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The Noncompete Clause and the Nurse Anesthetist: An Assessment of Knowledge, Perception, and Experience

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Economic pressures and the challenge to maintain competitive advantage have resulted in many health-care entities requiring their practitioners to contractually enter into noncompete clauses (NCCs). Many student registered nurse anesthetists (SRNAs) and Certified Registered Nurse Anesthetists (CRNAs) are unaware of NCCs in employee contracts.

An anonymous, web-based questionnaire regarding NCCs was distributed to SRNAs and CRNAs nationwide. Of 242 practicing CRNAs who responded, 147 (60.7%) were employed without a noncompete clause and 22 (9.1%) were unaware whether they had such a provision in their employment contracts. The knowledge level of the nurse anesthetist respondents was low (average score of 55.3%). There was a significant difference in knowledge level between independently

practicing CRNAs and group-practice CRNAs ($P = .007$) as well as practicing CRNAs vs SRNAs ($n = 8$, $P = .006$). Independent CRNAs had more experience with declining positions, changing positions, and loss of employment due to NCCs. More CRNAs believed the NCC is not applicable to practice, and no evidence existed to show a relationship between geographic location and having an NCC. Business-minded CRNAs with a practical knowledge of keyterms, concepts, and legal implications of NCCs are in a better position to bargain and negotiate against objectionable provisions.

Keywords: Contractual obligations, economic pressures, noncompete agreement, noncompete clause, restrictive covenants.

As a result of mounting economic pressures on healthcare organizations and the challenge of larger medical groups to maintain a competitive advantage, many healthcare entities now require their practitioners to enter into restrictive covenants such as noncompete clauses (NCCs). As many as 80% of working Certified Registered Nurse Anesthetists (CRNAs) are employed by medical groups or hospitals that tend to require such contracts.¹ These contracts can have a tremendous impact on the many CRNAs who are the sole anesthesia providers in rural communities, where they often provide care in medically underserved areas and in some states nearly 100% of the rural hospitals.^{2,3} Many CRNAs are unaware of restrictive covenants and of the NCC in employee contracts, which can limit their ability to successfully advance themselves and the nurse anesthesia profession as well as meet the needs of the communities they serve.

Often CRNAs do not become aware of the consequences of the NCC until they are directly affected by the geographic and time obligations mandated by an employee contract during an acquisition or joint venture merger. Negotiations that take place in an ever-competitive business environment typically are efforts to reduce healthcare cost, improve efficiencies, and

gain leverage. Large anesthesia management companies and dominant anesthesia groups have evolved and have been created through mergers; acquisitions of anesthesia groups by larger, well-funded groups; or through direct negotiations with a healthcare system to replace existing groups.⁴ Often these changes result in the loss of jobs for those CRNAs employed before the acquisition or merger.

Restrictive covenants include NCCs, nonsolicitation agreements, and confidentiality agreements.⁵ An NCC is a contractual provision between a company and an employee that prevents the contracting employee from engaging in certain conduct in a specified geographic area for a given time after the work relationship ends. Noncompete clauses can be complex and are set in place to protect the employer's legitimate business interests, maintain competitive advantage, and inhibit confidential information from being exploited.⁶ These types of agreements benefit the employer by protecting proprietary information and trade secrets.

Noncompete clauses have existed for centuries. The earliest known common-law case embodying restraint of trade dates to England in 1414 when John Dyer, after entering into an apprenticeship agreement, would repay his debt by not engaging in his trade for 6 months.^{7,8} English common law held these restrictions to be unenforceable

as a question of public policy until the watershed case of *Mitchel v Reynolds* of 1711. This particular case was a defining moment for restraint of trade and became the precursor to current competition law and the modern framework of enforceability of NCCs.⁹ *Mitchel v Reynolds* of 1711 established the rule of reasonableness and is still used in American courts to ensure that the public is not unduly harmed either by limitations set forth by time and geographic scope or in the trades that are prohibited.

The rule of reasonableness, as the name implies, mandates that an NCC must be reasonable to be enforceable, terms that vary from state to state.¹⁰ Not all noncompete agreements are enforceable and may not be appropriate in all industries of trade. The American Medical Association states: “to determine if a covenant is reasonable in terms of duration and geographic scope, a number of factors are weighed, including the nature of the practice as well as geographic and the population of the area from which it draws its patients.”⁶ It is important for not only healthcare organizations to understand the implication of these types of provisions but also employees who sign into contractual obligations where states and jurisdictions differ greatly on enforceability. In the past, many states favored more free and open competition and still hold that restrictive covenants are unenforceable in the healthcare context.⁵ The law in some states requires that these types of healthcare covenants not restrict access to healthcare and takes into consideration the public interest.¹⁰ In current jurisdictions, courts are more inclined to consider reasonableness of the NCC in light of particular patient care settings, consideration of hardship to the practitioner, and potential harm to the patient community in which the employee provides care.^{11,12}

Increased costs, economic pressures, complex regulatory structures, reduced reimbursements from private and public insurances, and high levels of competition between organizations have created a platform for restrictive covenants in healthcare. Being equipped with the knowledge surrounding complex restrictive covenants and contractual obligations with healthcare organizations can alleviate future unemployment and litigation circumstances. Moreover, CRNAs have the ability to bargain and advocate for themselves against objectionable provisions. Business-minded CRNAs who are confident in what they can bring to the healthcare community and who have practical knowledge of key terms, concepts, and legal implications of NCCs are in better positions to advocate for themselves and the CRNA profession. Thus, the purpose of this project was to examine the knowledge, perceptions, and experiences that the CRNA has related to the NCC in an effort to bridge the awareness gap surrounding the covenant not to compete.

Materials and Methods

This study was conducted by means of an Internet-

dispersed questionnaire using the American Association of Nurse Anesthetists (AANA) electronic survey delivery and management service as well as SurveyMonkey, an online web-survey company. SurveyMonkey supplied a secure link to the survey and collated the data under a certified privacy protection program, TRUSTe.¹³ Data were then added into a statistical product and service solutions database (SPSS version 21, IBM SPSS Statistics) database and analyzed. No forms of identification were included on the surveys, allowing for anonymity. Following approval of the study by a local university internal review board, the survey was activated for a 4-week enrollment period and submitted to 3,000 practicing CRNAs and student registered nurse anesthetists (SRNAs) throughout all states in the United States. The sample was randomly selected from current AANA members based on computer-generated numbers, with a uniform distribution from all regions to ensure nationwide CRNA representation. A cover letter preceded the survey and explained the inclusion and exclusion criteria as well as the provision for anonymity. Only the responsible investigators had access to survey files, and responses and surveys were destroyed after 12 months of initiation.

Demographic information was collected from independent CRNAs, group-practice or anesthesia care team (ACT) CRNAs, and SRNAs using a researcher-developed, 32-item, self-administered online questionnaire. The questionnaire was assessed for face and content validity by an expert panel of reviewers consisting of 6 CRNAs and 2 anesthesiologists. Demographic data, including gender, age, race/ethnicity, education level, work experience, geographic location, practice setting, practice type, practice model, and geographic setting (urban, suburban, or rural), were collected with the first 11 items on the questionnaire. Six knowledge questions concerning the NCC were scored with 1 point for each correctly answered item to assess knowledge level (total knowledge score = 6). The distribution of the NCC and the provisions of such NCCs were assessed with 3 items concerning the geographic and time restrictions enforced by such provisions. Perception and experience of the noncompete clause in CRNA practice were evaluated using the last 12 items located on the survey instrument.

Results

Of the 250 respondents to the online survey, 31.2% (n = 78) were independent-practice CRNAs and 65.2% (n = 163) of the CRNA respondents were group-practice or ACT group model CRNAs. All demographic data are presented in Table 1. Eight (3.2%) of the respondents were SRNAs, and 1 remaining participant responded as not currently practicing as a CRNA (0.4%). Roughly 40.5% (n = 100) were male participants, and 59.5% (n = 147) were female. Of the sample, 74% responded as having a master's degree (n = 185); 7.2% (n = 18) held a doctoral

Demographic feature	Independent practice (n = 78), No. (%)	Group practice (n = 163), No. (%)
Gender		
Male	43 (18.1)	54 (22.7)
Female	33 (13.9)	108 (45.4)
Age, y		
25-34	3 (1.3)	20 (8.4)
35-44	19 (17.9)	49 (20.5)
45-54	25 (10.5)	41 (17.2)
55-64	24 (10.0)	47 (19.7)
≥ 65	7 (2.9)	4 (2.5)
Ethnicity		
White	71 (30.1)	148 (62.7)
Hispanic or Latino	2 (0.8)	4 (1.7)
African American	1 (0.4)	4 (1.7)
Other	2 (0.8)	4 (1.7)
Education		
Diploma	2 (0.8)	3 (1.2)
Associate's degree	1 (0.4)	2 (0.8)
Bachelor's degree	15 (6.2)	17 (7.1)
Master's degree	55 (22.8)	128 (53.1)
Doctoral degree	5 (2.1)	13 (5.4)
Practicing as CRNA		
Yes	78 (31.2)	158 (65.2)
No	0 (0)	1 (0.4)
Student	0 (0)	8 (1.7)
Work experience, y		
0	0 (0)	3 (1.2)
1-9	19 (7.9)	72 (29.0)
10-19	23 (9.5)	41 (17.0)
20-29	17 (7.1)	22 (9.2)
≥ 30	19 (7.9)	25 (10.3)
Geographic region		
Pacific Northwest	6 (2.5)	2 (0.8)
Pacific Southwest	6 (2.5)	7 (2.9)
Central	31 (12.9)	43 (17.9)
Mountain	12 (5.0)	6 (2.5)
Northeast	5 (2.1)	41 (17.1)
Southeast	17 (7.1)	64 (26.7)
Opt-out status		
Opt-out state	27 (11.3)	33 (13.8)
Nonopt-out state	50 (20.8)	130 (54.2)
Practice setting		
Hospital	41 (17.2)	134 (56.3)
Ambulatory center	29 (12.2)	16 (6.7)
Office	2 (0.8)	0 (0)
Military	4 (1.7)	1 (0.4)
Faculty	0 (0)	5 (2.1)
Student	0 (0)	1 (0.4)
Other	2 (0.8)	3 (1.3)

Geographic practice location		
Urban	21 (8.8)	82 (34.3)
Suburban	16 (6.7)	58 (24.3)
Rural	41 (17.2)	21 (8.8)
Years at current position		
< 1	14 (5.8)	21 (8.7)
1-5	30 (12.4)	64 (26.6)
6-10	15 (6.2)	30 (12.4)
11-15	9 (3.7)	20 (8.3)
16-20	5 (2.1)	11 (4.6)
> 20	4 (1.7)	16 (6.6)

Table 1. Demographic Data of Study Participants
Abbreviation: CRNAs, Certified Registered Nurse Anesthetists.

degree; 15.2% (n = 38) held a bachelor's degree; 1.2% (n = 2) held an associate's degree; and 2.4% (n = 6) held a diploma. Approximately 90.8% of the sample population identified themselves as white or Caucasian (n = 227); 2.4%, as Hispanic or Latino (n = 6); 2.0%, as African American (n = 5); and 2.4%, as other (Native American or American Indian, Asian, and Pacific Islander). The average age of the sample group was 48.6 years (± standard deviation [SD] of 11.05), with a range of 25 to 75 years old, and the average length of work experience as a nurse anesthetist (± SD) was 15.7 ± 11.80 years. Most survey respondents in this study had a master's degree (74.0%), worked in a hospital setting (70.8%), and practiced in an urban location (42.0%).

The study hypotheses were evaluated by several different means. Demographic information such as gender, race/ethnicity, current practice status, geographic region in the United States, opt-out status, practice setting, supervision status, and geographic practice location were nominal/categorical levels of measurement. In a comparison of CRNAs in independent-practice and group-practice settings with respect to nominal variables of demographic data, χ^2 and Fisher exact tests were used. Alpha was set at $P < .05$. Mann-Whitney U was used for ordinal levels of measurement, such as age grouping, education level, work experience grouping, and years at current position. An independent t test was used for ratio/interval level of measurement for age (actual age) and work experience (actual years).

• **Prevalence of Noncompetent Clauses.** The distribution of practicing CRNAs who work under an NCC as a provision in a contract or practice agreement was evaluated by testing the difference in proportions in the 2 independent groups (independent CRNAs and group-practice [ACT group model] CRNAs) by means of the χ^2 test of independence. Of the 242 CRNAs who answered whether they have an NCC in their employment contract,

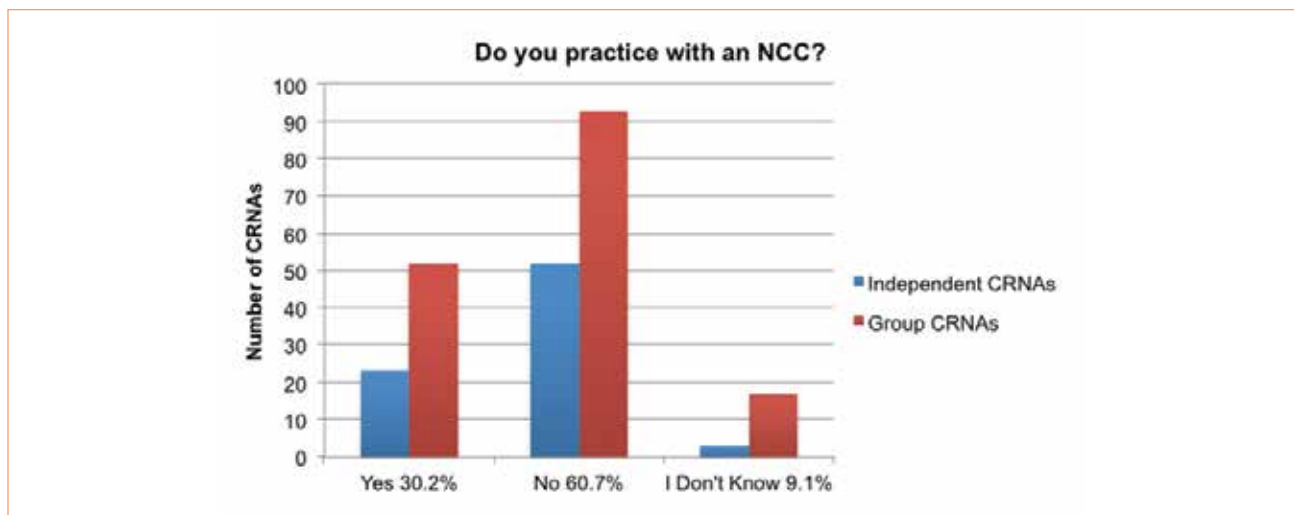


Figure 1. Presence of a Noncompetete Clause Reported by Practicing Certified Registered Nurse Anesthetists
Abbreviations: CRNA, Certified Registered Nurse Anesthetist; NCC, noncompetete clause.

Knowledge question	Independent practice (n = 78), No. (%)	Group practice (n = 163), No. (%)	P Value	SRNAs (n = 5), No. (%)
1. What is the definition of the noncompetete clause?	72 (92.3)	147 (91.9)	.895	2 (40.0)
2. NCCs are only for anesthesiologists? (True/False)	74 (94.9)	139 (86.9)	.110	3 (60.0)
3. The NCC can be negotiated? (True/False)	65 (83.3)	105 (65.6)	.010 ^a	1 (20.0)
4. NCCs cannot be changed after signed? (True/False)	39 (50.0)	66 (41.3)	.213	1 (20.0)
5. NCCs are enforced if found reasonable by federal law? (True/False)	10 (12.8)	7 (4.4)	.719	0 (0)
6. NCCs are commonplace for CRNAs? (True/False)	27 (34.6)	44 (27.8)	.202	0 (0)
Total correct responses (%)	61.3	53.0	.007 ^a	23.3
Mean knowledge level	3.67	3.17	.007 ^a	1.4

Table 2. Number and Percent of Correct Responses for Each Knowledge Question

Abbreviations: CRNAs, Certified Registered Nurse Anesthetists; NCC, noncompetete clause; SRNAs, student registered nurse anesthetists.

^a Statistically significant difference ($P < .05$) between those in independent practice and in group practice.

approximately 30.2% ($n = 73$) of all CRNA respondents practiced with an NCC, whereas most practicing CRNAs (60.7%, $n = 147$) did not have an NCC. A total of 22 (9.1%) participants were uncertain whether they had an NCC in their employment contract. The majority of CRNA respondents worked in a group practice (67.6%, $n = 163$) compared with independent CRNAs (32.4%, $n = 78$). There was no significant difference between independent CRNAs and group-practice CRNAs and the frequency of NCCs ($\chi^2 = 3.55$, $P > .05$; Figure 1).

• **Knowledge.** In a comparison of the difference in knowledge levels between practicing CRNAs and student CRNAs, there was a higher average knowledge score of

the independent CRNA group (Table 2). Although there were higher numbers of respondents in the practicing CRNA group, the results showed a difference between total knowledge scores of practicing CRNAs and SRNAs using the Mann-Whitney U test with a P value of .006 ($P < .05$); however, this finding was unreliable because of the small sample size in the student group. Distributions of mean knowledge scores were assessed across the categories of practicing CRNAs ($n = 237$, 99.1%) with a mean total knowledge score of 3.36 and for SRNAs ($n = 5$, 0.9%) with a mean total knowledge score of 1.4. Practicing CRNAs answered correctly 56.2% of the time vs student nurse anesthetists who answered correctly

Experience	Independent CRNA No.; Mean (range)		Group-Practice CRNA No.; Mean (range)		P Value t Test
Geographic restriction of NCC (miles)	18; 26.7 (0-100)		38; 24.9 (0-60)		.832
Time restriction of NCC (months)	20; 20.8 (1-60)		39; 16.0 (0-60)		.111
	Yes ^a	No ^a	Yes ^a	No ^a	χ^2
Awareness of the provisions of the NCC	21 (95.5)	1 (4.5)	44 (88.0)	6 (12.0)	.427
Declined a position because of requirement to sign an NCC	17 (23.0)	57 (77.0)	16 (12.4)	113 (87.6)	.002 ^b
Changed a job because of the enforcement of NCC	4 (6.0)	63 (94.0)	3 (2.2)	133 (97.8)	.001 ^b
Loss of employment as a result of NCC	11 (14.3)	66 (85.7)	3 (2.0)	150 (98.0)	.001 ^b
Incidence of relocation	4 (33.3)	8 (66.7)	0 (0.0)	8 (100.0)	.117

Table 3. Experience of CRNAs Regarding the Noncompete Clause

Abbreviations: CRNA, Certified Registered Nurse Anesthetist; NCC, noncompete clause.

^a Data on bottom half of table are presented as number (percentage).

^b Significant at $P < .05$.

23.3% of the time. Practicing CRNAs did not have an answer to the knowledge questions 22.6% of the time, whereas students were unsure of the 6 knowledge questions 63.3% of the time.

Of the 241 practicing CRNAs, a significant difference in knowledge scores between the 2 groups of practicing CRNAs was found ($P = .007$; see Table 2). The mean knowledge score for the independent CRNAs was 3.67 (61.1% score where total knowledge score = 6) with an SD of 1.29. The mean knowledge score for the group-practice group was 3.17 (52.8% score) with an SD of 1.31. Those in independent practice had a higher knowledge score (61.1% vs 52.8%). There was a significant difference in the distribution of mean knowledge scores for independent and group-practice CRNAs as reflected by a P value of 0.007. Independent CRNAs answered all knowledge questions 61.3% of the time, whereas group-practice CRNAs answered all the knowledge questions 53.0% of the time. Independent CRNAs did not have an answer or were unaware for 30.8% of all knowledge questions vs 33.8% of group-practice CRNAs. Both groups fell below 60% for knowledge questions 4 through 6 pertaining to the changing of an NCC after it has been signed; how NCCs are found reasonable in a court of law; and if NCCs are, in fact, commonplace for nurse anesthetists. Only 17 practicing CRNAs of all 238 answered how NCCs are not found reasonable by federal law, while 30.8% of independent CRNAs and 33.8% of group-practice CRNAs were unsure how NCCs are found reasonable. More respondents from both groups answered incorrectly (31.6%) or did not know (37.2%) whether NCCs are common in nurse anesthesia practice.

• **Experience.** The Fisher exact, t test, and χ^2 tests were used to analyze the data for the experiences of CRNAs

regarding the NCC (Table 3). There was no difference between practicing in an independent or group setting and being aware of noncompete provisions ($P > .05$). The difference between independent and group CRNAs, the mean distance in miles for the geographic restriction, and the mean amount of time in months required in an NCC between the 2 groups was not found to be significant ($t = 0.22$ and 1.62 , $P > .05$). When specific experiences with NCCs were compared between the 2 groups, the results found that independent CRNAs had more incidents of declining positions ($\chi^2 = 12.01$, $P < .05$), changing a job after starting ($P < .05$), and loss of employment due to a noncompete clause ($P < .05$). There was no difference between independent and group-practice CRNAs regarding the incidence of relocation resulting from loss of employment due to the enforcement of an NCC ($P > .05$).

• **Perception.** Figure 2 demonstrates the perceptions of CRNAs and SRNAs for the survey question, “In your opinion, why do CRNAs typically *not* negotiate or decline provisions such as NCCs in their current contract or future contract agreements?” The respondent answers were the same for each segment of the question: very likely, somewhat likely, neutral, slightly likely, and not likely. Half of respondents (50%) reported “lack of knowledge” being the reason that CRNAs do not negotiate or decline provisions such as NCCs as well as “fear of standing out negatively” (36.4%), “fear of damaging working relationships in the anesthesia community” (33.6%), “physician opposition” (28.4%), and “potential of lost income” (52.8%) being the most considerable. There was no difference between independent and group-setting CRNAs and the perceived applicability of the NCC to nurse anesthesia practice ($P = 0.234$) using the χ^2 test. Although 36.9% of respondents ($n = 87$)

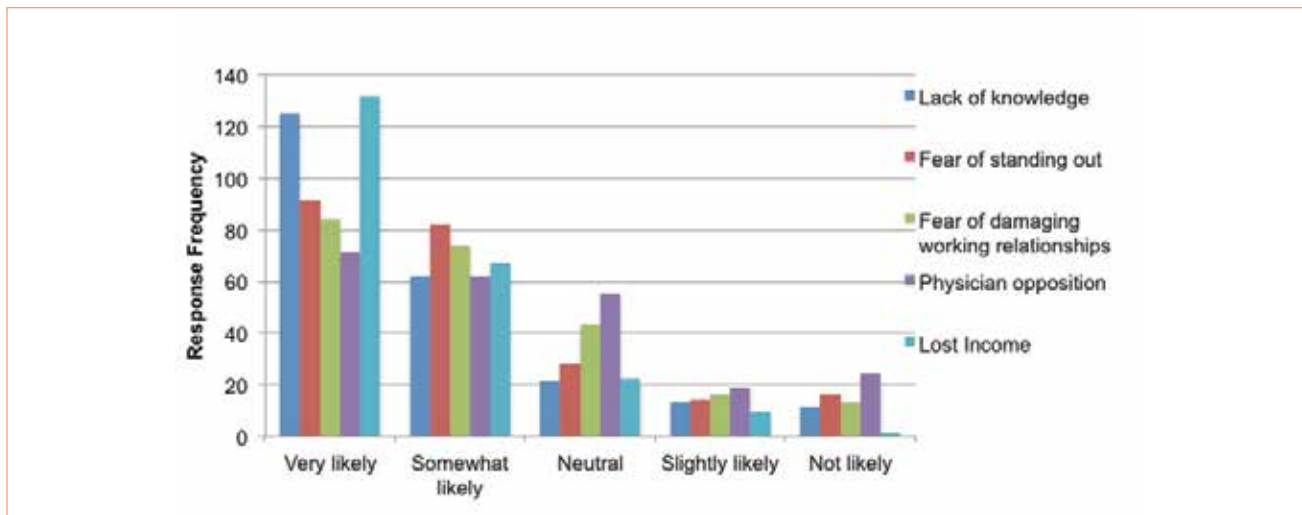


Figure 2. Reasons Why CRNAs Do Not Negotiate or Decline Provisions Such as Noncompete Clauses
 Abbreviations: CRNAs, Certified Registered Nurse Anesthetists; NCCs, noncompete clauses.

believed that the NCC was not applicable to nurse anesthesia practice, 29.7% (n = 70) responded by having no opinion at all to the applicability of the NCC.

Discussion

This study demonstrates a substantial knowledge gap in the nurse anesthesia community surrounding the NCC. Graduating nurse anesthetists who enter the healthcare market may be at a disadvantage because of the low levels of awareness concerning such provisions. Certified Registered Nurse Anesthetists who lack awareness and knowledge about the NCC may be placing themselves in adverse employment situations that may lead to geographic and time limitations for future employment and may increase potential job loss. With further changes seen with the Affordable Care Act and the impact on all practicing CRNAs, this could be unfavorable on the future abilities of CRNAs to successfully advocate for themselves and their profession to best meet the needs of the population they serve.

Predominately, NCCs have been used in physician contracts to protect proprietary knowledge, safeguard business interests, and shield referral/patient bases from competition. Nurse anesthetists are practical clinicians in a specific discipline void of the ability to establish patient referral bases or share trade secrets. Consequently, CRNAs have been penalized because of the enforcements of equivalent provisions in employee contracts that are not applicable to the profession. As healthcare organizations seek financial leverage, CRNAs are subjected to complex, restrictive provisions designed to protect the business interests of the former employer. Noncompete clauses are enforceable only if the former CRNA contract holders are genuine competitors and are unlikely to be enforceable if determined as overly broad. It is imperative to ascertain the reasonableness of the NCC and times

when it is used as an economic weapon in unfair business practices.

Historically, the potential competitive relationship between CRNA and anesthesiologist proves to be yet another aspect for the nurse anesthetist to be informed on current payment and reimbursement regulations that affect employee relationships where contractual interactions exist. In addition, emphasis should also be placed on CRNA services in rural areas where access to care is compromised and anesthesiologists' presence is reduced. In geographic areas where CRNA demand is high, CRNAs must be well informed to contract with employers and hospitals. The data from this study indicate that the NCC functions as an aspect of business practice that necessitates vocal and political presence.

One limitation to this study is the small number of SRNAs who responded to the electronic survey. Students may have been reluctant to answer if they believed that they could be penalized for giving their real opinion or may not have wished to reveal what they know or do not know on the subject. Another limitation noted during the data analysis was the number of respondents who skipped answers, which may have indicated respondent fatigue. This study was conducted using a researcher-designed questionnaire, and it was difficult to ascertain the respondents' level of understanding of the questions. Additionally, it was difficult to examine complex issues and opinions of the study's participants, such as perception, given the use of open-ended questions that can lack the ability to interpret the depth of detail.

There are many opportunities for CRNA educators and nurse anesthesia educational programs to incorporate the legal concepts of contractual obligations to the professional aspects of anesthesia education curriculum. The results from this study demonstrate a need for SRNAs and CRNAs to understand the importance of the NCC and

its effects on employment and hiring decisions. It is also apparent that practicing CRNAs need access to tools and resources concerning complex contractual guidelines. Leadership in the nurse anesthesia community is needed for additional education in the area of NCCs and the implications that surround them.

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DISCLOSURES

The authors have declared no financial relationships with any commercial interest related to the content of this activity. The authors did not discuss off-label use within the article.

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