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Physician Restrictive Covenants: The Neglect of the Incompetent Patients' Interests

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I. INTRODUCTION

The physician-patient relationship is unique in our society. Physicians[1] help safeguard one of the most important of human needs—health and well-being. Unfortunately, many physicians must balance the sometimes competing aims of providing personalized, high-quality care to their patients and running a profitable business. This tension is clearly evident in the current battles over the legality of physician restrictive covenants.[2]

Those entities that employ physicians—such as Health Maintenance Organizations[3] ("HMOs"), hospitals, and practice

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1. For the purposes of this Article, the term physician encompasses those persons courts define as physicians—all those licensed to practice medicine. Although this Article focuses on restrictive covenants as applied to physicians, the trend among courts appears to broaden the range of health care providers who are subject to such restrictive covenants, including nurse practitioners, physical therapists, medical technicians, and other health care professionals. *See* James W. Lowry, *Covenants-not-to-compete in Physician Contracts: Recent Trends Defining Reasonableness at Common Law*, 24 J. LEGAL MED. 215, 232 (2003).

2. Throughout this Article, the terms "restrictive covenant", "noncompete agreement", and "covenant-not-to-compete" will be used interchangeably. The terms refer to a clause in an employment contract that restricts the right of the physician to practice medicine within a specified geographic area for a specific amount of time after terminating employment. *See* BLACK'S LAW DICTIONARY 392 (8th ed. 2004); 6 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS §13:1 (4th ed. 1995).

3. An HMO is one type of prepaid medical service in which members pay a monthly fee for all health care, including doctors' visits, emergency care, hospitalization, lab tests, x-rays, surgery, and therapy. BARRY R. FURROW ET AL., HEALTH LAW §11-11 (1995).

groups—often protect their business interests by using restrictive covenants.[4] A physician restrictive covenant is a clause typically found in employment agreements between physicians and their employers that restricts the right of a physician to engage in a business similar to or competitive with that of the employer after the conclusion or termination of the physician's employment.[5] Physicians are usually required by their employers to sign such covenants prior to beginning their practice. The contractual clauses obligate physicians to refrain from engaging in or establishing a competitive medical practice within a certain geographic region for a limited time period. The restrictive covenant typically will also prohibit a physician from treating patients at hospitals within the same geographic area.[6]

Physician restrictive covenants have steadily gained in use and importance within the medical community, in part due to the increased professional mobility of physicians. Physicians today are more likely to change employers than in the past. Prior to 1990, less than two percent of physicians changed jobs during their career. Physicians entering the workforce after 1990, in comparison, had switched employers on average about three times before 2000.[7] In fact, recent studies indicate that approximately ten percent of physicians may change jobs annually.[8] Many of these physicians are unaware of the impact that restrictive covenants[9] can have on their

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4. For an excellent historical perspective on restrictive covenants in employment contracts, see Harlan M. Blake, *Employee Agreements Not to Compete*, 73 HARV. L. REV. 625, 626-28 (1960).

5. *See, e.g.*, 15 GRACE MCLANE GIESEL, CORBIN ON CONTRACTS § 80.16 (Joseph M. Perillo ed., rev. ed. 2003).

6. *See, e.g.*, Ballesteros v. Johnson, 812 S.W.2d 217, 220 (Mo. Ct. App. 1991) (examining a covenant-not-to-compete that specified seven hospitals where the departing physician cardiologists could not practice). For a thorough discussion of physician restrictive covenants, their impact on physicians and patients, and physician relocation policies, see generally Paula Berg, *Judicial Enforcement of Covenants-not-to-compete Between Physicians: Protecting Doctors' Interests at Patients' Expense*, 45 RUTGERS L. REV. 1 (1992). The underlying assumption is that "most of a departing physician's patients will choose to be treated by the employer or by the departing physician's replacement rather than to follow the physician to an inconvenient location outside the covenant area." *Id.* at 4.

7. Howard Markel, *Doctors Now Need Well-Honed Skills In Job Hunting*, N.Y. TIMES, May 22, 2001, at F5.

8. *Id.*; *see also* Am. Acad. of Family Physicians, *More Docs Job Hunting*, FAM. PRAC. MGMT., July/Aug. 2001, at 23.

9. *See* Arthur S. Di Dio, *The Legal Implications of Noncompetition Agreements in Physician Contracts*, 20 J. LEGAL MED. 457, 457 (1999) ("[U]nder current law, the physician-employee faces an uphill battle in challenging a restrictive covenant."); *see also* Derek W. Loeser, *The Legal, Ethical, and*

mobility and professional opportunities.[10] Doctors are regularly forced to stop or relocate their practices due to the enforcement of physician restrictive covenants. Although a physician who chooses to leave a practice in spite of a restrictive covenant may suffer financially because of the loss of a patient base, the physician has an ongoing responsibility to the patients with whom he is no longer legally permitted to have a relationship.[11] Thus, for physicians, these covenants often present difficult economic and ethical challenges.

Court opinions tend to emphasize the negative impact of these covenants upon the doctors themselves.[12] However, individual patients of these doctors can also suffer from the enforcement of these covenants. A patient's quality of care is often directly affected by the stability of the patient's relationship with his or her physician, particularly in fields such as pulmonology and psychiatry.[13] Physician restrictive covenants can inhibit the formation of long-term relationships between physicians and patients and, thus, result in a lesser quality of care for the patient.[14]

Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign, 31 J.L. MED. & ETHICS 283, 284 (2003).

10. Physicians expend significant time and energy developing professional relationships with hospitals and other physicians. When faced with a restrictive covenant, a physician must choose between staying in the employment relationship or leaving and effectively completely terminating his practice. *See* Brian Wyatt, *Scrutinize Restrictive Covenants*, PHYSICIAN'S NEWS DIG., June 1997, http://www.physiciansnews.com/law/697wyatt.html; *see also* Michael R. Burke, *Limiting Restrictive Covenants*, FAM. PRAC. MGMT., Apr. 2001, at 50, 50.

11. *See* Di Dio, *supra* note 9, at 474-75.

12. *See, e.g.*, Keeley v. Cardiovascular Surgical Assocs., 510 S.E.2d 880, 885 (Ga. Ct. App. 1999) (upholding a noncompetition agreement to protect the former employer's "legitimate business interests" in maintaining its "substantial patient base and network of referring physicians throughout the [protected territory]"); Willman v. Beheler, 499 S.W.2d 770, 777 (Mo. 1973) (upholding the restrictive covenant because of the importance of respecting "a counterbalancing public policy . . . in enforcing contractual rights and obligations"), *abrogated by* State *ex rel.* Leonardi v. Sherry, 137 S.W.3d 462 (Mo. 2004) (concerning the request for a jury trial in litigation arising from a restrictive covenant in a contract between a physician and a pharmaceutical company conducting a pharmaceutical trial).

13. *See* Berg, *supra* note 6, at 31-34.

14. *See* Debra Pressey, *Sore Issue for Some Physicians*, CHAMPAIGN-URBANA NEWS-GAZETTE, Oct. 5, 2003, http://www.news-gazette.com/news/local/2003/10/05/sore_issue_for_some_physicians/. An orthopedic surgeon who had introduced state legislation to ban restrictive covenants between physicians in Illinois stated that "he's watched dozens of doctors forced to take their specialties out of the community just because they wanted to leave one of the local clinics. And, he contends, it's the patients who ultimately suffer." *Id.*

One might assume that physician restrictive covenants would receive special treatment by the judiciary given the unique problems they present. Unfortunately, the vast majority of courts currently view the physician-patient relationship as analogous to a simple merchant-customer relationship, thus comparing a very complex relationship to an overly simplified one.[15] These courts do not analyze physician restrictive covenants any differently than they analyze covenants-not-to-compete between commercial parties. As is the case with restrictive covenants between commercial parties, the courts apply a "rule of reason" test to determine whether physician restrictive covenants are enforceable.[16] Under the rule of reason test, a restrictive covenant is reasonable, and therefore enforceable, if it 1) is no broader than necessary to protect a legitimate interest of the employer, 2) does not unduly burden the employee, and 3) does not harm the public.[17] The rule of reason test historically offers little hope of success to physicians seeking to avoid enforcement of restrictive covenants.[18] Applying the rule of

15. A few states have independently banned such agreements. *See* Berg, *supra* note 6, at 10-14. Although eight states have invalidated noncompetition agreements between physicians, only Colorado, Delaware, and Massachusetts specifically prohibit such agreements by statute. *See* COLO. REV. STAT. § 8-2-113(3) (2004) (prohibiting restrictive covenants but permitting damage awards on the termination of a physician employment agreement); DEL. CODE ANN. tit. 6, § 2707 (2005); MASS. ANN. LAWS. ch. 112 § 12X (LexisNexis 2004). Though the Alabama, California, Florida, Louisiana, Montana, and North Dakota antitrust statutes do not specifically address physician restrictive covenants, they prohibit the use of noncompetition agreements among professionals including physicians. Berg, *supra* note 6, at 12. *See generally* Michael G. Getty, *Enforceability of Non-Competition Covenants in Physician Employment Contracts: Confusion in the Courts*, 7 J. LEGAL MED. 235 (1986) (discussing the evolution, effects, and inconsistent judicial enforcement of and proposing an alternative system to noncompetition agreements in physician employment contracts).

16. *See, e.g.*, Weber v. Tillman, 913 P.2d 84, 96-97 (Kan. 1996) (enforcing a noncompetition agreement among physicians as a reasonable contractual agreement); Karlin v. Weinberg, 390 A.2d 1161, 1169-70 (N.J. 1978) (applying a reasonability test to a noncompetition agreement among dermatologists); Iredell Digestive Disease Clinic, P.A. v. Petrozza, 92 N.C. App. 21, 26-27, 373 S.E.2d 449, 452 (1988), *aff'd*, 324 N.C. 327, 377 S.E. 2d 750 (1989); Holzer Clinic, Inc. v. Simpson, No. 97CA9, 1998 WL 241887, at *6-7 (Ohio Ct. App. Apr. 28, 1998) (applying a reasonability test to a noncompetition agreement between a physician and former employer).

17. RESTATEMENT (SECOND) OF CONTRACTS § 188 (1981).

18. *See, e.g.*, Prairie Eye Ctr. v. Butler, 768 N.E.2d 414, 419-21 (Ill. App. Ct. 2002); Wash. County Mem'l Hosp. v. Sidebottom, 7 S.W.3d 542, 545-46 (Mo. Ct. App. 1999); Hauser v. Harding, 126 N.C. 175, 177-78, 35 S.E. 586, 587-88 (1900) (upholding a physician restrictive covenant without acknowledging the parties' occupations as physicians as relevant to validity of noncompete agreement).

reason test, courts have only rarely invalidated physician restrictive covenants solely out of concern for the public welfare.[19] This approach does not respect the unique role a physician can play in the community. Some factors courts have downplayed or ignored are the physician's ability to provide optimal care and the patients' ability to choose their physician freely. Surprisingly, nearly identical considerations[20] have been applied by most courts to limit, or completely bar, the enforceability of attorney restrictive covenants.[21] This strangely disparate treatment of two professional groups exists despite the fact that the physician-patient relationship is at least as important from a public policy standpoint as that of attorney and client.[22] The rule of reason test, as currently applied

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19. Several courts have summarily dismissed the argument that noncompetition agreements between physicians are against public policy. *See, e.g.*, Phoenix Orthopedic Surgeons, Ltd., v. Peairs, 790 P.2d 752, 758 (Ariz. Ct. App. 1989); Raymundo v. Hammond Clinic Ass'n., 449 N.E.2d 276, 280-81 (Ind. 1983).

20. *See, e.g.*, Dowd & Dowd, Ltd. v. Gleason, 693 N.E.2d 358, 369 (Ill. 1998) (finding that the bar on noncompetition agreements among lawyers "is designed both to afford clients greater freedom in choosing counsel and to protect lawyers from onerous conditions that would unduly limit their mobility"); *see also* Jacob v. Norris, McLaughlin & Marcus, 607 A.2d 142, 146 (N.J. 1992) (stating that the ethical bar is "designed to serve the public interest in maximum access to lawyers"); Cohen v. Lord, Day & Lord, 550 N.E.2d 410, 413 (N.Y. 1989) ("While a law firm has a legitimate interest in its own survival and economic well-being and in maintaining its clients, it cannot protect those interests by . . . restricting the choices of the clients to retain and continue the withdrawing member as counsel.").

21. Although most courts do not explicitly describe their analysis as the application of a per se rule, that characterization has been used by a number of commentators. *See, e.g.*, Stephen E. Kalish, *Covenants-not-to-compete and the Legal Profession*, 29 ST. LOUIS U. L.J. 423, 425 (1985). A well-considered law review article that discusses the impact of this approach upon the law firm structure is Larry E. Ribstein, *Ethical Rules, Agency Costs, and Law Firm Structure*, 84 VA. L. REV. 1707, 1730-38 (1998). Other law review commentaries on lawyer noncompetition agreements are cited in Joseph M. Perillo, *The Law of Lawyers' Contracts Is Different*, 67 FORDHAM L. REV. 443, 477 n.235 (1998).

22. The reasoning behind the ABA's decision to deem restrictive covenants unethical in 1960 illuminates the enhanced status that relationships between professionals and their clients or, in this case, patients, requires.

> A general covenant restricting an employed lawyer, after leaving the employment, from practicing in the community for a stated period, appears to the Committee to be an unwarranted restriction on the right of a lawyer to choose where he will practice and inconsistent with our professional status. Accordingly, the Committee is of the opinion it would be improper for the employing lawyer to require the covenant and likewise for the employed lawyer to agree to it.

ABA Comm. on Prof'l Ethics, Formal Op. 300 (1961); *see also* 2 GEOFFREY C. HAZARD, JR. & W. WILLIAM HODES, THE LAW OF LAWYERING § 47.4 (3d ed. 2001 &

by the courts, overemphasizes freedom of contract principles and economic harm to physician employers. The courts have failed to recognize that physician restrictive covenants are partly at odds with professional medical ethics and good medical care.

This Article advances an argument that courts must modify the traditional rule of reason test in future evaluation of physician restrictive covenants. Courts must consider the impact that enforcement of restrictive covenants will have on the relationships between physicians and their patients within the public-interest prong of the rule of reason analysis. As part of this public-interest calculus, courts must weigh the potential harm to patient choice and to the professional and ethical obligations of physicians to their patients. These considerations should supplement the traditional test's vague public-interest prong with the more discrete concerns of the patients of a particular physician.[23]

Contemporary courts' application of the rule of reason to physician restrictive covenants[24] is summarized in Part II of this Article. Typically, a court will only refuse to enforce a noncompetition agreement when doing so would create a scarcity of physicians, thereby causing unjustifiable damage to the public welfare.[25] But defining the public interest so narrowly ignores the harm to existing patients who, in most instances, suffer when they lose the continuity, trust, and understanding offered by their original physician.[26] The shortcomings of defining the public

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Supp. 2005). The ABA Committee on Professional Ethics originally opposed lawyers' covenants-not-to-compete because they smacked of commercialism. ABA Comm. on Prof'l Ethics, Formal Op. 300 (1961); *see also* Charles E. Cantu & Jared Woodfill, V, *Upon Leaving a Firm: Tell the Truth or Hide the Ball*, 39 VILL. L. REV. 773, 784 (1994) (noting that in its decision, the ABA Committee emphasized that law is a profession rather than a business, and that clients must be seen as more than merchandise).

23. The few courts that have recognized the depth of this prong essentially allow it to devour the other prongs of the rule of reason, holding that a violation of public policy makes all other prongs moot. *See* Valley Med. Specialists v. Farber, 982 P.2d 1277, 1285-86 (Ariz. 1999) (concluding that restrictive covenants between physicians must be "strictly construed" because of the weighty public policy considerations). Interestingly, since the public policy analysis was almost exclusively general, the court found it necessary to remind the reader that it was not voiding all restrictive covenants between doctors per se. However, the court only vaguely indicated that any covenants may be legal in the future. *Id.*

24. *See infra* notes 31-47 and accompanying text.

25. *See, e.g.*, Iredell Digestive Disease Clinic, P.A. v. Petrozza, 92 N.C. App. 21, 28, 373 S.E.2d 449, 453-54 (Ct. App. 1988) (refusing to enforce a restrictive covenant because doing so would create a shortage of gastroenterologists in the area), *aff'd*, 324 N.C. 327, 377 S.E.2d 750 (1989).

26. *See infra* notes 79-97 and accompanying text.

interest in broad, yet vague, notions—such as "scarcity"—rather than recognizing its complex nature, are also addressed in Part II of this Article.[27]

Part III discusses some solutions to the indiscriminate application of the rule of reason to physician restrictive covenants.[28] In Part IV, the author proposes that in future cases, incumbent patients should be treated as third-party beneficiaries of restrictive covenants, giving them an explicit interest in the balancing of harms under the rule of reason test.[29] By the end of Part IV, it should be clear that once courts address the interests of incumbent patients when evaluating physician restrictive covenants, what results is a new reasonability analysis that better balances the interests affected by enforcement of such covenants.[30] This new rule of reason will permit enforcement of a competition restraint if it 1) is limited to prevent only unfair competition, 2) does not improperly elevate an employer's economic interests above the departing physician's interests, and 3) does not substantially harm the physician's incumbent or potential patient base.

II. THE APPLICATION OF RESTRICTIVE COVENANTS TO MEDICAL PROFESSIONALS

A. *The Rule of Reason Generally*

Physician employers commonly include noncompetition provisions in physician employment contracts.[31] These provisions apply in the event a physician leaves his or her employer and act to limit a physician's ability to practice medicine within specified geographic areas. They further contain nonsolicitation clauses, which bar the physician from advising patients to follow the physician to his or her new place of employment. Even though these provisions are contrary to the ideals of free competition and the ability of an individual to choose his or her profession, courts uphold these noncompete agreements in most instances, applying the rule of reason standard.[32] Under the rule of reason, a noncompete agreement is enforceable as long as it is reasonable as to time and geographic restrictions and its enforcement is not against public policy. The rule of reason protects the employee's interests, while also protecting the employer's legitimate business interests.[33]

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27. *See infra* notes 61-83 and accompanying text.
28. *See infra* notes 145-204 and accompanying text.
29. *See infra* notes 205-27 and accompanying text.
30. *See infra* notes 236-48 and accompanying text.
31. *See supra* note 5 and accompanying text.
32. 15 GIESEL, *supra* note 5, § 80.6.
33. *See id.*

When applying the rule of reason, courts consider whether (1) the employer has a legitimate protectable interest,[34] (2) the restrictive covenant is reasonably designed to protect that interest, (3) enforcement will unduly burden the employee,[35] and (4) the enforcement will violate public policy.[36] The judiciary usually views restrictive employment covenants skeptically,[37] reasoning that a postemployment restraint is difficult to justify because it may impede an employee's ability to earn a livelihood and deprive the public of an employee's skills and services but not significantly advance an employer's economic interests.[38] Each jurisdiction's analysis of restrictive covenants is unique. Generally, however, courts will first determine whether consideration for the covenant

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34. Enforcement of physician restrictive covenants has been "justified on the ground that the employer has a legitimate interest in restraining the employee from appropriating valuable trade information and customer relationships to which he has had access in the course of his employment." RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. b (1981). Although the mere threat of competition is not a sufficient interest to justify enforcement of a restraint on competition, *see, e.g.*, Duffner v. Alberty, 718 S.W.2d 111, 112 (Ark. Ct. App. 1986) ("[T]he law will not enforce a contract merely to prohibit ordinary competition."), courts have recognized that employers have protectable interests in retaining patients, *see, e.g.*, Duneland Emergency Physician's Med. Group v. Brunk, 723 N.E.2d 963, 966-67 (Ind. Ct. App. 2000) (finding no legitimate protectable interest in retaining patients since restricted physician worked in an emergency room setting); confidential information, *see, e.g.*, Dental E., P.C. v. Westercamp, 423 N.W.2d 553, 555 (Iowa Ct. App. 1988) (enforcing covenant-not-to-compete because departing dentist had access to employer's methods of operation and business techniques as well as to its patients' names); training, *see, e.g.*, Oudenhoven v. Nishioka, 190 N.W.2d 920, 921 (Wis. 1971) (characterizing a typical noncompete between physicians as a sacrifice often made by a younger physician in order to receive valuable training); and goodwill, *see, e.g.*, Raymundo v. Hammond Clinic Ass'n, 449 N.E.2d 276, 279 (Ind. 1983) (holding that the covenant "did nothing more than protect the Clinic's goodwill against piracy by a mutinous partner").

35. To show a restrictive covenant is unduly burdensome, a physician must show the agreement imposes some severe and unique personal hardship. *See* Blake, *supra* note 4, at 684-86; *see also* Lewis v. Surgery & Gynecology, Inc., No. 90AP-300, 1991 WL 35010, at *4 (Ohio Ct. App. March 12, 1991) (holding that enforcement of a restrictive covenant would impose an undue burden by forcing a physician to relocate and remove her developmentally disabled daughter from a special school).

36. For a brief overview of the public interests involved, see Michael R. Sullivan, Note, *Covenants Not to Compete and Liquidated Damages Clauses: Diagnosis and Treatment for Physicians*, 46 S.C. L. Rev. 505, 514 (1995) (citing Andrea Cooper, *Law and Medicine: Restrictive Covenants*, 248 J. AM. MED. ASS'N 3091 (1982)).

37. *See* Blake, *supra* note 4, at 647.

38. *See id.*

exists.[39] If the employee received adequate consideration for signing the covenant, judges will proceed to examine separately the interests of the employer, the employee, and the public in order to determine whether the restrictive covenant is reasonable under the circumstances.[40] Generally, a restrictive covenant is unreasonable if 1) it is broader than necessary to protect the employer's legitimate interests,[41] or 2) the employer's interests are outweighed by the interests of either the employee or the public.[42] Courts have applied this "rule of reason" test to noncompetition agreements signed by accountants,[43] doctors,[44] veterinarians,[45] as well as other

39. *See* RESTATEMENT (SECOND) OF CONTRACTS § 71 (1981).

40. *See* E. ALLAN FARNSWORTH, CONTRACTS § 5.3, at 356 (2d ed. 1990).

41. If an employer does have a protectable interest, the court will proceed to consider whether the restrictive covenant is reasonable as to its duration, geographical area, and type of medical practice restricted. *See* Valley Med. Specialists v. Farber, 982 P.2d 1277, 1284 (Ariz. 1999) ("The idea is to give the employer a reasonable amount of time to overcome the former employee's loss, usually by hiring a replacement and giving that replacement time to establish a working relationship."); *see also* Berg, *supra* note 6, at 23-27; Blake, *supra* note 4, at 676-81; Mark A. Glick et al., *The Law and Economics of Post-Employment Covenants: A Unified Framework*, 11 GEO MASON L. REV. 357, 371-72 (2002) (providing a general overview of technicalities of the modern rule of reason test). The average mileage restriction for restrictive covenants that are enforced is 33.9 miles. Empirical Study, *A Statistical Analysis of Noncompetition Clauses in Employment Contracts,* 15. J. CORP. L. 483, 511 (1990); *see, e.g.*, Northside Hosp., Inc. v. McCord, 537 S.E.2d 697, 699 (Ga. Ct. App. 2000); *see also* Zulima V. Farber et al., *Are Physician Post-Employment Noncompete Agreements Enforceable?*, METRO. CORP. COUNSEL, March 2004, at 4 (discussing the varying enforceable distances in various states' physician restrictive covenants).

42. RESTATEMENT (SECOND) OF CONTRACTS § 188(b) (1981); *see, e.g.*, Mantek Div. of NCH Corp. v. Share Corp., 780 F.2d 702, 711 (7th Cir. 1986) (holding that a provision prohibiting salesmen from selling a competing product in their former territories is unnecessary to protect an employer's interest because only a prohibition on calling customers with whom the employee came into contact during employment is reasonable); Ferrofluidics Corp. v. Advanced Vacuum Components, Inc., 789 F. Supp. 1201, 1210 (D.N.H. 1992) (holding that a covenant-not-to-compete that prohibited employees from working for competing magnetic fluid manufacturer for five years is an undue burden on employees), *aff'd*, 968 F.2d 1463 (1st Cir. 1992).

43. *See, e.g.*, Fuller v. Brough, 411 P.2d 18, 22 (Colo. 1966) (upholding as reasonable a restrictive covenant prohibiting a withdrawing accountant from practicing within forty-five miles of city for five years); Peat, Marwick, Mitchell & Co. v. Sharp, 585 S.W.2d 905, 908 (Tex. Civ. App. 1979) (declaring that a restrictive covenant agreed to by an accountant was unreasonable because the clause failed to designate a specific geographic area).

44. *See, e.g.*, Odess v. Taylor, 211 So. 2d 805, 810 (Ala. 1968) (holding unreasonable and unenforceable a restrictive covenant prohibiting a specialist from practicing in area where shortage of specialists existed); Gelder Med. Group v. Webber, 363 N.E.2d 573, 577 (N.Y. 1977) (upholding a reasonable

professionals.[46] The rule of reason test is the "dominant judicial approach to enforceability."[47]

B. Current Application of the Rule of Reason to Physician Restrictive Covenants: A One-Dimensional View of the Doctor-Patient Relationship

1. Economics Over Patients: Prioritizing the Employer's Interests

Physician employers argue that they are entitled to the enforcement of covenants-not-to-compete based upon protectable interests in their customer base, confidential information, training, and customer goodwill.[48] Of these, physician employers most often assert a protectable interest in keeping existing patients after an employee's departure.[49] The physician employer fears that patients who have been treated continually by a specific physician will wish to maintain the relationship with that physician even after the physician resigns from practice with the physician employer.[50]

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covenant restricting a physician's right to practice within thirty miles of former partnership based on lack of injury to the public).

45. *See, e.g.*, Cukjati v. Burkett, 772 S.W.2d 215, 218 (Tex. App. 1989) (invalidating as unreasonable a covenant-not-to-compete in veterinarian's employment contract which prohibited him from practicing veterinary medicine within twelve miles of his employer's clinic); Hopper v. All Pet Animal Clinic, Inc., 861 P.2d 531, 544-45 (Wyo. 1993) (upholding covenant restricting competition by declaring that restricting veterinarian from practicing on small animals within five-mile radius of city limits was reasonable, but that a three-year limit was unreasonable).

46. *See, e.g.*, Ridley v. Krout, 180 P.2d 124, 132-33 (Wyo. 1947) (declaring unreasonable and unenforceable an agreement restricting mechanic from working for seven years in specific cities and counties); Keller v. Cal. Liquid Gas Corp., 363 F. Supp. 123, 125-28 (D. Wyo. 1973) (analyzing a noncompete agreement between a buyer and seller of a liquid gas business). *See generally* 14 SAMUEL WILLISTON & WALTER H.E. JAEGER, A TREATISE ON THE LAW OF CONTRACTS § 1636 (3d ed. 1972).

47. Rachel S. Arnow-Richman, *Bargaining for Loyalty in the Information Age: A Reconsideration of the Role of Substantive Fairness in Enforcing Employee Noncompetes*, 80 OR. L. REV. 1163, 1172 (2001).

48. *See* RESTATEMENT (SECOND) CONTRACTS § 188 cmt. b (1981); *see, e.g.*, Folsom Funeral Serv. v. Rodgers, 372 N.E.2d 532, 533 (Mass. App. Ct. 1978) (declaring a restrictive covenant unreasonable because customer relationships and contacts did not have a great impact on the undertaking business); Purchasing Assocs., Inc. v. Weitz, 196 N.E. 2d 245, 248 (N.Y. 1963) (reversing the lower court's judgment in favor of a restrictive covenant after discovering no loss of trade secrets, customers, and unique and extraordinary services).

49. *See* Prairie Eye Ctr., Ltd. v. Butler, 768 N.E.2d 414, 421 (Ill. App. Ct. 2002) ("[M]edical practices have a protectible interest in the patients of their physicians and this interest is inferred from the nature of the profession.").

50. *See id.* at 422.

Courts generally accept this reasoning by treating patients as assets of the physician employer that could be unfairly appropriated by the physician, thus warranting protection by a covenant-not-to-compete.[51] Such an approach subordinates the personal relationship of the doctor-patient to the economic relationship between a patient-customer and a clinic, office, or practice group. Consider, as an example, the Minnesota Supreme Court's decision in *Granger v. Craven*.[52]

In that case, followed by a majority of courts,[53] the Minnesota Supreme Court upheld a physician restrictive covenant because, according to the court's reasoning, it did no more than necessary to protect a practice group against a departing physician's "hold" on his patients.[54] The *Granger* court set the tone for later courts that continued to view patients merely as customers, rather than individuals whose unique relationships with their physicians would normally distinguish them from otherwise indiscriminate commercial clients.[55]

Courts have even gone as far as to enforce physician restrictive covenants despite recognition that such covenants would be enforced to the detriment of the physician's patients.[56] In *Dickinson Medical*

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51. *See* Blake, *supra* note 4, at 662 ("Restraints upon professional employees, such as associates or technical assistants of lawyers, doctors, architects, accountants, and dentists, are also generally upheld when the customer relationships are substantial."). *But see* Mandeville v. Harman, 7 A. 37, 40-41 (N.J. Ch. 1886) (holding that protection of a medical practice's patient base was not a sufficient interest to warrant judicial enforcement of a covenant-not-to-compete).

52. 199 N.W. 10 (Minn. 1924).

53. *See* Berg, *supra* note 6, at 17.

54. *See Granger*, 199 N.W. at 13-14.

55. *See, e.g.*, Keeley v. Cardiovascular Surgical Assocs., P.C., 510 S.E.2d 880, 884 (Ga. Ct. App. 1999) (upholding a noncompetition agreement among cardiovascular surgeons that barred the employee from any competing cardiovascular surgery practice within seventy-five miles of the former employer for a two-year period after termination to protect the former employer's "legitimate business interests" in maintaining its "substantial patient base and network of referring physicians throughout the protected territory").

56. *See* Prairie Eye Ctr., Ltd. v. Butler, 768 N.E.2d 414, 421 (Ill. App. Ct. 2002) ("Despite our sympathy for the rights of patients to choose their own doctors, we are constrained to follow the long line of precedent finding noncompetition agreements enforceable in the medical profession." (internal citations omitted)); Bloomington Urological Assocs., S.C. v. Scaglia, 686 N.E.2d 389, 394 (Ill. App. Ct. 1997) (declaring a noncompete agreement between physicians enforceable but acknowledging the sacrosanct relationship between the contracting physician and his patients); *see also* Willman v. Beheler, 499 S.W.2d 770, 777 (Mo. 1973) (holding a covenant-not-to-compete valid even though a shortage of surgeons existed in the area because such shortages

Group v. Foote,[57] a hospital's only board-certified staff oncologist resigned and left with a computer print-out of the names and addresses of all the cancer patients she had treated with chemotherapy.[58] Although Dr. Foote's employment contract barred her from treating former patients, Dr. Foote argued that she had a professional and ethical responsibility to contact her former patients to offer continuity of treatment.[59] Though the Delaware court sympathized with the plight of her patients, it determined the patient list was a protectable trade secret wrongfully appropriated by Dr. Foote and consequently enforced the restrictive covenant.[60]

2. *Public Interest as a Numbers Game: "Patients are not . . . property or chattel."*[61]

The public interest, or public policy, element of the rule of reason test has been a magic wand of sorts for courts to use as they please in upholding or striking down restrictive covenants between physicians. Unfortunately, the vast majority of contemporary evaluations of the public interest prong focus almost exclusively on the interest of the public at large,[62] rather than also considering the interests of individual patients.[63] Courts upholding covenants between doctors either ignore this prong altogether[64] or interpret it

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existed in many areas).

57. No. 834-K, 1984 WL 8208, at *1 (Del. Ch. May 10, 1984).

58. *See id.*

59. *Id.* at *2. For further discussion of some of the ethical issues raised by physician restrictive covenants, see Derek W. Loeser, *supra* note 9, at 286-87.

60. Chancellor Brown noted:

> [The issue of the case] lacks the ring of humanitarianism that once was associated with the practice of medicine. Prior to this application, I never had reason to equate a list of persons suffering from cancer and other illnesses with a proprietary 'customer list' as that term is normally employed in the world of commerce. But I guess business is business, regardless of the form it takes.

Dickinson, 1984 WL 8208 at *2.

61. Humana Med. Plan, Inc. v. Jacobson, 614 So. 2d 520, 522 (Fla. Dist. Ct. App. 1992).

62. *See* Weber v. Tillman, 913 P.2d 84, 93-95 (Kan. 1996) (discussing the public interest in the ability to access physician care). Courts often simply calculate the numbers of certain specialists needed in the pertinent geographical area without any inquiry into the quality of the care or the interests of individual patients.

63. *See, e.g.*, Rash v. Toccoa Clinic Med. Assoc., 320 S.E.2d 170, 173 (Ga. 1984) (viewing the harm to the public of upholding the restrictive covenant as mitigated by treating one community's loss of a doctor as another community's gain); Willman v. Beheler, 499 S.W.2d 770, 777 (Mo. 1973) (noting that most communities are short of medical doctors).

64. *See Rash*, 320 S.E.2d at 173-74 (dismissing the public policy prong as

to require only a certain number of physicians or specialists in a certain geographic area.[65] Those courts that strike down covenants between physicians often use the public interest prong to overshadow and render moot the other elements of the rule of reason test.[66] These small minority of latter courts have, to a varying degree, identified and explored the "public interest" in relation to the doctor-patient relationship, often viewing the issue as much more complex than simply a game of dueling statistics.[67]

In many of the most recent cases over disputed physician restrictive covenants, the courts have not found the potential harm to the public to be substantial enough to rescind the covenants.[68] The lack of attention given by the Kansas Supreme Court in *Weber v. Tillman*[69] to the impact enforcement would have on the public

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essentially irrelevant since a doctor in one city is as useful as a doctor in another).

65. *See Rash*, 320 S.E.2d at 173-74; Marshall v. Covington, 339 P.2d 504, 506-07 (Idaho 1959) (citing Bauer v. Sawyer, *infra*, for the same proposition); Bauer v. Sawyer, 126 N.E.2d 844, 851 (Ill. App. Ct. 1955) (finding no evidence that enforcement would create a shortage of doctors in the restriction area and, thus, finding no public harm); Cogley Clinic v. Martini, 112 N.W.2d 678, 682 (Iowa 1962) (finding that a sufficient number of doctors remained available to the community to avoid public harm from enforcement). *But see* Duffner v. Alberty, 718 S.W.2d 111, 113-14 (Ark. Ct. App. 1986) (striking down a restrictive covenant on a finding that the agreement "constitutes an undue interference with the interests of the public right of availability of the orthopedic surgeon it prefers to use and that the covenant's enforcement would result in an unreasonable restraint of trade"). Even if enforcement would create a shortage of doctors within the restriction area, the resulting harm still may not always be deemed sufficient to justify denying enforcement. *See, e.g.*, *Weber*, 913 P.2d at 96 (enforcing a restriction). The *Weber* court noted that each of the cases it cited for having held a restriction unenforceable because of the potential shortage of physicians dealt with "a shortage of physicians [in] specialties which were, for lack of a better term, medically necessary." *Id.* at 95 (internal citations omitted).

66. *See infra* notes 127-44 and accompanying text.

67. *See id.*

68. *See, e.g.*, *Willman*, 499 S.W.2d at 777 (enforcing a restrictive covenant despite evidence of shortage of surgeons in the northwest part of the state); Gant v. Hygeia Facilities Found., Inc., 384 S.E.2d 842, 846 n.7 (W. Va. 1989) (enforcing a restrictive covenant that required a covenantor to leave a rural area despite evidence of a statewide shortage of rural doctors).

69. 913 P.2d 84 (Kan. 1996). The restrictive covenant barred the doctor's practice of dermatology within a thirty-mile radius of his former practice for a period of two years. If he chose to violate the covenant, he was required to pay six-months salary plus bonuses to Dr. Weber. *Id.* at 87. Forty to fifty percent of the departing doctor's patients had been patients of the former practice. The competition restriction, however, barred all practice in the designated geographic area and was not limited to only the treatment of former patients of the employer. *See id.* at 92.

welfare is typical. Dr. Weber, the only dermatologist in northwest and north central Kansas, hired Dr. Tillman on the condition that he would not practice dermatology within thirty miles of Dr. Weber's office for a period of two years following termination.[70] The court upheld the noncompetition clause,[71] finding the covenant was not against public policy[72] despite expert testimony that the community's dermatological needs would be jeopardized if Dr. Tillman was banned from practicing in the restricted area.[73]

The court seemed relatively unconcerned by this danger,[74] especially because of the possibility Dr. Tillman might "buy out" the restriction. "[A]s a practical matter, the people [of the area] . . . may not lose Dr. Tillman's services as a dermatologist," the court observed.[75] "[T]heir welfare is not injured if they have to travel further to obtain dermatology services should Dr. Tillman elect not [to buy out the restriction]," the court stated.[76] Because the lack of any "substantial public injury" to potential patients compared unfavorably to Dr. Weber's "investment of years, education, and effort in establishing his practice and the value of goodwill developed over 17 years,"[77] the court held the covenant's scope protected Dr. Weber from any competitive advantage Dr. Tillman might derive from his former employer's goodwill.[78]

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70. *Id.* at 87. To stay in practice, Dr. Tillman was required to pay liquidated damages totaling more than $82,000. *Id.* at 88.

71. The *Weber* court noted that it had previously found a ten-year noncompetition clause between two physicians to be reasonable in time although it reduced the geographic scope from one-hundred miles to five miles. *See id.* at 90 (discussing Foltz v. Struxness, 215 P.2d 133, 133 (Kan. 1950)).

72. *See id.* at 96. *But see also, e.g.*, Duffner v. Alberty, 718 S.W.2d 111, 113-14 (Ark. Ct. App. 1986) (holding a noncompetition agreement invalid as an unreasonable restraint of trade). The *Duffner* court invalidated the covenant because it prohibited only ordinary competition and declared that the physicians had no valid economic interest to protect because:

> [There were no] trade secrets, formulas, methods, or devices which gave appellant an advantage . . . . At the time he joined the association he had received his training and skills elsewhere and brought them with him. There is nothing . . . to indicate that he learned any trade secret or surgical procedures . . . which were not readily available to other[s].

Id. at 114.

73. *See Weber*, 913 P.2d at 93. Dr. Weber himself admitted that the community could support two or more dermatologists. *Id.* For a further discussion of liquidated damages clauses, *see infra* notes 168-72 and accompanying text.

74. *See Weber*, 913 P.2d at 93-95.

75. *Id.* at 96.

76. *Id.*

77. *Id.* at 92, 96.

78. *Id.* at 95. Note the difficulty Dr. Weber had in locating a physician to

Even when courts recognize how a scarcity of physicians will affect the public interest, they sometimes attempt to mitigate its significance by suggesting that though one community may lose a physician, another must necessarily gain one. This analysis, however, not only ignores the intimate nature of the doctor-patient relationship, but improperly shifts the focus from the affected community to an unrelated community.[79] For example, in *Gillespie v. Carbondale & Marion Eye Centers, Ltd.*,[80] an Illinois appellate court enforced a restrictive covenant against a physician even though statistics presented during trial indicated that doing so could have caused a shortage of eye specialists in the community and could have left hospitals "unable to provide adequate medical care at a reasonable cost."[81] The court reasoned that because the doctor was prohibited from practicing in one area, any public harm would be mitigated by his provision of those same medical services in another community.[82] The interests of the patients in the restricted area were completely ignored.[83] Indeed, the notion that the benefit of

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come to the area initially. Evidence showed that the departing physician-employee "had no connection to the community prior to his employment, and he brought with him no patients . . . . [He] acknowledged that he benefited by beginning his career in an established practice rather than starting his own." *Id.* at 92; *see also* Canfield v. Spear, 254 N.E.2d 433, 434 (Ill. 1969) (placing importance upon the fact that a departing doctor had been "a newcomer to the community, and it was doubtless through the opportunities provided by this association [with the employer] that he became known in the city"). *But see* Damsey v. Mankowitz, 339 So. 2d 282, 283 (Fla. Dist. Ct. App. 1976) (finding a noncompetition agreement unreasonable when there was a shortage of physicians in the area).

79. *See, e.g.*, Willman v. Beheler, 499 S.W.2d 770, 777 (Mo. 1973) (rejecting the public harm argument and explaining that, while enforcement of the restrictive covenant would lead to a shortage of health care providers in the restricted area, it would result in an increase in health care providers in the area in which the departing physician established a new practice). The *Willman* court also upheld the provision because of "a counterbalancing public policy . . . in enforcing contractual rights and obligations." *Id.* Thus, any harm to the public within the covenant area would be offset by a benefit to those who reside within the departing physician's new service area. *Id.*

80. 622 N.E.2d 1267 (Ill. App. Ct. 1993).

81. *Id.* at 1269.

82. *Id.* at 1270.

83. Likewise, the Georgia court in *Rash v. Toccoa Clinic Medical Associates*, 320 S.E.2d 170 (Ga. 1984), considered the interests of potential medical patients only briefly and reached a similar conclusion. Recognizing that the enforcement of this restriction might "limit the right of potential patients" in a certain area "to avail themselves" of the doctor's services, the court found the point to be unpersuasive. *Id.* at 173.

> [I]t can be argued with at least equal conviction that this would afford countless other people in other areas, both in and outside of the state, the opportunity to have a physician in their areas. There is no reason

adding a new doctor to a to-be-announced location equals the cost to incumbent patients caused by losing their doctor is ridiculous. The incumbent patients suffer in the short term a great deal more than the potential new patients gain. Also, the analysis depends on how many specialists are in a market. If the city of Washington, D.C. has two thousand dermatologists, losing one does not impede patient choice. If Lexington, Virginia, however, has only two dermatologists, losing one of the two dermatologists to a noncompete clause is a big deal.

C. Issues Ignored in the Current Analysis of Physician Restrictive Covenants

1. Continuity of Care

The current application of the rule of reason to physician restrictive covenants is contrary to many well-respected medical studies showing that continuity of care in the doctor-patient relationship fosters greater quality of health care.[84] It is also contrary to research that indicates that the involuntary termination of this relationship may have long-term negative effects on patients.[85]

A patient's ability to build a lasting relationship with the physician of his or her choice is an important aspect of healthcare. Continuity of care is a term of art used within the medical community to mean health care that is given by a single physician over some period of time and that includes an evolving relationship between the physician and patient.[86] Research indicates that the benefits of continuity of care stem from a patient's repeated visits to the same physician, as opposed to a patient's repeated visits to the same clinic or office.[87] One study shows that it takes a few to several

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> to conclude . . . that the need for the appellant's services, in the context of this case, is sufficient to outweigh the law's interest in upholding and protecting freedom to contract and to enforce contractual rights and obligations.

Id. at 173-74; *see also Canfield*, 254 N.E.2d at 435 (holding that a doctor "can be as useful to the public at some other place in the State" as he can be in the place where the non-competitor agreement is effective because "the health of persons elsewhere is just as important").

84. Margaret M. Love et al., *Continuity of Care and the Physician-Patient Relationship*, 49 J. FAM. PRAC. 998, 1002 (2000).

85. Tim Stokes et al., *Ending the Doctor-Patient Relationship in General Practice: A Proposed Model*, 21 FAM. PRAC. 507, 513 (2004).

86. *See* Am. Acad. of Family Physicians, Continuity of Care, Definition of, http://www.aafp.org/x6694.xml (last visited Feb. 10, 2006).

87. *See* Arch G. Mainous III & James M. Gill, *The Importance of Continuity of Care in the Likelihood of Future Hospitalization: Is Site of Care Equivalent to a Primary Clinician?*, 88 AM. J. PUB. HEALTH 1539, 1539-40 (1998) (finding

visits for a patient to even feel comfortable with a new physician, while it may take several years before a patient feels the physician knows him or her well.[88] Continuity of care has been linked to improved patient satisfaction,[89] and patients who are more satisfied with their physician are more compliant with suggested treatment regimens.[90] For instance, patients with Type 2 Diabetes who have greater continuity of care with a primary care provider experience better glucose control, a product of the patient following the physician's recommended diet changes.[91] Continuity of care has been further linked to increased utilization of preventative services,

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within the Delaware Medicaid Program that greater continuity of care with a physician decreases the likelihood of subsequent hospital visits and further noting that it is the physician-patient relationship that is relevant, not necessarily the relationship a patient has with a specific clinic).

88. *See* Keith Sinusas, *Patients' Attitudes Toward the Closing of a Medical Practice*, 28 J. FAM. PRAC. 561, 561-63 (1989) (reporting the results of a survey of two hundred patients after their family physician closed his practice and finding that in a majority of cases it took the physician longer to understand emotional problems than physical ones). The study revealed that one half of patients needed a few visits to become comfortable with a new physician, one third needed several visits to be comfortable, and a small number of people needed a few years to become comfortable. *Id.* at 561-62. Most of the respondents said that it took two to five years for a physician to know their medical problems well and over five years to believe that their emotional problems were very well known to the physician. *Id.* at 563.

89. *See* Love et al., *supra* note 84, at 998, 1002 (analyzing adult Kentucky Medicaid recipients and finding that continuity of care was an important predictor of provider communication and patient influence). The study also found that for patients with asthma, a chronic illness, continuity of care was the only variable that predicted patient perceptions of physician-patient communication. This seems to show that there is a special relationship that exists between patients with chronic illnesses and their physicians and that continuity of care may be even more important to them than to people who have acute illnesses. *Id.* at 1002-03.

90. *See* Marjorie A. Bowman, *Good Physician-Patient Relationship = Improved Patient Outcome?*, 32 J. FAM. PRAC. 135, 136 (1991) (citing Francis J. Martin & Martin J. Bass, *The Impact of Discussion of Non-Medical Problems in the Physician's Office,* 6 FAM. PRAC. 254, 255-56 (1989) (discussing a study in which patients who believed that the "[d]octor tells me all I want to know about my illness" and the "[d]octor gives me a chance to say what is really on my mind" had higher rates of compliance with physician's ordered treatments)).

91. *See Abstracts*, 287 J. AM. MED. ASS'N 2475 (2002) (reporting a study by Michael L. Parchman et al., *Continuity of Care, Self-management Behaviors, and Glucose Control in Patients with Type 2 Diabetes*, that analyzed a random sample of adults who had been diagnosed with Type 2 Diabetes and found that patients who advanced one or more stages in their change of diet regimen had higher levels of continuity with their physicians than did patients who had not advanced).

such as breast and cervical cancer screening in adult women[92] and vaccination in children.[93] Hospitalizations are less likely for patients who experience continuity of care.[94] Studies in both the pediatric and adult populations have shown that greater continuity of care tends to decrease emergency-department use.[95] Continuity of care also has been linked to lower health care costs in older Americans.[96] Long-term continuity of care is difficult to achieve, however, when a patient must see a different physician frequently and cannot build a trusting relationship with a physician.[97]

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92. *See* Ann S. O'Malley et al., *Continuity of Care and the Use of Breast and Cervical Cancer Screening Services in a Multiethnic Community*, 157 ARCHIVES INTERNAL MED. 1462, 1462, 1467 (1997) (reporting the existence of a "linear trend" in the increase of nonmammogram breast and cervical cancer screening rates, that rates of cancer screenings were higher in women with a usual source of care than women who did not, and that rates of screenings were even higher in women who had a regular clinician at the usual source of care).

93. *See* Dimitri A. Christakis et al., *The Association Between Greater Continuity of Care and Timely Measles-Mumps-Rubella Vaccination*, 90 AM. J. PUB. HEALTH 962, 963-64 (2000) (finding that patients who were enrolled in Group Health Cooperative from birth to fifteen months with high and medium continuity with their physicians were more likely to be immunized by fifteen months than those who had low continuity with the physician).

94. *See* Mainous & Gill, *supra* note 87, at 1539-40 (finding that Delaware Medicaid patients with greater continuity of care with a physician decreases the likelihood of subsequent hospital visits).

95. *See* Dimitri A. Christakis et al., *Is Greater Continuity of Care Associated With Less Emergency Department Utilization?*, 103 PEDIATRICS 738, 739-41 (1999) (finding that children with high levels of continuity of care experienced less emergency-department visits than children with low levels). The study also found that attending doctor continuity mattered more than resident doctor continuity in predicting emergency-department visits among children. Christakis posited that this may be because attending physicians interact with the patients over a longer span of time and have a greater knowledge of patients, whereas residents only work one half day per week and are temporary. *Id.* at 740; *see also Abstracts*, 284 J. AM. MED. ASS'N 548 (2000) (reporting a study of Medicaid clients by James M. Gill et al., *The Effect of Continuity of Care on Emergency Department Use*, which found that patients with greater continuity of care were less likely to visit the emergency room a single time and that high continuity of care was even more strongly associated with a lower likelihood of visiting the emergency department more than once).

96. *See* Linda J. Weiss & Jan Blustein, *Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans*, 86 AM. J. PUB. HEALTH 1742, 1743, 1745 (1996) (studying Americans who were sixty-five or older, who participated in the Medicare Current Beneficiary Survey in 1991, and who had a usual source of care, and finding that patients who had continuous relationships with a physician for ten years or more spent $495.61 less for Medicare Part A benefit reimbursements and $316.78 less for Part B reimbursement costs than patients who had a relationship with their physician that had gone on for one year or less).

97. *See* Walter W. Rosser & Jan Kasperski, *The Benefits of a Trusting*

In sum, medical research on continuity and discontinuity in provider care has established that the involuntary loss of a physician is a significant physical and psychological hardship that may be experienced by the patient for an extended period.[98] The rules applying to restrictive covenants and their proper interpretation should serve to encourage provider continuity in health care, not undermine it.

2. The Physician's Ethical Duties

While forced discontinuity of care may have detrimental effects for the patient when it occurs because of a restrictive covenant, [99] it is equally troublesome for the physician. The American Medical Association ("AMA") Official Guidelines state that once a physician-patient relationship is formed, the physician has a legal and ethical duty to continue providing care as long as the patient needs it.[100] When a physician must terminate the patient relationship due to a restrictive covenant, she must simultaneously fulfill this ethical obligation. Doing so requires that the physician give the patient reasonable notice of termination, as well as sufficient opportunity to find an alternative provider.[101] The AMA provides steps that a physician should follow in terminating the relationship, including providing the patient with a reason for terminating the relationship, continuing to provide treatment while the patient attempts to locate

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Physician-Patient Relationship, 50 J. FAM. PRAC. 329, 329-30 (2001). The study found that certain behaviors of physicians are associated with enhanced trust of patients, including comforting and caring, demonstrating competency, encouraging and asking questions, and explaining medical issues. Further, the factors that influence trust in a negative manner include system intrusions on the relationship, such as mandating screening tests for all and disallowing the ordering of specific tests. The study also found that patients trusted physicians salaried on a fee-for-service basis more than they trusted physicians salaried by HMOs. *Id.*

98. *See supra* notes 84-98 and accompanying text.

99. *See* Berg, *supra* note 6, at 31-36 (discussing in detail the harm to the physician-patient relationship, particularly to those patients who are hospitalized, that results from the enforcement of physician restrictive covenants).

100. *See* AMA, Ending the Patient-Physician Relationship (Mar. 7, 2005), http://www.ama-assn.org/ama/pub/category/4609.html.

101. *See, e.g.*, Payton v. Weaver, 182 Cal. Rptr. 225, 229 (Cal. Ct. App. 1982) (upholding the rule that physicians may terminate the patient-physician relationship as long as they give notice to the patient and the patient has sufficient opportunity to secure care from another physician); Ricks v. Budge, 64 P.2d 208, 211-12 (Utah 1937) (holding that the failure to satisfy the duty to notify the patient when the physician terminates the relationship can result in abandonment liability if the patient suffers an injury as a result of the termination).

a new provider, recommending a new provider at the patient's request, and transferring the patient's files to another physician only with the patient's permission.[102] Many physicians are prohibited from contacting their former patients under restrictive covenants and are therefore unable to fulfill these legal and ethical obligations.[103]

The physician-patient relationship is unlike most other business relationships. When a physician must terminate his or her relationship with a patient because of a restrictive covenant, the patient may suffer the consequences physically. In most other cases, the customer who is denied the service of the professional under a noncompetition clause is harmed only financially. Because physicians have an ethical duty to put the welfare of their patients above their own, a noncompetition clause undermines those ethics when it places the employers' financial interests above patients' interests.[104] Thus, physician restrictive covenants should be viewed in a very different manner from covenants existing in other business relationships. The potential harm to the patient should play a more active role in determining whether or not to enforce a restrictive covenant.

3. The Realities of Modern Medicine

Courts often do not declare physician restrictive covenants injurious to the public because patients can still see the physician of their choice—albeit at a location that may be undesirable.[105] In some cases, this is highly impractical. The average geographic scope for restrictive covenants that are enforced is 33.9 miles.[106] This can be a great distance to be forced to drive to see one's physician of choice, especially if a patient is ill and in urgent need of a doctor. Moreover, the geographic scope fails to account for the quality of the

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102. *See* AMA CODE OF MEDICAL ETHICS §§ 8.11, 8.115 (1996); AMA, *supra* note 100; *see also* Sleweon v. Burke, Murphy, Constanza & Cuppy, 712 N.E.2d 517, 520 (Ind. Ct. App. 1999) (discussing a physician who sued his attorneys in part for mismanagement of his patients' files after he breached a covenant-not-to-compete).

103. *See, e.g.*, Jeff Sturgeon, *Prevented from Practicing*, ROANOKE TIMES, Mar. 18, 2001, at 1; *see also* Bloomington Urological Assocs., S.C. v. Scaglia, 686 N.E.2d 389, 394 (Ill. App. Ct. 1997) (upholding a covenant-not-to-compete between physicians but reversing contempt conviction of doctor who tried to contact a former patient to inquire about his condition under AMA Code § 8.11).

104. *See* Loeser, *supra* note 9, at 287.

105. *See* Keeley v. Cardiovascular Surgical Assocs., P.C., 510 S.E.2d 880, 885 (Ga. Ct. App. 1999) (upholding covenant-not-to-compete as reasonable because the plaintiff "attracted patients and referrals from throughout the designated area").

106. *See* Empirical Study, *supra* note 41, at 511.

hospital outside the covenant area or for patients who are generally immobile, have no access to vehicular transportation, or do not have the financial resources to travel so far to visit their physician.

Further, the current rule of reason analysis of physician restrictive covenants also fails to address the fundamental role that Preferred Provider Organization ("PPO")/HMO payment schemes now play in the United States health care system. More is involved today with a restrictive covenant than the inconvenience associated with the distances patients may have to travel to continue seeing their physician. Many managed care networks are highly localized. A physician subject to a restrictive covenant may move to a new town and receive staff privileges at a new hospital that is fairly close to the former patient. For the patient, if the new hospital in the new town is not part of the patient's HMO or PPO network, the patient may well receive no benefits or, at best, reduced benefits from the patient's health insurer. This lack of health insurance coverage may mean that even a small change in physician location can deprive the patient of the doctor's services. Thus, the evolving structure of managed care can exacerbate the effects of restrictive covenants.[107]

In addition, the duration of the covenant may be quite long. Courts have routinely upheld covenants lasting up to five years,[108]

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107. As the health care industry becomes more integrated, physicians combine or affiliate with one another to control costs and expand their access to patients through managed care plans. This process is reflected in the dramatic growth of HMOs, entities which combine health care delivery and financing in one prepaid capitative benefit plan. *See* FURROW ET AL., *supra* note 3, § 9-10. Additionally,

> the number of Americans in HMOs rose rapidly from fifteen million in 1984 to more than fifty million in 1996. . . . In 1983, about four percent of private-sector employees belonged to an HMO. By 2000, ninety-two percent of workers at companies with ten or more employees were in managed care.

William G. Kopit, *Price Competition in Hospital Markets: The Significance of Managed Care*, 35 J. HEALTH L. 291, 297-98 (2002) (footnote omitted). However, the amount of workers covered by "more restrictive HMOs has remained stable since 1998," and the amount covered by "preferred provider organizations has grown from [thirty-five] percent in 1998 to [forty-one] percent in 2000," and American society has seen somewhat of a backlash against managed care. *Id.* (footnote omitted). The integration of health care delivery creates new contractual concerns for physicians. To effectively compete for patients, physicians join HMOs or form their own associations. In today's medical marketplace, physicians are more likely than ever to be employees, rather than owners or partners. *See* David J. Schiller, *What You Should Bargain for in a Restrictive Covenant*, MED. ECON., July 11, 1994, at 51, 51.

108. *See* Rash v. Toccoa Clinic Med. Assocs., 320 S.E.2d 170, 171 (Ga. 1984) (three years); Dick v. Geist, 693 P.2d 1133, 1135 (Idaho Ct. App. 1985) (two years); Prairie Eye Ctr., Ltd. v. Butler, 768 N.E.2d 414, 417 (Ill. App. Ct. 2002) (two years); Weber v. Tillman, 913 P.2d 84, 87 (Kan. 1996) (two years).

explaining that this duration provides employers with a reasonable period of time to hire new doctors and gives those doctors sufficient time to demonstrate their competence to patients.[109]

4. Physician Immobility

When 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.[110] A physician must be licensed to practice in each state in which he or she desires to practice;[111] no national physician licensing system currently exists.[112] Thus, a physician forced to move out of one state must pay for and pass the licensing examination in the new state in order to practice his craft. Accordingly, the power to terminate a physician and leave him subject to a restrictive covenant is a significant power in the hands of the employer.[113]

Courts often opine that physicians are not restricted from

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109. *See* Pollack v. Calimag, 458 N.W.2d 591, 599 (Wisc. Ct. App. 1990) ("Reasonableness [of duration requirements] depends upon the period of time required to obliterate in the minds of the . . . customers the identification formed during the period of the . . . employment." (quoting Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 133 (Wisc. Ct. App. 1981))). Courts will not uphold covenants of unlimited duration. Rakestraw v. Lanier, 30 S.E. 735, 735 (Ga. 1898) (striking down a covenant for unlimited duration); House of Vision, Inc. v. Hiyane, 225 N.E.2d 21, 22, 25 (Ill. 1967) (invalidating a covenant lasting the life of the contracting physician); Darrow v. Kolczun, No. 90CA004759, 1991 WL 35120, at *2 (Ohio Ct. App. Mar. 6, 1991) (calling a noncompete fundamentally flawed for being unlimited in duration).

110. Physicians must comply with state licensing laws. *See* FURROW ET AL., *supra* note 3, § 3-1. Compliance with state regulations and licensing laws is both time consuming and costly. *See* MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 810 (6th ed. 2003); Kerry A. Kearney, *Medical Licensure: An Impediment to Interstate Telemedicine,* 9 HEALTH LAW (ABA HEALTH LAW SECTION), No. 4, 1997, at 14, 14. Doctors who violate licensing statutes risk numerous sanctions including civil and criminal penalties, disciplinary proceedings, Medicare debarment, invalidation of mandatory malpractice insurance, and removal from specialty boards. *See* FURROW ET AL, *supra* note 3, § 3-11; HALL ET. AL, *supra*, at 815-16.

111. *See generally* FURROW ET AL, *supra* note 3, §3-1.

112. *See* Susan E. Volkert, *Telemedicine: Rx for the Future of Health Care*, 6 MICH. TELECOMM. & TECH. L. REV. 147, 177-80 (1999-2000) (discussing the need for a national licensing system).

113. *See* Peter B. Jurgeleit, Note, *Physician Employment Under Managed Care: Toward a Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians*, 73 IND. L.J. 255, 276 & n.110 (1997) (citing Lawrence E. Blades, *Employment at Will vs. Individual Freedom: On Limiting the Abusive Exercise of Employer Power*, 67 COLUM. L. REV. 1404, 1405-06 (1967) (arguing that the nonunion employee's immobility makes the absolute right of discharge the employer's prime source of power over the employee)).

practicing all medicine, only that which they were practicing for the contracted employer.[114] A license to practice medicine is a general license: the physician can practice any type of medicine he chooses.[115] Thus, it is true that a specialist such as a dermatologist could stay in a restricted area if he chose to practice general medicine instead of dermatology. However, this view ignores the reality of the situation.

Physicians typically train for years to acquire the requisite expertise for their chosen specialty (including even the broader fields of family practice or internal medicine), and this investment of time would, for most physicians, need to be repeated to shift practices areas. In addition, the physician is not likely board certified for other medical work.[116] Board certification is a step above licensing. It means that a physician has been trained and supervised in a specialty and has demonstrated competence in an examination process.[117] To achieve board certification, a physician typically must complete a three-to-seven-year residency. During this training, the physician must participate in and conduct a minimum number of medical procedures. Following the residency training, the physician must pass both an oral and written examination in a specific area (e.g., internal medicine, family practice, or obstetrics and gynecology).[118]

The days of the Norman Rockwell era in which the doctor treats everyone in the community for every ailment are over. The requirement of board certification affects the ability of physicians to practice in multiple ways.[119] For example, lack of certification affects

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114. *See* Berg, *supra* note 6, at 23.

115. *See* FURROW ET AL., *supra* note 3, § 3-5.

116. Doctors must be licensed by a state to practice medicine. *See* HALL ET AL., *supra* note 110, at 811. Thus, doctors can practice medicine without being "certified." *See* Laura Meckler, *Periodic Reviews Urged for Health Care Professionals*, REG., Oct. 24, 1998, at 20 (arguing for periodic review of professional credentials). However, these minimal licensing standards only serve to ensure that "the most egregiously incompetent health professionals are prohibited from practicing." *Id.* (quoting former Senator George Mitchell, Chairman, Pew Health Professions Commission).

117. Am. Bd. of Med. Specialists, Ask AMBS: FAQ, What Does It Mean for a Doctor to Be Board Certified?, http://www.abms.org/faq.asp#DBC (last visited Jan. 24, 2006).

118. AMA, Physician Education, Licensure, and Certification, http://www.ama-assn.org/aps/physcred.html (last visited Jan. 24, 2006).

119. For an example of the potential trouble of practicing medicine without being board certified, see Julie Bell, *Recovery in Works at Md. General: Scandal-Scarred Hospital Makes Changes That Aid in Regaining Its Patients and Its Credibility*, BALT. SUN, July 17, 2005, at 1A. Maryland General Hospital was subject to multiple lawsuits when many of its physicians were not board certified in the areas in which they were performing. For example, one

salary, the ability to obtain and the cost of malpractice insurance, the validity of informed consent,[120] admission to hospital staffs, election to membership in professional societies, and credibility as an expert witness.[121]

In recent years, the United States has suffered from a shortage of physicians particularly in the area of primary care,[122] which is obviously a further threat to patients receiving adequate health care.[123] Restrictive covenants additionally restrict patients' access to physicians of their choosing.[124] Some communities are truly

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half of the anesthesiology department was not board certified. The hospital then reformed their organization to employ only physicians who are board certified. *Id.*

120. Howard v. Univ. of Med. and Dentistry of N.J., 800 A.2d 73, 83 (N.J. 2002) (finding that a physician's misrepresentation to a patient regarding board certification and experience affected the validity of consent obtained in a malpractice suit); *see also* John J. Smith, *Legal Implications of Specialty Board Certification*, 17 J. LEGAL MED. 73, 77-78 (1996).

121. *See* Marsingill v. O'Malley, 58 P.3d 495, 501 (Alaska 2002) (recognizing that courts have allowed admission of evidence of lack of board certification in "cross-examination or in rebuttal when it counteracts affirmative defense evidence introduced to show a special degree of skill, knowledge, or relevant expertise").

122. Physician shortage areas, designated by the Health Care Financing Administration, are geographic "areas in the country which have an insufficient supply of health care providers to meet the needs of the [surrounding] population." Thomas D. Bixby, *Network Adequacy: The Regulation of HMOs' Network of Health Care Providers*, 63 MO. L. REV. 397, 409 n.122 (1998). "[I]n 1994, there were 2663 shortage areas in the United States designated as having less than one primary care physician [(family practitioner, pediatrician, or general internist)] per 3500 people." Kathleen M. Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 AM. J.L. & MED. 185, 200 n.92 (1998); *see* U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH RES. & SERVS. ADMIN., BUREAU OF HEALTH PROFESSIONS, SHORTAGE DESIGNATION, http://bhpr.hrsa. gov/shortage (last visited Jan. 24, 2006) (providing links to complete statistics on which areas of the country are designated as shortage areas).

123. Approximately nineteen percent of the U.S. population, or forty-seven million Americans, resided in physician shortage areas in 1994. Boozang, *supra* note 122, at 200 n.92. Moreover, physician shortage areas tend to impact the rural and inner-city poor far more severely than the rest of the country. "Most private doctors are not located where poor people live and the number of poor needing quality, continuous health care far exceeds the capacity of well-meaning private physicians." Anna-Katrina S. Christakis, Comment, *Emergency Room Gatekeeping: A New Twist on Patient Dumping*, 1997 WIS. L. REV. 295, 297 n.9 (citations omitted); *see also* Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 196-97 (1995) (describing the shortage of private physicians in inner-city and rural communities that result from low Medicaid reimbursements).

124. Some courts have recognized that physician restrictive covenants may

endangered by the shortage of available physicians caused by restrictive covenants,[125] but according to most courts, this does not present a sufficient public interest.[126]

D. Viewing the Public Interest with More Depth: Elevating the Physician-Patient Relationship Through Application of a New Test

Although almost all states have faced and struggled with the issues that arise under physician restrictive covenants,[127] over the past two decades, only a very small minority of courts has come to grips with this contradiction. In some cases, this minority has explored the depth of the doctor-patient relationship and how restrictive covenants may affect individual patients. In *Duffner v. Alberty*,[128] an Arkansas appellate court found that the public interest involved in a covenant-not-to-compete between orthopedic surgeons included "the public right of availability of the [specialist] it prefers to use."[129] The court also found that the surgeons attempting to enforce the covenant did not have a significant interest in the patients with which the departing physician had a preexisting relationship.[130] While this brief opinion did not expound further on this point, it is significant that the court felt it necessary to make a distinction between those patients who may have desired a

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harm the public if enforcement will lead to a shortage of health care providers within the covenant areas. *See, e.g.*, Odess v. Taylor, 211 So.2d 805, 809-10 (Ala. 1968) (refusing to uphold a restrictive covenant because of a recognized need for more Ear, Nose, and Throat specialists within the area and thus "it would be adverse to the public interest" to prevent the physician from practicing medicine there); Fumo v. Med. Group of Mich. City, Inc., 590 N.E.2d 1103, 1109 (Ind. Ct. App. 1992); Karlin v. Weinberg, 390 A.2d 1161, 1169-70 (N.J. 1978); Statesville Med. Group v. Dickey, 106 N.C. App. 669, 673-74, 418 S.E.2d 256, 259 (1992); Nalle Clinic Co. v. Parker, 101 N.C. App. 341, 344-45, 399 S.E.2d 363, 366 (1991); New Castle Orthopedic Assocs. v. Burns, 392 A.2d 1383, 1387-88 (Pa. 1978).

125. *See* Joe Manning, *Frustration Grows with Racine's Doctor Shortage: As Physicians Leave Town, Focus is on Dominant All Saints Health System*, MILWAUKEE J. SENTINEL, June 28, 1998, at D1.

126. *See, e.g.*, Long v. Huffman, 557 S.W.2d 911, 915 (Mo. Ct. App. 1977) (noting that the shortage of doctors was so "pandemic" that to lose a physician in one area means that the physician will then be more available elsewhere).

127. For a representative sample, see Valley Med. Specialists v. Farber, 982 P.2d 1277 (Ariz. 1999); Farthing v. San Mateo Clinic, 299 P.2d 977 (Cal. Dist. Ct. App. 1956); Univ. of Fla. Bd. of Tr. v. Sanal, 837 So.2d 512 (Fla. Dist. Ct. App. 2003); Gen. Surgery, P.A. v. Suppes, 953 P.2d 1055 (Kan. Ct. App. 1998); Oak Orchard Cmty. Health Ctr. v. Blasco, 800 N.Y.S.2d 277 (N.Y. Sup. Ct. 2005); Mkparu v. Ohio Heart Care, Inc., 740 N.E.2d 293 (Ohio Ct. App. 1999); Hosp. Consultants, Inc. v. Potyka, 531 S.W.2d 657 (Tex. Civ. App. 1975).

128. 718 S.W.2d 111 (Ark. Ct. App. 1986).

129. *Id.* at 113-14.

130. *Id.* at 114.

continuation of their relationship with the departing physician and those who had never seen that physician.[131] While not explicitly addressing the rights of individual patients to choose their physicians, the *Duffner* court was one of the earliest at least to identify the individual patients as parties that must be considered as part of the public policy inquiry.

Other courts have examined the issue of patient choice more closely, but only when the surrounding circumstances force them to do so.[132] For instance, in *Iredell Digestive Disease Clinic, P.A. v. Petrozza*,[133] the North Carolina Court of Appeals refused to enforce a restrictive covenant that would have created at least a temporary monopoly even though the duration and geographic scope of the covenant were found reasonable.[134] In striking down a restrictive covenant between gastroenterologists, the court stated that "[t]he doctor-patient relationship is a personal one and we are extremely hesitant to deny the patient-consumer any choice whatsoever,"[135] siding with the departing physician who argued the covenant would create a shortage of gastroenterologists in the area.[136]

Although this sort of geographical and statistical analysis can be useful in constructing the underpinnings of a more thoughtful public policy analysis, other courts have approached the analysis from a different and factually based perspective. The Ohio Court of

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131. *Id.*

132. *See* Pathology Consultants v. Gratton, 343 N.W.2d 428, 436 (Iowa 1984) (refusing to enforce a covenant that would result in a monopoly on laboratory services on the grounds that a monopoly was "not in the best interests of the public"); Statesville Med. Group v. Dickey, 106 N.C. App. 669, 672-74, 418 S.E.2d 256, 258-60 (1992) (voiding a covenant-not-to-compete between endocrinologists because the enforcement would have created a two-year monopoly and would have deprived a rural community of the only endocrinologist who both lived and worked therein). *But see* Canfield v. Spear, 254 N.E.2d 433, 435 (Ill. 1969) ("If a severe shortage exists in any particular place [because of enforcement] young doctors will tend to move there, thus alleviating the shortage.").

133. 92 N.C. App. 21, 373 S.E.2d 449 (1988). In *Petrozza*, a North Carolina professional association of gastroenterologists sought enforcement of a restrictive covenant that barred a departing physician-employee from practicing for three years within twenty miles of the clinic's principal place of business and within five miles of any hospital or office served by the corporation. *Id.* at 22-23, 373 S.E.2d at 450-51.

134. *See id.* at 27, 30-31, 373 S.E.2d at 453, 455. "The creation of a monopoly also raises the issue of the public's interest in having some choice in the selection of a physician." *Id.* at 31, 373 S.E.2d at 455. The court also noted throughout the opinion that gastroenterologists are likely to be needed in an emergency context, raising the stakes in the public interest analysis. *Id.*

135. *Id.* at 31, 373 S.E.2d at 455.

136. *See id.* at 28, 31, 373 S.E.2d at 453, 455.

Appeals in *Ohio Urology, Inc. v. Poll*,[137] for instance, overturned a district-court referee's ruling that voided restrictive covenants between physicians per se but, in so doing, acknowledged that the public policy consideration must include the rights of *individual* patients.[138] Notably, this court also stated that competition, especially between doctors, must be encouraged.[139]

Drawing on the *Duffner* and *Petrozza* decisions, the Arizona Supreme Court rendered a thoughtful and in-depth analysis of the physician-patient relationship and its effect on restrictive covenants between doctors in *Valley Medical Specialists v. Farber*.[140] The Arizona high court is one of the only courts in the nation to have fully integrated the AMA guidelines into its public interest analysis. The court upheld a lower court opinion that struck down a restrictive covenant between pulmonologists partly because of the "sensitive and personal nature of the doctor-patient relationship,"[141] finding that "the doctor-patient relationship is special and entitled to unique protection. It cannot be easily or accurately compared to relationships in the commercial context."[142] In so doing, the court noted that while the AMA discouragement of restrictive covenants was not binding on the physicians, it was relevant to the public interest inquiry, especially in light of the fact that such agreements between lawyers were illegal.[143] While the court did not rule that covenants between physicians were per se against public policy, it did warn that they must be "strictly construed" in light of their impact on the doctor-patient relationship.[144]

137. 594 N.E.2d 1027 (Ohio Ct. App. 1991). The trial-court referee's decision relied heavily on AMA guidelines in banning the covenants. The appellate court, however, held that the AMA guidelines only discourage restrictive covenants, and do not ban them. *Id.* at 1030-31. For a further discussion of restrictive covenants in Ohio, see generally Pierre H. Bergeron, *Navigating the "Deep and Unsettled Sea" of Covenant Not to Compete Litigation in Ohio: A Comprehensive Look*, 31 U. TOL. L. REV. 373 (2000).

138. *Ohio Urology*, 594 N.E.2d at 1030.

139. *Id.* (citing an AMA provision as support, the court stated that "competition among physicians is to be encouraged").

140. 982 P.2d 1277 (Ariz. 1999).

141. *Id.* at 1285.

142. *Id.* at 1283.

143. *Id.* at 1282-83.

144. *Id.* at 1286.

III. SOLUTION STOCKPILE: PROFFERED SOLUTIONS FOR EVALUATING PHYSICIAN RESTRICTIVE COVENANTS

The interests of incumbent patients must be considered in any judicial evaluation of a physician restrictive covenant for two reasons: the potential health risks created when incumbent patients are not allowed to continue care with their doctor and the importance of allowing physicians to fulfill their professional duties to their patients. The rule of reason test as presently applied fails to accord proper weight to these considerations. The courts must fashion a new approach to bring incumbent patient interests to the fore of the analysis. Several solutions to this problem have been suggested by commentators and applied by courts.[145]

One potential solution discussed below is for the AMA to take a stronger stance against physician restrictive covenants, much like the American Bar Association ("ABA") guidelines, that courts can then follow.[146] However, the author concludes that the courts should apply a reformulated rule of reason test wherein incumbent patients are treated as quasi third-party beneficiaries to physician restrictive covenants.[147]

A. The AMA's Indecision

Courts usually will enforce restrictive covenants against most professionals; however, attorneys are a notable exception. Most courts simply invalidate attorney restrictive covenants by citing a per se rule derived from the profession's own ethical standards.[148] The per se rule is an absolute bar to enforcement of any restriction on a lawyer's right to practice.[149] Although the judiciary has applied this per se rule to covenants between attorneys, such an approach has not been adopted for physicians. Instead, when dealing with

145. *See infra* notes 146-204 and accompanying text.

146. *See infra* notes 152-64 and accompanying text.

147. *See infra* Part V.

148. *See, e.g.*, Anderson v. Aspelmeier, Fisch, Power, Warner & Engberg, 461 N.W.2d 598, 601-02 (Iowa 1990) (invalidating an agreement that stopped payment of withdrawal benefits if the withdrawing partner committed an act detrimental to the firm); Minge v. Weeks, 629 So. 2d 545 (La. Ct. App. 1993); Denburg v. Parker Chapin Flattau & Klimpl, 624 N.E.2d 995 (N.Y. 1993); Spiegel v. Thomas, Mann & Smith, P.C., 811 S.W.2d 528, 530-31 (Tenn. 1991) (declaring unenforceable an agreement which provided that an employee who withdrew from the firm would receive deferred compensation unless she continued to practice law). *But see* Howard v. Babcock, 863 P.2d 150 (Cal. 1993); Haight, Brown & Bonesteel v. Superior Court, 285 Cal. Rptr. 3d 845 (Cal. Ct. App. 1991); Jacob v. Norris, McLaughlin & Marcus, 588 A.2d 1287 (N.J. Super. Ct. App. Div. 1991), *rev'd,* 607 A.2d 142 (N.J. 1992).

149. *See* cases cited *supra* note 148.

physician restrictive covenants, courts apply the same rule of reason test as used for commercial parties.[150] Thus, despite the apparent professional similarities between doctors and lawyers, the courts have treated similar contractual relationships within the two professions quite differently.[151]

One key reason for this disparity involves the divergent ethical codes of the two professions.[152] The ABA Committee on Professional Ethics has explicitly declared that restrictive covenants between attorneys are unethical[153] whereas the AMA's position on the issue has been neither clear nor consistent.[154]

In 1933, the AMA declared that restrictive covenants were unethical,[155] but it subsequently reversed itself in 1960.[156] While more recently the AMA has discouraged physician restrictive covenants as "not in the public interest,"[157] it has come just short of

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150. *See* Berg, *supra* note 6, at 4-6 ("[N]on-competition agreements between physicians, like noncompetition agreements between attorneys, should be per se invalid.").

151. Robert W. Hillman, *Law Firms and Their Partners: The Law and Ethics of Grabbing and Leaving*, 67 TEX. L. REV. 1, 20 (1988) ("The reasons for distinguishing lawyering from other professions in this context are vague, and it is questionable whether the availability of choice for the client is any less critical when the professional engaged is a physician, for example, rather than a lawyer."); *see also Howard*, 863 P.2d at 160; Karlin v. Weinberg, 390 A.2d 1161, 1171 (N.J. 1978) (Sullivan, J., dissenting) ("Both [the doctor-patient and lawyer-client] relationships are consensual, highly fiduciary and peculiarly dependent on the patient's or client's trust and confidence in the physician consulted or attorney retained."); Ladd v. Hikes, 639 P.2d 1307, 1310-12 (Or. Ct. App. 1982) (Buttler, J., dissenting) (arguing for the application of the per se rule to doctors).

152. *See* AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION: INCLUDING THE PRINCIPLES OF MEDICAL ETHICS AND RULES OF THE JUDICIAL COUNCIL, § E-9.06 (1982). For a comparison of the AMA advisory rules to the ABA rules of ethics, see *Karlin*, 390 A.2d at 1167-68 & n.6.

153. *See* ABA Comm. on Prof'l Ethics, Formal Op. 300 (1961).

154. In 1960, the AMA focused primarily upon the fairness of a noncompetition agreement as between the affected doctors, indicating that noncompetition agreements are not inherently unethical. *See* Berg, *supra* note 6, at 6-9. The AMA, however, did acknowledge, at least, that questions remained as to whether enforcement of an agreement was harmful to the public. *See id.* at 7.

155. *See id.* at 6-7 (citing AMA, 1846-1958 DIGEST OF OFFICIAL ACTIONS 123 (1959)).

156. *See id.* at 7 (citing AMA, OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL 25 (1960)).

157. AMA, CURRENT OPINIONS OF THE COUNCIL ON ETHICS AND JUDICIAL AFFAIRS § 9.02 (1989). Several other provisions of the AMA's Code of Medical Ethics state that "[f]ree choice of physicians is the right of every individual," AMA CODE OF MEDICAL ETHICS § 9.06 (1994), and that competition among

calling the pacts unethical, except in particular cases where the covenants are "excessive in geographic scope or duration . . . or if they fail to make reasonable accommodation of patients' choice of physician."[158]

Furthermore, the AMA's guarded warning on restrictive covenants is merely advisory and does not bind AMA members, unlike the Model Rules of Professional Conduct of the ABA.[159] The AMA concedes most states will enforce reasonable noncompetition agreements.[160] The AMA even goes so far as to suggest that physicians forming a medical practice should consider the advantages of restrictive and liquidated damages covenants.[161] Many courts do not consider the AMA opinions because restrictive covenants are not expressly prohibited by them and because the AMA is not an agency of the government.[162] And, while most states have adopted some form of the ABA's Model Rules, AMA opinions have been neither adopted nor codified.[163]

Although AMA opinions do not bind their members, the AMA is a persuasive, policy-guiding body for physicians.[164] If the AMA took a stronger stance against physician restrictive covenants, courts might be convinced of the importance of the public policies against oppressive restrictive covenants. However, because the AMA is not a government agency, even a stronger statement by the AMA may

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physicians is not only ethical but encouraged, *id.* § 6.11.

158. AMA CODE OF MEDICAL ETHICS § 9.02 (2004); *see also* Cathy Tokarski, *No Way Out: When Practice Management Firms Fail, Restrictive Covenants Can Make a Bad Situation Worse*, AM. MED. NEWS, Nov. 9, 1998, at 27

159. *See* AMA Judicial Council, Op. 9.06 (1982). For a comparison of the AMA advisory rules to the ABA rules of ethics, see Karlin v. Weinberg, 390 A.2d 1161, 1167-68 (N.J. 1978).

160. *See* Michael R. Sullivan, Note, *Covenants-not-to-compete and Liquidated Damages Clauses: Diagnosis and Treatment for Physicians*, 46 S.C. L. REV. 505, 514 (1995) (citing Andrea Cooper, *Restrictive Covenants*, 248 JAMA 3091, 3091 (1982)).

161. *Id.* Liquidated damages covenants can be just as troubling as covenants-not-to-compete because they may persuade a physician to choose economic interests over patient interests, thus harming the doctor-patient relationship. *See* Joelyn Knopf Levy, *Because Judges Went to Law School, Not Medical School: Restrictive Covenants in the Practices of Law and Medicine*, 30 J. HEALTH & HOSP. L. 89, 98-100 (1997) (arguing that courts should treat restrictive covenants between physicians the same way they treat those between attorneys).

162. There are some notable exceptions. *See, e.g.*, Valley Med. Specialists v. Farber, 982 P.2d 1277, 1283 (Ariz. 1999) (holding that the similarity between AMA discouragement of restrictive covenants and the ABA's ban on such to be relevant to the public policy inquiry).

163. *See* Knopf, *supra* note 161, at 93.

164. *See* AMA, About AMA Policy, http://www.ama-assn.org/ama/pub/category/8151.html (last visited Jan. 24, 2006).

not be a sufficient solution.

B. The Blue Pencil Rule: Make Your Own Contract

The blue pencil rule has been used by courts to modify unreasonable covenants-not-to-compete. The majority approach is exemplified by the U.S. District Court of the Southern District of Indiana in *Product Action International, Inc. v. Mero*.[165] The Indiana court stated that the blue pencil rule allows a court to strike unreasonable portions of a covenant-not-to-compete if those portions are logically and grammatically severable from the remainder of the contract.[166] Although this approach allows a court to enforce reasonable terms in the contract, a court may not create a new contract by adding new terms to which the parties did not agree.[167] This solution may work to protect an employee from undue hardship or an employer's protectable interest. On the other hand, the blue pencil is not a solution that protects a patient's interests. The blue pencil doctrine does not force courts to consider an incumbent patient's interests in a physician's covenant-not-to-compete. If courts are forced to consider the patient's interests in the public policy prong as proposed, the blue pencil doctrine may then be used to ensure the covenant-not-to-compete is only as restrictive as necessary to protect the employer's legitimate interest. However, standing alone, the blue pencil doctrine does not do enough to protect patients' interests.

C. Liquidated Damages

Many covenants-not-to-compete between physicians give the contracting physician the option of paying liquidated damages in the alternative to abiding by the geographical and time restrictions of the agreement.[168] Some courts and commentators argue that these damages are less harmful to physicians and their patient relationships than enforcement of the restrictive covenant through injunctive relief.[169] The amounts of these damages are often

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165. 277 F. Supp. 2d 919 (S.D. Ind. 2003).

166. *Id.* at 926.

167. *Id.* at 928.

168. *See, e.g.*, *Farber*, 982 P.2d at 1279; Dickinson Med. Group, P.A. v. Foote, No. 834-K, 1984 WL 8208, at *3 (Del. Ch. May 10, 1984); Raymundo v. Hammond Clinic Ass'n, 449 N.E.2d 276, 278 (Ind. 1983); *see also* Serena L. Kafker, *Golden Handcuffs: Enforceability of Non-Competition Clauses in Professional Partnership Agreements of Accountants, Physicians, and Attorneys*, 31 AM. BUS. L.J. 31, 40-41 (1993) (noting how common liquidated damages clauses are in restrictive covenants).

169. *See, e.g.*, Dental East, P.C. v. Westercamp, 423 N.W.2d 553, 555 (Iowa Ct. App. 1988); *see also* Lowry, *supra* note 1, at 232 (noting that liquidated

extremely high.[170] While arguments may be made that such provisions are a workable alternative for physicians who wish to preserve relationships with their patients, the reality is that such provisions are only an option for only the wealthiest physicians.[171] Additionally, viewing the payment of liquidated damages as making a plaintiff whole in cases involving noncompete clauses between physicians only furthers the problematic view that a physician's patients are merely constituent parts of a commercial marketplace and nothing more. It is also important to note that courts that have found covenants-not-to-compete between physicians to be unenforceable for public policy reasons have found alternative liquidated damages clauses to be similarly void.[172]

D. The Per Se Rule: The Pitfalls of Fighting Fire with Fire

Many highly respected judges and scholars advocate adopting the per se rule, currently applied to analyze the validity of attorney restrictive covenants, to physician restrictive covenants.[173] Both Professor Berg[174] and a variety of judges,[175] argue that physicians

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damages act to compensate the former employer "without hindering the public's choice of physicians").

170. *See, e.g.*, Junkin v. Ne. Ark. Internal Med. Clinic, P.A., 42 S.W.3d 432, 435 (Ark. 2001) (stating that liquidated damages clause required payment of $174,388 in instance of breach).

171. *See generally* Charles A. Sullivan, *Revisiting the "Neglected Stepchild": Antitrust Treatment of Postemployment Restraints of Trade*, 1977 U. ILL. L.F. 621 (arguing that antitrust law should be applied to restrictive covenants).

172. *See Junkin,* 42 S.W.3d at 438 ("Common sense dictates that if a restrictive covenant cannot be specifically enforced because it violates public policy, then a related liquidated-damages provision also cannot be enforced."); Duneland Emergency Physician's Med. Group v. Brunk, 723 N.E.2d 963, 967 (Ind. Ct. App. 2000) ("[B]ecause the non-compete covenant is unenforceable, Duneland is not entitled to liquidated damages.").

173. *See* Berg, *supra* note 6 at 36-37; Richard P. Bergen, *Practical Considerations on Restrictive Covenants*, 203 JAMA 197, 198 (1968); Hillman, *supra* note 150, at 20; *see also* Odess v. Taylor, 211 So. 2d 805, 811 (Ala. 1968) (emphasizing the similarities in the relationships between a doctor and patient and lawyer and client: "[t]he patient or client is not a 'customer'").

174. *See* Berg, *supra* note 6, at 36-37. She argues:

> The inconsistent judicial treatment of restrictive covenants between these two types of professionals cannot be justified. Indeed, the philosophical and public policy underpinnings of the per se rule apply with greater force to restrictive covenants between physicians than to restrictive covenants between attorneys. Simply put, if the reasoning behind the per se rule for attorneys is valid, the reasoning applies even more strongly to physicians.

Id.

175. For example, Justice Sullivan, in *Karlin v. Weinberg*, states his concerns eloquently:

> The restrictive covenant, which the Court is upholding in principle,

should be subjected to a per se rule against restrictive covenants, just as lawyers are currently, since the per se rule provides for greater protection for physician-employees as well as their patients. Applying the per se rule to physician covenants is sometimes advocated because it is an easy and efficient rule for courts to apply.[176] If all physician covenants are presumed by courts to be void, fewer cases will likely be brought, and those that are brought are more easily decided, saving judicial resources. Another reason for extending the per se rule to physicians is the law's inconsistent treatment of two professions that seem to share a great many similarities: physicians and attorneys.[177] An apparent inconsistency also exists between the high regard for a physician/patient relationship at trial and the low regard for that same relationship for continuity of care.[178]

If state supreme courts were to adopt a per se rule for restrictive covenants among physicians, as they are adopting regarding attorneys, the criticisms directed at the current majority use of the rule of reason test would be just as apt. Moreover, two additional problems arise when a per se rule is applied to physicians: 1) a per se rule is an utterly inflexible means of weighing both the clients' and employers' interests and 2) though a physician is not a plumber, many find it hard to believe that a physician is sufficiently analogous to an attorney for the per se rule and its rationale to apply.[179]

If a per se rule against restrictive covenants were applied to physicians, many of their interests would be ignored and trampled. Doctors who leave an organization may exploit personal and referral relationships they gained while employed with the company. Without some enforcement of restrictive covenants, individual

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> does violence to the concept of the physician-patient relationship. A person requiring medical treatment and advice goes to the doctor of his or her choice. . . . The relationship is so personal and so sensitive, and the right of a patient to consult the physician of one's own choice so fundamental, that a restrictive covenant which substantially intrudes on that relationship and interferes with that fundamental right should be held contrary to public policy.

Karlin v. Weinberg, 390 A.2d 1161, 1170-71 (N.J. 1978) (Sullivan, J., dissenting).

176. *See Antitrust HealthCare Advancement Act of 1996: Hearing on H.R. 2925 Before the H. Comm. on the Judiciary*, 104th Cong. (1996) (statement of Robert Pitofsky, Chairman, FTC), *available at* http://www.ftc.gov/speeches/pitofsky/pithtl.htm.

177. *See Odess*, 211 So. 2d at 811; Berg, *supra* note 6, at 36-37.

178. *See* Di Dio, *supra* note 9, at 474-75.

179. *See, e.g.*, *Karlin*, 390 A.2d at 1167-69; Ohio Urology, Inc. v. Poll, 594 N.E.2d 1027, 1030-32 (Ohio Ct. App. 1991).

physicians would be permitted to pull patients away from the very company that trained them and provided them with the knowledge necessary to accommodate those patients. The medical profession is a delicate one, involving many interests of many different parties, and a per se rule against restrictive covenants would only serve to ignore those different individual interests.

The primary shortcoming of the per se rule as applied to either attorneys or physicians is that it assumes that a particular result is always appropriate. The main thrust of this Article has not been to discredit the need for restrictive covenants between physicians in all contexts. Rather, it has been to highlight the disturbing incongruities that exist between the very complex web of relationships and interests among doctors and patients and the pitifully simple regime that many courts have adopted in order to evaluate those relationships. In fact, the per se rule as it stands regarding attorneys in nearly every jurisdiction is vulnerable to these same criticisms.[180] California also has recognized this flaw in the per se approach and has adopted a judicial mechanism, which more closely resembles the rule of reason test, allowing more factors than just the interest of the client to be taken into account.[181]

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180. *See* Glenn S. Draper, Comment, *Enforcing Lawyers' Covenants not to compete*, 69 WASH. L. REV. 161, 174 (1994); Kalish, *supra* note 21, at 451.

181. *See* Howard v. Babcock, 863 P.2d 150, 156 (Cal. 1993) (upholding noncompete clause in partnership agreement); *see also* Haight, Brown & Bonesteel v. Superior Court, 285 Cal. Rptr. 845, 848 (Cal. Ct. App. 1991) (upholding a restrictive covenant that financially penalized departing attorneys by causing forfeiture of post-breakup fees). "These decisions [result partially from] the fact that California's ethical code is slightly different from the *Model Code* or *Model Rules* and can be read to allow enforcement of restrictive covenants." John Ritsick, *Ethical Concerns in Law Firm Breakups: Solicitation, Restrictive Covenants, and Conflict Issues*, 11 GEO. J. LEGAL ETHICS 355, 362 (1998). California's Rules of Professional Conduct provide that "[a] member [of the State Bar] shall not be a party to or participate in offering or making an agreement . . . [that] restricts the right of a member to practice law." CAL. RULES OF PROF'L CONDUCT R. 1-500(A) (2006). Similarly, Model Rule 5.6(a) provides that "[a] lawyer shall not participate in offering or making (a) a partnership or employment agreement that restricts the rights of a lawyer to practice after termination of the relationship." MODEL RULES OF PROF'L CONDUCT R. 5.6(a) (1983). The *Haight* court, however, interpreted the California state provision to prohibit only agreements which caused attorneys to "refrain altogether from the practice of law." *Haight*, 285 Cal. Rptr. at 848. The *Haight* court decided to expand its interpretation of Rule 1-500, in part, based on an 1872 Civil Code. *Id.* at 847. Additionally, the court noted that "Business and Professions Code section 16602 provides that '[a]ny partner may . . . agree that he will not carry on a similar business within a specified [geographic area].'" *Id.* The *Haight* court noted the 1872 provision had "never been amended to prohibit attorneys from availing themselves of the contractual rights contained therein." *Id.* For a further discussion of the *Haight* case, see

Moreover, a number of scholars have argued for the application of the rule of reason to attorney restrictive covenants to permit for more flexibility.[182] For example, Professor Wilcox argues for the termination of the per se rule for lawyers. He contends that it is "[a] fundamental principle of contract law" that "any harm to the public resulting from enforcement [of restrictive covenants] must not outweigh the value of the interests protected by the restriction."[183] The per se rule, therefore, wrongly assumes that the public interest will always outweigh the benefits to law firms, or physician employers, who wish restrictive covenants enforced.[184] As noted above, physician-employers may wish to protect patient lists; likewise, law firms may wish to protect client patronage in matters already handled by the firm and protecting new matters involving existing clients.[185]

From a practical perspective, implementing a per se rule would be nothing short of revolutionary in most jurisdictions and would likely be met with resistance. While the public policy prong of the rule of reason test must be strengthened significantly, it should not devour the other prongs as it has in most jurisdictions regarding lawyers. The fact that many of the rational underpinnings of the per se rule have been reiterated and buttressed in this Article does not mean that a per se rule is the appropriate result. Advocating such would simply be replacing one overly simplistic and oppressive regime with another.

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generally Kirstan Penasack, Note, *Abandoning the Per Se Rule Against Law Firm Agreements Anticipating Competition: Comment on* Haight, Brown & Bonesteel v. Superior Court of Los Angeles County, 5 GEO. J. LEGAL ETHICS 889 (1992).

182. *See, e.g.*, Kafker, *supra* note 168, at 58 ("As the practice of law has become more and more a business, the justification for treating legal partnerships differently from other professions has become less compelling, notwithstanding the ethical code of the legal profession. A reasonable forfeiture clause would not impose an absolute restriction and would protect the dominant interest of the client as well as those of the departing partner and the firm."); Robert M. Wilcox, *Enforcing Lawyer Non-Competition Agreements While Maintaining the Profession: The Role of Conflict of Interest Principles*, 84 MINN. L. REV. 915, 937-41 (2000); Wm. C. Turner Herbert, Comment, *Let's Be Reasonable: Rethinking the Prohibition Against Noncompete Clauses in Employment Contracts Between Attorneys in North Carolina*, 82 N.C. L. REV. 249, 266-78 (2003) (urging the revision of ethical rules to permit law firms to use noncompetition agreements with the application of the common law reasonableness standard).

183. Wilcox, *supra* note 182, at 965.

184. *See id.* at 932.

185. *See supra* notes 48-60 and accompanying text.

E. The Antitrust Approach: Another Method of Oversimplification

Over the years, physician-employees have sought to use federal and state antitrust laws to challenge covenants-not-to-compete.[186] This antitrust analysis may be viewed as a variation of the per se rule described above, as the restrictive covenant, if in violation of antitrust rules, will not be enforced due to its anticompetitive effects. Such an analysis, proffered by Charles Sullivan and Arthur Di Dio, among others, does not offer the enhanced flexibility that a more nuanced rule of reason approach would provide.[187]

Professor Sullivan observes that the common law rule of reason for restrictive covenants overvalues the individual interests of the employer and employee, while failing to sufficiently consider the agreement's broader anticompetitive effects.[188] He convincingly argues that the application of federal antitrust principles would demand a more precise analysis for the noncompete agreement's impact on the relevant market because these principles would better assess the overall reasonableness of anti-competition agreements.[189] However, this antitrust approach fails to differentiate the unique and special relationship between physicians and their patients from other commercial relationships.[190] Moreover, it fails to take note of the difficulties that physicians have using antitrust laws to void restrictive covenants.

In his article, *The Legal Implications of Noncompetition Agreements in Physician Contracts*, Di Dio discusses the many legal hurdles a physician will face in using federal antitrust law to challenge the validity of a noncompetition agreement.[191] The first challenge is jurisdictional: whether or not federal antitrust law is applicable requires that the noncompetition agreement (or rather, the enforcement thereof) substantially affects interstate commerce.[192] Although the Supreme Court held that the "learned professions," including attorneys[193] and physicians,[194] are part of

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186. *See, e.g.*, Blank v. Preventive Health Programs, 504 F. Supp. 416, 418-20 (S.D. Ga. 1980).

187. *See* Di Dio, *supra* note 9, at 464-71; Charles A. Sullivan, *Revisiting the "Neglected Stepchild": Antitrust Treatment of Postemployment Restraints of Trade*, 1977 U. ILL. L.F. 621, 625-32.

188. Sullivan, *supra* note 187, at 642.

189. *Id.* at 643.

190. *See id.* at 625-26.

191. *See* Di Dio, *supra* note 9, at 465-71. *See generally* Jill Moore Mayo, Comment, *The Antitrust Ramifications of Noncompetition Clauses in the Partnership and Employment Agreements of Doctors*, 30 LOY. L. REV. 307 (1984).

192. *See* 15 U.S.C. § 1 (2000).

193. Goldfarb v. Va. State Bar, 421 U.S. 773, 787 (1975).

194. Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 348-49 (1982); *see* Carl F. Ameringer, *Federal Antitrust Policy and Physician Discontent: Defining*

trade and commerce for Sherman Act purposes, the problem has been demonstrating that restrictive covenants have an anticompetitive effect.[195] Di Dio outlines in detail the potential difficulties a physician may have in establishing such an anticompetitive effect.[196] He states:

> This anticompetitive effect must occur in the relevant market; it is not sufficient that the plaintiff demonstrate that the covenant hindered the plaintiff's ability alone to compete in the market. That anticompetitive effects "must be judged in relation to the market" rather than in relation to the plaintiff alone is a potential barrier to a successful antitrust challenge to a covenant not to compete.[197]

He concludes that most courts find that the procompetitive justifications of a restrictive covenant outweigh any "anticompetitive effects."[198]

Moreover, a 1982 Federal Trade Commission ("FTC") complaint leveled at the medical community ordered, among other things, that the AMA cease and desist from declaring that restrictive covenants in physician contracts were unethical.[199] The basis for this FTC order came from economists who argued that "ethical restrictions on advertising, solicitation, and contract practice increased costs."[200] For a time, the nation trusted that decentralized, competitive markets in health care and insurance would constrain costs while encouraging quality.[201] Now, some commentators suggest that a lack of regulation of both HMO mergers and physician practice groups has led to an increase in anticompetitive behavior that federal enforcement is either unwilling or unable to control.[202]

Moments in the Struggle for Congressional Relief, 27 J. HEALTH POL. POL'Y & L. 543, 549 (2002).

195. The requirement that the antitrust activity substantially affect interstate commerce was explained by the Court in *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991). The Court stated, "[t]he competitive significance of [a single surgeon's] exclusion from the market must be measured . . . by a general evaluation of the impact of the restraint on other participants and potential participants in the market from which he has been excluded." *Id.* at 332.

196. *See* Di Dio, *supra* note 9, at 469-71.

197. *Id.*

198. *See id.* at 470-71.

199. *See* Ameringer, *supra* note 194, at 550-51.

200. *Id.* at 550.

201. *See* Thomas L. Greaney, *Whither Antitrust? The Uncertain Future Of Competition Law in Health Care*, 21 HEALTH AFF., Mar./Apr. 2002, at 185, 186; *see also* Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L. J. 1071, 1072-74.

202. Greaney, *supra* note 201, at 186; John A. Powers, Note, *The Stifling of*

Another reason for the possible increase of antitrust activity is that lower courts "find themselves at sea" trying to interpret and apply the complex economic inquiry required to determine if antitrust activity has resulted in "cause-effect relationships between professional restraints and economic outcome."[203] So, even if antitrust legislation may be applicable to physician restrictive covenants, the complexity, cost, and uncertain nature of legal action in this area cannot currently provide a practical solution to the problems arising from restrictive covenants.

If these jurisdictional requirements are met, the courts will apply the rule of reason to covenants-not-to-compete. Therefore, such an analysis provides no nuanced solution to the problem of physician restrictive covenants; it simply clears the way for federal antitrust law to augment the rule of reason test used by a majority of jurisdictions.[204] Such an approach is helpful only to the extent that a court may take such factors into consideration as a component of a more far-reaching factual inquiry and subsequent in-depth analysis.

IV. BORROWING FROM THIRD-PARTY BENEFICIARIES: AN ENLIGHTENED RULE OF REASON TEST

The application of the current rule of reason framework to physician restrictive covenants fails to adequately protect the physician-patient relationship. In balancing the freedom to contract and this special relationship, courts should not automatically favor the employer's interest in protecting its business interests over the physician-employee's relationship with his or her patients.

Absent from current rule of reason analysis is a recognition that protecting the physician-patient relationship serves important public policy and health values.[205] Although an employer may have legitimate, and even compelling reasons, for enforcing a restrictive covenant in some specific contexts,[206] these facts provide no justification for abandoning a priori the importance of a patient's continuing relationship with a physician in all situations. An evaluation of a physician restrictive covenant should be cabined by a

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Competition by the Antitrust Laws: The Irony of the Health Care Industry, 15 J. L. & HEALTH 223, 224 (2000-2001).

203. Greaney, *supra* note 201, at 189.

204. Di Dio, *supra* note 9, at 469 ("Under the federal antitrust laws, a covenant-not-to-compete is valid if it is ancillary to the main business purpose of a lawful contract and necessary to protect the covenantee's legitimate property interests, which require that the covenants be as limited as is reasonable to protect the covenantee's interests.").

205. *See supra* notes 84-98 and accompanying text.

206. *See supra* notes 48-55 and accompanying text.

guiding principle recognizing that the interest of incumbent patients to maintain their relationship with their physician has value and deserves greater protection in appropriate contexts.

Courts must not permit an employer to squelch physician-patient relationships for any reason. On the other hand, not all physician-patient relationships are deserving of a high level of protection.[207] In short, courts must evaluate the strength of a physician-employee's claim for nonenforcement of a restrictive covenant on a content-specific basis, providing greater scrutiny at times, while applying a normal rule of reason standard to other cases.

The current rule of reason treats all physician-patient relationships as having equal value to the patient and the patient's health.[208] The result of this analytical approach is decisions that often appear arbitrary and unfair.[209] Most courts look at the public policy prong of the rule of reason test to only require that a minimum number of physicians reside in a particular area, rather than taking into account weighty issues such as preservation of patient choice, encouragement of competition between physicians, quality of patient care, and continuity of that care.[210] Such a greater content-specific approach may be had by applying a quasi third-party beneficiary analysis to the incumbent patients under the public policy prong of the rule of reason.

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207. Some physician-patient relationships are of short duration due to the type of medicine a doctor practices. A meeting with a radiologist generally will not lead to a long-term health care relationship. Other doctors, such as oncologists, see a patient frequently and develop a deeper and continuing relationship with the patient.

208. *Cf.* Iredell Digestive Disease Clinic, P.A. v. Petrozza, 92 N.C. App. 21, 29-31, 373 S.E.2d 449, 454-55 (1988) (focusing its rule of reason analysis on the availability of any gastroenterologist to the community rather than focusing on availability of a particular gastroenterologist to the community), *aff'd*, 324 N.C. 327, 377 S.E.2d 750 (1989).

209. *See* Prairie Eye Ctr., Ltd. v. Butler, 768 N.E.2d 414, 421 (Ill. App. Ct. 2002) ("Despite our sympathy for the rights of patients to choose their own doctors, we are constrained to follow the long line of precedent . . . finding non-competition agreements enforceable in the medical profession." (internal citations omitted)); Bloomington Urological Assocs., SC v. Scaglia, 686 N.E.2d 389, 394 (Ill. App. Ct. 1997) (acknowledging the sacrosanct relationship between the contracting physician and his patients before declaring a noncompete agreement between physicians enforceable); Willman v. Beheler, 499 S.W.2d 770, 777 (Mo. 1973) (holding a covenant-not-to-compete valid even though a shortage of surgeons existed in the area because there existed such shortages in many areas).

210. *See, e.g.*, Duffner v. Alberty, 718 S.W.2d 111, 113-14 (Ark. Ct. App. 1986). *But see, e.g.*, Valley Med. Specialists v. Farber, 982 P.2d 1277, 1283 (Ariz. 1999).

A third-party beneficiary is "[a] person who, though not a party to a contract, stands to benefit from the contract's performance."[211] There are two separate classes of third-party beneficiaries: intended beneficiaries and incidental beneficiaries. A party outside of a contract qualifies as an intended third-party beneficiary if the parties to the contract intended to give that outside party the benefit of the contract's promised performance.[212] Both parties to the contract must undertake a clear and direct obligation to the third party;[213] it is not enough to show a party will derive some benefit from the contract.[214] Although other parties may be affected by contracts (incidental beneficiaries), only intended third-party beneficiaries have rights under a contract for their benefit.[215]

Courts have found third-party beneficiaries to exist in a wide variety of contractual situations,[216] affecting a wide variety of relationships between the parties to the contract and the would-be third-party beneficiary. For instance, courts have often found tenants of buildings, whether commercial or residential, to be third-party beneficiaries of contracts to improve, expand, or otherwise physically alter the property.[217] Children are always third-party

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211. BLACK'S LAW DICTIONARY 165 (8th ed. 2004).

212. RESTATEMENT (SECOND) OF CONTRACTS § 302 (1981).

213. However, according to *Perry v. Baptist Health*, No. 03-1130, 2004 WL 1406092 (Ark. June 24, 2004), it is not necessary to name a person in the contract if that person is a member of a class sufficiently described or designated in the contract. *Id.* at *3.

214. *Id.*; Collins v. Anthem Health Plans, Inc., No. X01CV990156198S, 2000 WL 1768354, at *8 (Conn. Super. Ct. Oct. 31, 2000) ("[T]hird-party beneficiary status is not established merely by showing that one will receive some benefit from the contract or that one is affected by it.").

215. *See, e.g.*, Pelham v. Griesheimer, 440 N.E.2d 96, 98 (Ill. 1982) (holding that intent to benefit the third party must be the primary or direct purpose of the transaction or relationship and is "an indispensable element of a third-party beneficiary theory of recovery").

216. *See, e.g.*, Little Rock Wastewater Util. v. Larry Moyer Trucking, Inc., 902 S.W.2d 760, 763-64 (Ark. 1995) (holding that a highway construction firm was a third-party beneficiary of a contract between the state and utility company when utility company took too long to finish a job, thus delaying the construction company's work); Gateway Co. v. DiNoia, 654 A.2d 342, 347 (Conn. 1995) (considering a landlord to be a third-party beneficiary to agreement assigning a lease from one tenant to another); Tredrea v. Anesthesia & Analgesia, P.C., 584 N.W.2d 276, 282 (Iowa 1998) (holding that independent anesthesiologists were third-party beneficiaries to a contract hospital entered into with anesthesia partnership, wherein hospital could use independent anesthesiologists with partnership's consent); L.A.C. *ex rel.* D.C. v. Ward Parkway Shopping Ctr. Co., L.P., 75 S.W.3d 247, 262 (Mo. 2002) (holding that a shopper who was raped at mall was third-party beneficiary of contract between mall and security company).

217. *See* K-Mart Corp. v. Balfour Beatty, Inc., 994 F. Supp. 634, 635-36

beneficiaries of divorce settlements between their parents.[218] Patients can be third-party beneficiaries to contracts between HMOs and the patients' doctors.[219] It seems logical that a physician's patients are necessarily a third-party beneficiary to any employment agreement into which the physician enters.

While the benefit conferred onto a third-party must be more than incidental, which normally entails that it be either financial or legal in nature, contracts which by their nature affect the physical well-being or health of an outside party will create a third-party interest in that outside party.[220] Because physicians are unique among professionals in their overriding duty to attend to the well-being of those they serve, any contract which may affect their employment, especially a restrictive covenant, will always deeply affect their patients as well.[221] From the Hippocratic Oath to the overall theme of the AMA guidelines, every action that a physician takes in relation to her employment is undertaken for the benefit of her patients, whether the patients are viewed as a class or as individuals with individual needs.[222] Physicians are employed almost exclusively for the purpose of treating patients, and thus, inherent in every employment contract is an understanding from both parties, the physician and the employer, that patients will

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(D.V.I. 1998); Dist. Moving & Storage Co., Inc. v. Gardiner & Gardiner, Inc., 492 A.2d 319, 322 (Md. Ct. Spec. App. 1985).

218. *See* Smith v. Smith, 218 N.E.2d 473, 476 (Ohio Ct. App. 1964) ("As third party beneficiaries the beneficial provisions of the contract ordinarily may not be modified to their detriment without their consent and may be enforced by them or for them."); Chen v. Chen, 840 A.2d 355, 358 (Pa. Super. Ct. 2003). Some commentators have advocated allowing students to sue as third-party beneficiaries to the employment contracts between their teachers and their school districts as well. *See* Kevin P. McJessy, Comment, *Contract Law: A Proper Framework for Litigating Educational Liability Claims*, 89 NW. U. L. REV. 1768, 1807-10 (1995).

219. St. Charles v. Kender, 646 N.E.2d 411, 412 (Mass. App. Ct. 1995).

220. *See* 9 ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS § 775 (interim ed. 2002) ("[Another] case may be supposed in which [a third party's] legal relations will not be affected but where performance will necessarily involve his person, as where B promises A to render personal service to [that third party], such as instruction, advice, or personal care . . . . [T]he personal contact necessarily involved no doubt makes it easier to show an intention on the part of the promisee to make [that third party] the beneficiary."). *See also* Gooch v. Buford, 262 F. 894, 898 (6th Cir. 1920).

221. *See* Devine v. Roche Biomedical Lab., 659 A.2d 868, 870-71 (Me. 1995) (holding that a patient would "clearly" be a third-party beneficiary of a service contract between a laboratory and his doctor).

222. *See* AMA, Principles of Medical Ethics, http://www.ama-assn.org/ama/pub/category/print/2512 (last visited Jan. 30, 2006); Nat'l Library of Med., Greek Medicine, http://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Jan. 30, 2006).

directly benefit from the contract.

While at least some courts have recognized the relationship between physician-patient relationships and third-party beneficiary status,[223] they are not exact corollaries and granting third-party beneficiary status has some downsides. Third-party beneficiaries traditionally have a right to bring a claim for breach of contract.[224] Where the goal of a patient is continuity of care, it is not an adequate remedy for that patient to have a right to sue a physician or employer for a breach of contract. Allowing patients to sue for breaches of employment contracts also jeopardizes the ability of employers to make independent hiring and firing decisions. Another difficulty with permitting third-party beneficiary status is that the scope of the contract limits the scope of the beneficiary status.[225] If courts grant patients third-party beneficiary status, employers may attempt to avoid liability by refusing to mention the quality of care physicians must provide, or by refusing to mention treating patients at all. Additionally, under some states' laws, third-party beneficiary status is currently unavailable to patients because state statutes control the definition of beneficiary status.[226] Although granting third-party beneficiary status to patients would force courts to recognize the important physician patient relationship, courts have been reluctant to grant this status because of the inherent problems associated with third-party beneficiary status.[227]

One case that illustrates the difficulties courts have with finding the correct approach to the doctor patient relationship is *Daniel Boone Clinic, P.S.C. v. Dahhan*.[228] In the case, Dr. Dahhan signed a restrictive covenant-not-to-compete in consideration of his employment with the Daniel Boone Clinic ("DBC").[229] After the cessation of his employment, two patients Dr. Dahhan had been treating for chronic pulmonary and cardiac problems filed actions seeking an injunction to prohibit enforcement of the covenant.[230] A Kentucky district court issued an opinion stating that the patients and general public were third-party beneficiaries of the contract between Dr. Dahhan and DBC, and that the patients were thus

223. Yeager v. Bloomington Obstetrics & Gynecology, Inc., 585 N.E.2d 696, 698 (Ind. Ct. App. 1992) (quoting Webb v. Jarvis, 575 N.E.2d 992, 996 (Ind. 1991)).

224. *See, e.g.*, Cherry v. Crow, 845 F. Supp. 1520, 1523 (M.D. Fla. 1994).

225. *See* Jeffcoat v. Principi, 17 Vet. App. 213, 219-20 (Vet. App. 2003).

226. Oja v. Kin, 581 N.W.2d 739, 744 (Mich. Ct. App. 1998) (citing MICH. COMP. LAWS § 600.1405 (2005)).

227. *See supra* notes 223-26 and accompanying text.

228. 734 S.W.2d 488 (Ky. Ct. App. 1987).

229. *Id.* at 489.

230. *Id.* at 490.

entitled to timely and adequate notice of termination of treatment.[231]

The appellate court, however, took a different view. The Kentucky Court of Appeals upheld the covenant-not-to-compete, stating, "[g]enerally, such provisions are held valid, and not against public policy unless the particular circumstances of the case would cause serious inequities to result."[232] When the appellate court examined whether enforcing the covenant-not-to-compete would cause serious inequities, it found none.[233] The appellate court neglected the importance of continuity of care, saying the clinic has a duty to provide professional care but not a duty to provide a physician of the patient's choice or notice of personnel changes.[234] The court went on to say that patients are merely incidental beneficiaries to the employment contract between Dr. Dahhan and DBC.[235]

Clearly, the two courts were both applying the same general law, and both were trying to determine whether the covenant-not-to-compete would violate public policy. However, the vague definition of public policy and the fine line between intended and incidental third-party beneficiaries leaves too little guidance for courts to determine what is in the public interest. A better approach is for courts to modify the rule of reason test to accommodate specific analysis of the physician patient relationship under the public policy prong.

Using the public policy prong of the rule of reason analysis, courts should consider the impact restrictive covenants may have on the patients of a contracting doctor in a more in-depth and multi-dimensional fashion. Such an approach would require a court to make inquiries into the impact that enforcement of a covenant would have on individual patients, as well as on the patients of a physician challenging an agreement as a whole. As quasi-third-party beneficiaries to the employment contract, the impact of enforcement of a restrictive covenant on patients would become an important factor of public policy consideration. For example, a court inquiring into the impact that enforcement of a restrictive covenant against an oncologist would have on her patients as a class would almost universally find continuity of care issues to be so vital in this particular field that rescission of the covenant would almost always be necessary. On the other hand, a court looking into that same impact on a dermatologist would typically find diminished continuity of care issues in that class of patients, making rescission

231. *Id.*
232. *Id.*
233. *Id.*
234. *Id.* at 491.
235. *Id.*

much less likely. By considering the public interest of a class of patients, this approach also allows a court to consider the impact a restrictive covenant would have on a physician's future patients and the general medical needs of a community.

However, this third-party approach will also allow courts to look at physicians' relationships with individual patients, providing for a more nuanced version of the rule of reason that allows much more flexibility. Rather than make sweeping judgments about the relative importance of a physician's specialty, this approach will require a court to look at the nature of that physician's relationship with his patients.[236] For example, a urologist may or may not have a large percentage of patients for whom enforcement of a covenant would bring about disastrous healthcare consequences.[237] By protecting the doctor-patient relationship courts will free physicians to treat patients who require long-term care without fear that the physician will be forced to ignore her medical and ethical obligations. Elevation of the individual relationship between doctor and patient will force courts to consider this impact on much more of a case-by-case basis. Further, it will ultimately result in better, more informed opinions that will simultaneously promote the well-being of patients and the economic interest of physicians. Such interests are not, and should not be, diametrically opposed, but the current tests that enjoy popularity among courts often treat them as such.

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236. Even the most progressive opinions regarding patient rights have declined to look into the details of the contracting physician's relationship with her patients. It is unknown, for instance, the extent to which the trial court that issued the original *Farber* opinion relied on any specific information about the contracting physician's relationships with his patients or the extreme importance that continuity-of-care issues may play in the effectiveness of a pulmonologist's treatments. *See* Valley Med. Specialists v. Farber, 982 P.2d 1277 (Ariz. 1999). The *Duffner* court apparently saw the plights of individual patients or the nature of an orthopedic practice as irrelevant, as neither are even briefly mentioned. *See* Duffner v. Alberty, 718 S.W.2d 111 (Ark. Ct. App. 1986).

237. For an illustration concerning physicians practicing pediatrics and neonatology, see Dick v. Geist, 693 P.2d 1133 (Idaho App. 1985). This court, in an indirect manner, was actually able to look at relatively detailed information regarding the contracting physicians' relationships with at least potential patients. *See id.* at 1136-37. While disruptions in patient relationships with pediatricians and neonatal experts may or may not result in major problems for the quality of patient care, this court was able to look at the unique circumstances that neonatal specialists in a rural area may experience, and in so doing, voided the covenant-not-to-compete for public policy reasons. *Id.* at 1137.

A. *Contracts Should Be Efficient*

Notwithstanding the deficiencies of the current rule of reason approach, a one-size-fits-all approach to all restrictive covenants has some support in the legal academy. Many law and economics scholars argue that a more flexible rule will be confusing and add ambiguity to the contract and its future enforceability.[238] These scholars contend that clear rules promote efficient transactions, if those rules are known, and that contract law can be used to embrace them.[239] Accordingly, these scholars would likely view this proposed change to the evaluation of physician restrictive covenants as rather dicey because the parties would have difficulty predicting in advance, at least until the law became more settled, whether the restrictive covenant would be valid. The current per se rule as applied to attorneys and the rule of reason as applied to physicians avoids this uncertainty. Currently, there does not exist much ambiguity as to whether a physician covenant-not-to-compete will be enforced, as most of them will be found reasonable.[240]

My argument is that it is more efficient and fair to permit restrictive covenants to exist with judicial limitations. First, application of restrictive covenants to physicians seems to be a very inefficient way in which to regulate competition for health care services in a market. In a small community, there might be only two dermatologists. If one tries to be independent but cannot because of a restrictive covenant, then the community loses the benefit of competition. Surely there are more competition-friendly ways of protecting the investment an established doctor makes in a new addition to her practice?

Noncompetition clauses are a result of two competing policies that courts must grapple with each time a clause is litigated in court: freedom to contract and a policy against restraint of trade.[241]

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238. *See* A. MITCHELL POLINSKY, AN INTRODUCTION TO LAW AND ECONOMICS 13 (1983) ("[T]he preferred legal rule is the rule that minimizes the effect of transaction costs. These effects include the actual incurring of transaction costs and the inefficient choices induced by a desire to avoid transaction costs."). *See generally* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW (3d ed. 1986) (advocating the use of economics in judicial decision making); R.H. Coase, *The Problem of Social Cost*, 3 J. LAW & ECON. 1 (1960). For a slightly different perspective, see generally Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089 (1972).

239. *See generally* POSNER, *supra* note 238. *But see generally* James M. Buchanan, *Good Economics–Bad Law*, 60 VA. L. REV. 483 (1974); Jerome M. Culp, *Judex Economicus*, 50 LAW & CONTEMP. PROBS. 95 (1987); Mario J. Rizzo, *The Mirage of Efficiency*, 8 HOFSTRA L. REV. 641 (1980).

240. *See supra* notes 51-65 and accompanying text.

241. *See* Empirical Study, *supra* note 41, at 486.

According to some scholars, the closest courts have come to balancing these policies for noncompete clauses is the rule of reason.[242] The rule of reason approach is the best solution thus far because it seeks to examine the many factors that contribute to each of the competing policies.[243] Instituting the proposed solution of adopting the quasi-third-party beneficiary status will take time like any other solution. However, some commentators suggest that time is quickly running out to bandage the wounds caused by restrictive covenants.[244]

> Patient choice is being eroded and will likely continue unless we stop treating physicians as we do salesmen and make a concerted effort to enable patients to choose their physician and remain a patient, regardless of the physician's employment status. . . . The courts should not compound the problem for patients by treating the 'freedom to contract' as a higher public good than the right of a patient to choose and remain a patient of a particular physician regardless of the employment status of that physician.[245]

With that consideration in mind, it is essential that courts recognize the importance of the flexibility that restrictive covenants require in the physician context, and examine covenants on a case-by-case basis. Although this method may be less judicially efficient, it is more efficient in the long run if it can protect patient, physician, and practice groups' interests more effectively.

B. Judicial Discretion

A second criticism is that the enhanced public policy prong of the physician restrictive covenant increases judicial discretion and, thus, increases the likelihood that unfair or arbitrary results will occur when courts review covenants-not-to-compete for their

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242. *Id.* at 487.

243. As one author observed:

> And, allowing reasonable restrictive covenants avoids the inequitable results of applying the per se rule. The reasonableness rule enforces the parties' expectations, rather than allowing one party to shift the costs of complying with public policy to another party.
>
> The essence of the reasonableness rule is an individualized inquiry into the circumstances of the parties to the restrictive covenant.

Draper, *supra* note 180, at 180.

244. *See* Leonard Opperman & Jason R. Burke, *The Freedom of Contract vs. Patient's Rights to Choose: Non-Competition Agreements in Physicians' Employment Contracts*, RES GESTAE, Sept. 1999, at 24, 30.

245. *Id.* at 30.

validity.[246] Courts will be called on to determine the precise nature of the physician's relationship with his or her patients and to establish what will be a tolerable level of disruption to this relationship. The decision to permit some physician restrictive covenants to be enforced, even at the cost of some disruption of the physician-patient relationship, necessarily requires an exercise of discretion.[247] As in any case, a judge's particular sensitivities may well determine the level of protection that a physician's patients receive. Thus, the implementation of this approach will result in some physician-employers believing that their right to contract has been unfairly denied or circumscribed and in some physicians feeling that their relationship with their patients has been undervalued.[248]

In the physician context, however, judicial discretion will not lead to lesser protection of any physician-patient relationship. The new approach creates the opportunity for the physician-patient relationship to be viewed in a different manner setting forth a new ceiling but not removing the basic rule of reason that exists today. Thus, application of the enhanced public policy prong in the rule of reason will not leave any physician-patient relationship less protected than it is under current law. Instead, this new test would provide a higher degree of protection in appropriate circumstances. If anything, the existing rule of reason standard is more troublesome because it concludes before any balancing occurs that all physician-patient relationships enjoy little, if any, protection.

Judges under the new approach will have to use their discretion to characterize the nature of the physician-patient relationship involving a physician restrictive covenant claim. Although this task is not an easy one and creates the possibility of an arbitrary characterization of that relationship (and perhaps a denial of that physician-patient relationship in individual cases), the benefits of providing greater protection to the physician-patient relationship more than compensate for the opportunity cost.

V. CONCLUSION

The bond between a physician and her patient is one of the most sensitive and important in American society. It is also one of the most unique. The attitude that many jurisdictions take when

246. For a discussion of this line of legal reasoning in general, see Lawrence C. George, *King Solomon's Judgment Expressing Principles of Discretion and Feedback in Legal Rules and Reasoning*, 30 HASTINGS L.J. 1549, 1559-66, 1573-75 (1979).

247. *See* Draper, *supra* note 180, at 180.

248. *See generally* Opperman & Burke, *supra* note 244.

evaluating the degree to which this relationship should be protected by law is at best inconsistent, and at worst incoherent and insensitive. This does not mean that courts can also disregard entirely the economic realities of practicing medicine in America today. Courts must therefore also mind the sometimes competing interest that the public has in promoting the profitable and stable practice of medicine. Unfortunately, one thing that courts of all jurisdictions have in common is the lack of a workable judicial standard that can effectively allow them to walk the line between these two competing public interests.

The vast majority of the sources cited in this Article, whether judicial opinions or scholarly analysis, serve as evidence of the current polarized state of the law in the area of physician restrictive covenants, espousing either an outright rejection of physician restrictive covenants in every instance or, alternatively, employing an outdated analysis that is often incapable of achieving any meaningful protection for the bond between patient and physician. Somewhat ironically, taking sides in this tug-of-war will never solve this problem. Instead, courts must be given the proper tools in order to evaluate these complex issues in a complete and in-depth manner. The third-party beneficiary analysis will serve as the perfect instrument for courts to make better and more informed decisions in the future.