcement that would disrupt Albert’s relationship with Dr. Smith because Albert has had HIV for years; HIV is a chronic condition, not an acute illness.

Similarly, in Wichita Clinic, the physician could only continue to treat her patients if she violated a non-compete the court determined enforceable. Allowing covenant enforcement to sever the doctor-patient relationship harms patients by disrupting continuity of care and depriving patients of the choice to continue treatment with their doctors. State statutes should clarify that non-competes are

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336 See supra Section I.B.
337 See supra Section I.B.
339 See supra Section I.A.
340 TEX. BUS. & COM. CODE ANN. § 15.50(b)(3).
341 Malloy, supra note 5, at 205–06 (indicating that continuity of care has been “linked to increased utilization of preventative services,” which are the types of services that a patient gets from her general practitioner).
342 See Wichita Clinic, P.A. v. Louis, 185 P.3d 946, 949, 962–63 (Kan. Ct. App. 2008) (indicating that the patients could only be treated if the enforceable non-compete was violated).
343 See Steinbuch, supra note 12, at 1054–55 (arguing that physician restrictive covenants reduce access for patients as “[m]any patients are forced into existing practices and are not offered the opportunity, when those doctors leave their employment practices, to stay with doctors with whom they have developed relationships”).
unenforceable if they prohibit a physician from treating patients. Rather, non-compete clauses can only be enforced to limit the location in which a physician practices medicine. Given a clear mandate, courts will then refuse to enforce non-compete clauses that prohibit doctors from treating patients and only enforce non-compete clauses that limit the location in which doctors practice for a period of time. Statutory language will inform covenant holders, doctors, patients, and courts that patients can always travel to continue treatment with their doctors. Doctors, like Dr. Smith, will feel free to continue to treat their patients, like Albert, without fear of breaching non-compete clauses. Without guidance, covenant holders, like Sunshine Hospital, will continue to prohibit doctors from treating their patients after they depart, causing doctors to sever relationships with patients who will then experience poorer health outcomes.

iii. Prohibit injunctions for restrictive covenant breaches and enforce only liquidated damages provisions.

Many states prohibit enjoining a physician’s practice pursuant to a restrictive covenant but allow provisions providing for damages resulting from breach, including damages suffered because the physician competed with the covenant holder. These liquidated damages clauses are often called buyout provisions. Scholars and courts have posited that “[l]iquidated damages are less burdensome on public interests than an injunction restraining the physician from practicing medicine.” Although the physician may have to pay damages, the covenant does not deprive the public of the services of the physician. If the liquidated damages are cost prohibitive, however, physicians may have no choice but to comply, which would negatively impact patients to the same extent an injunction would. Jurisdictions should evaluate a buyout clause pursuant to the common law or statutory guidance in that jurisdiction. Usually this guidance prevents enforcement of liquidated damages clauses that act as penalties. Buyout provisions are better for patients than injunctions since they potentially allow the physician to continue to practice in the area covered by the covenant.

iv. Prohibit blue penciling overbroad restrictive covenants.

For every overreaching covenant a physician contests, there are tenfold the number of overbroad covenants with which physicians comply and thereby harm patients. In the healthcare context, state legislatures should prohibit courts from

344 See supra Section II.B.i.
345 Koons, supra note 140, at 270–71.
346 Id. at 286.
347 Id.
348 Id.
349 See supra note 285and accompanying text.
350 See Koons, supra note 140, at 271.
351 Swift, supra note 258, at 254–55 (describing the in terrorem impact of non-compete and stating that rewriting an overbroad non-compete does nothing to discourage the covenant holder from seeking the broadest protection possible).
rewriting overly broad covenants even if merely scratching out grammatically
severable overreaching clauses.\textsuperscript{352} Physician restrictive covenants implicate the
doctor-patient relationship, continuity of care, and access to care.\textsuperscript{353} Prohibiting blue
penciling incentivizes covenant holders to: (1) craft reasonable covenants narrowly
tailored to serve legitimate interests, and (2) consider the covenant’s impact on
patients.\textsuperscript{354} The legislature should require courts to invalidate overly broad restrictive
covenants. Covenant holders should get one chance to craft a reasonable covenant.\textsuperscript{355}
Legislative prohibition of blue penciling will make lawyers recognize and explain to
their practice group clients that courts will not salvage overreaching covenants;
lawyers and their clients will more fairly evaluate competing interests and consider
transactional options.

v. Enact transactional incentives to lower patient costs and expand patient choice
and access by making covenant enforcement turn on the extent to which the
covenant furthers healthcare reform goals.

The model physician restrictive covenant statute below provides transactional
incentives to expand patient choice and access and control costs to patients by
making covenant enforcement turn on the extent to which the covenant supports
healthcare reform goals. Current frameworks fail to incentivize physicians to:
(1) accept lower reimbursement coverage and (2) reduce costs to patients.\textsuperscript{356} The
model statute below provides these transactional incentives that are critical in the
U.S. where many patients face barriers to care. Below, this Section articulates sample
statutory language that a state legislature could simply adopt. Then, this Section sets
forth sample legislative commentary that instructs contracting parties on how to
prevail at the evidentiary hearing concerning the healthcare reform goals prong of
the physician restrictive covenant statute.

\textbf{MODEL STATUTE}

\textit{Enforcement of Physician Restrictive Covenants}

(1) \textit{Enforcement Only to Support Legitimate Interests.} The physician restrictive
covenant is only enforceable if it supports one or more of the listed legitimate
interests by protecting the covenant holder’s: (a) investment in training,
(b) investment in credentialing, (c) investment in medical equipment, (d) confidential business information and trade secrets, (d) patient referral sources, (e) ability to expand patient access to care (i.e., by controlling costs to enable the practice to accept Medicare, Medicaid, TRICARE, or other low reimbursement coverage, and provide affordable fee-for-service and concierge care).

(2) Reasonableness. The restrictive covenant shall be no greater than necessary to support the legitimate identified interests. Reasonableness will be evaluated in terms of geographic, temporal, and practice area scope. Restrictive covenants that are broader than necessary to serve the legitimate identified interests are not enforceable.

(3) Healthcare Reform Goals. The restrictive covenant is enforceable only if the court makes a written finding that the restrictive covenant, in the totality of the circumstances, supports and does not undermine the following healthcare reform goals: (a) expanding patient choice and access, (b) improving quality of care, and (c) containing costs to patients. After conducting an evidentiary hearing allowing the parties to proffer evidence concerning the restrictive covenant’s impact on the listed healthcare reform goals, the court shall make a written finding determining whether, after weighing the evidence, the restrictive covenant has the overall impact of supporting the listed healthcare reform goals.

COMMENTARY

Evidentiary Hearing: Covenant Holder's Perspective

At the evidentiary hearing concerning whether the covenant furthers healthcare reform goals, the covenant holder (employer) might consider proffering the following evidence. The employer could present healthcare economist expert witness testimony illustrating that there are ample physicians in the relevant specialty in the covered geographic area. This helps illustrate that covenant enforcement does not undermine patient choice and access and quality of care to the covered community. The employer could present testimony from the administrator responsible for creating and administering the covenant that explains how the covenant was crafted to urge physicians who choose to leave the practice to relocate to underserved areas. If applicable, the administrator might describe how covenant enforcement in the past resulted in physicians relocating to underserved areas. The employer might even craft the covenant to provide a financial incentive for physicians who choose to leave the practice to relocate to underserved areas, thereby helping to improve choice, access, and quality in underserved communities.

The employer could present healthcare economist expert testimony to explain how restrictive covenants enable providers to protect investments in credentialing and training new doctors, thereby enabling doctors to form small-group practices. Such small-group practices increase competition by expanding the number of providers. Competition helps control healthcare costs.

With respect to the individual practice of the covenant holder, a clinic
The following is an explanation of evidence that a physician employee might proffer to prevail on the healthcare reform goals analysis of the model statute. A healthcare economist expert witness might testify that there is a shortage of physicians of the relevant specialty in the geographic area covered by the covenant. A shortage of the relevant specialty could exist in the geographic area, even if there is a large number of physicians who practice in the specialty, if not all of those doctors accept lower cost coverage such as TRICARE, Medicare, and Medicaid, and the physician intends to accept this coverage. This type of testimony supports that covenant enforcement undermines the healthcare reform goals of improving patient choice, access, and quality.

The physician might testify about her plans to join or start a practice accepting lower reimbursement coverage and offering low-cost fee-for-service and concierge care that the covenant holder does not. Such testimony illustrates that covenant enforcement undermines healthcare reform goals of containing patient costs and expanding access to underserved populations.

A healthcare economist witness could testify regarding the importance of competition in preserving patient choice, access, quality, and cost containment. Covenant enforcement would preclude the physician from opening a competing practice in the covered geographic area, thereby undermining competition. The healthcare economist testimony could explain why competition is important to contain costs.

CONCLUSION

States should enact this Article’s model framework for evaluating physician restrictive covenants. Specifically, states should require practices to allow departing physicians to access patient information to fulfill patient notification responsibilities and refuse to enforce non-solicitation agreements prohibiting physicians from soliciting their own patients. Second, states should refuse to enforce restrictive covenants in a way that disrupts continuity of care and should clarify that covenants can only restrict the location where a physician treats patients and cannot prohibit a physician from treating patients. Third, states should prohibit injunctions for physician restrictive covenant breaches and enforce only liquidated damages provisions. Fourth, states should prohibit blue penciling overly broad physician restrictive covenants. Finally, states should enact transactional incentives to lower patient costs and expand patient choice and access by making covenant enforcement
turn on the extent to which the covenant furthers healthcare reform goals. Implementing these recommendations will help ensure patients like Albert and Amelia have access to affordable care and do not suffer a disruption in continuity of care but can freely choose their doctors.