



Restrictive Covenants and Non-Compete Clauses for Physicians: A Review and Analysis

**American College of Cardiology Board of
Governors Work Group on Restrictive
Covenants**

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ACC Board of Governors Work Group on Restrictive Covenants 2021-22

J. Jeffrey Marshall, MD, FACC, Work Group Chair; Governor for Georgia

Frank Ryan, JD; Senior Advisor, ACC State Government Affairs

Joseph E. Marine, MD, MBA, FACC, Chair ACC BOG

Mahi Ashwath, MD, FACC; Governor for Iowa

James M. Daniel, JD, MBA; Partner, Hancock Daniel

John Jefferies, MD, FACC ; Governor for Tennessee

Srihari Naidu, MD, FACC ; Governor for New York (Downstate)

Gautam Nayak, MD, FACC; Governor for Washington

Arthur Reitman, MD, FACC; Governor-elect for Georgia

Stephen Smalley, MD, FACC; Governor for Minnesota

Gabriel E. Soto, MD, FACC; Governor-elect for Missouri

Jonathan M. Sumrell, JD; Partner, Hancock Daniel

Andrew Waxler, MD, FACC; Governor for Pennsylvania (Eastern)

I. Introduction

The American College of Cardiology (ACC) Board of Governors (BOG) began hearing concerns from many Fellows of the ACC (FACCs) regarding the restrictive covenants in their contracts. In response to these grassroots concerns, the Chair of the BOG established a workgroup in spring of 2021 to investigate the changing landscape of restrictive covenants and non-compete clauses. His charge to the subcommittee was to define the legal basis of restrictive covenants, establish the current status of restrictive covenants in individual states, to evaluate reasons to retain restrictive covenants, and discuss reasons to limit or reduce restrictive covenants. The workgroup designed and administered a survey to the BOG and MedAxiom physician leaders listserv to gauge broader interest and opinions on this topic. Finally, the last goal was to produce a white paper to be presented to the Health Affairs Committee (HAC) of the ACC for consideration as a formal answer to these grassroots requests for assistance from those we serve, our ACC members. This white paper serves as a report from the BOG to the HAC on this subject and does not constitute official ACC policy.

II. Background

In 2008, a MedAxiom survey (Fig. 1) of practicing cardiologists revealed that 10% were in integrated/employed models of practice with the vast majority, 90%, in private practice. Ten years later, the proportion of employed versus in private practice had completely flipped (84% integrated/employed; 16% private practice).¹

This dramatic reduction in the proportion of cardiologists in independent private practice versus in employed and integrated models of employment did not happen spontaneously. One of the catalysts for this trend was the imaging reimbursement cuts in the 2005 Budget Reconciliation Act, which took effect in 2008. The reductions in imaging reimbursement for non-invasive

cardiovascular studies in the office-based setting, compared to hospital-based reimbursements, were dramatic since hospital-based testing was not reduced by the 2005 legislation. A second

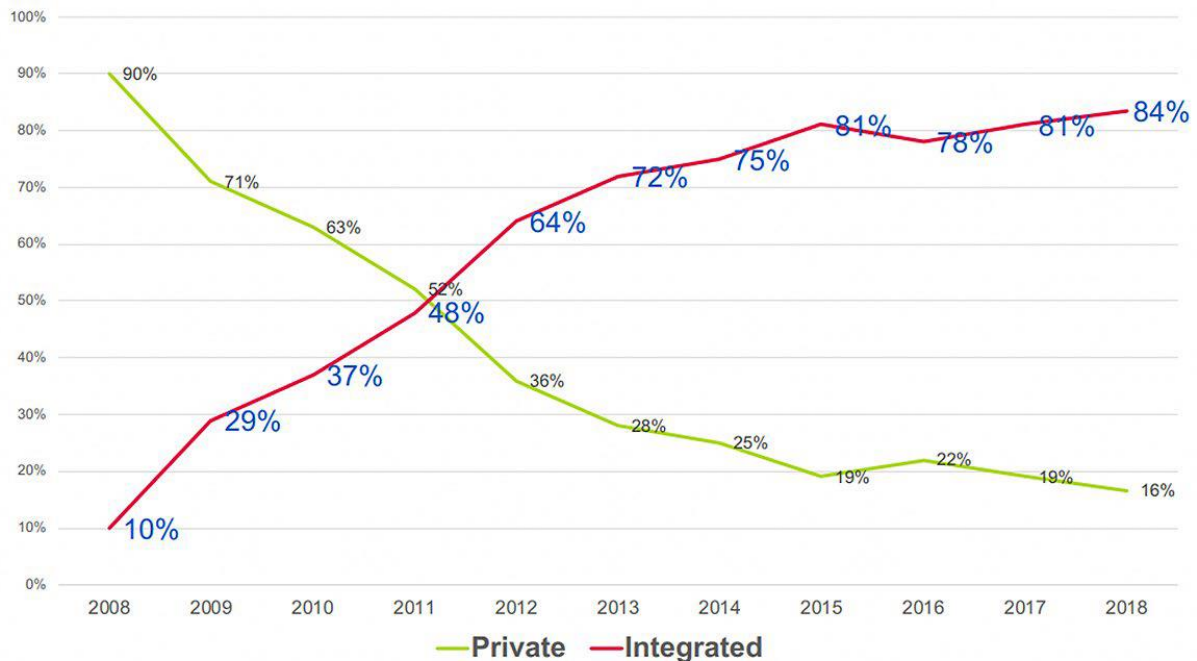


Figure 1. Percentage of Cardiologists in Private- vs Integrated-Practice from 2008-2018

governmental force occurred almost simultaneously when the Center for Medicare and Medicaid services (CMS) eliminated codes for consultative services, codes frequently used by specialists including cardiologists, which were replaced with evaluation and management codes (E&M) that were reimbursed at a much lower rate. These two governmental reimbursement changes resulted in a substantial reduction in cardiologists' reimbursement for office-based evaluation and testing. In 2008, when the legislation was implemented, the differences in reimbursement, along with other non-fiscal issues, drove private practice cardiologist into employed/integrated models to avoid staff reductions, prevent curtailment of services to their patients, and to preserve work-life balance while attempting to maintain prior levels of compensation. In many

instances, private physician groups felt forced either to compete with large healthcare systems or to integrate with them.

When physicians are employed, the employer (whether a health system or independent practice) may utilize contractual non-compete clauses to protect their legitimate business interests. Additionally, to comply with anti-inurement (Stark) requirements, physician employment contracts are usually evaluated by third-party fair market evaluation firms. These third-party, fair market valuations ensure that physician compensation is not determined in any manner that takes volume of referrals into account. One technique for preserving or increasing the value of an employed physician to a given practice is to have a more restrictive non-compete covenant. More restrictive non-compete covenants, with larger radii and longer terms, further limit a physician's ability to leave the hospital systems for competing hospitals or independent practices. This encumbrance on the physician has value and can be reassuring for the health system employer. These more restrictive non-compete covenants may therefore be translated into a higher value for the physician contract.

However, restrictive covenants have other, unintended consequences. As healthcare systems grow and consolidate smaller hospitals into larger and larger healthcare organizations, non-compete clauses have become increasingly restrictive for several reasons. The mileage radius from the initial, small hospital systems grows larger as hospitals cover more geography by acquisition of new locations. So, what may have been a 10-mile radius from a single health system or clinic site could rapidly become multiple 10-mile radii from all system locations covering large portions of entire states or regions.

Another factor that has stimulated new discussion regarding non-compete clauses is the growth of healthcare systems into oligopolies. It is estimated that the top 6 healthcare systems in the United States now cover almost 1/3 of the US population. This rapid growth of the largest healthcare systems has attracted the attention of the federal government. The Federal Trade

Commission (FTC) held a workshop on January 9, 2020, entitled "Non-competes in the workplace: Examining antitrust and consumer protection issues"². This was followed on July 9, 2021, with an Executive Order from President Biden on "Promoting Competition in the American Economy"³. The Executive Order has many directives, one of which was to encourage the FTC to examine unfair use of non-compete clauses. After debate and open comments from the AMA⁴, the ACC⁵, and others, it now appears unlikely that the FTC will take any near-term action on physician non-competes. However, these market-based and governmental changes in policy have stimulated healthy debate about the fairness of physician non-competes. FACCs around the country have contacted the BOG with their concerns and the BOG has initiated significant study into non-competes in the Work Group and this White Paper.

This White Paper reviews the following topics: 1) the legal perspectives on restrictive covenants, 2) the current status of restrictive covenants in individual states, 3) reasons to retain restrictive covenants 4) arguments in favor of eliminating or limiting restrictive covenants, and 5) results of BOG and MedAxiom physician member surveys.

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2. Fed. Trade Comm'n, *Non-Competes in the Workplace: Examining Antitrust and Consumer Protection Issues* (Jan. 9, 2020, 8:30 AM). <https://www.ftc.gov/news-events/events-calendar/non-competes-workplace-examining-antitrust-consumer-protection-issues>.
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III. Legal Perspectives on Restrictive Covenants

To anticipate the future legal landscape for restrictive covenants, it is useful to review the evolution of this area of law in the shared jurisprudence of England and the United States. The legality and enforceability of restrictive covenants has shifted significantly through the years. English judges deemed restrictive covenants invalid in the Middle Ages because they were perceived as causing “undue personal hardship and public injury.”¹ However, this outright prohibition eventually gave way to an exception in the early eighteenth century. English courts held that restraints on trade, such as a restrictive covenant, may be enforceable if they were *reasonable*.² This concept was eventually imported to the United States, where it is applied in some form in most states.³

The federal government has largely left questions of restrictive covenant enforceability to the states. As a result, there is a patchwork of parallel, though distinct, state laws addressing whether a restrictive covenant is reasonable and enforceable. These laws are often the product of common law established by previous court decisions. But there is also a growing number of states that have seen their legislatures pass measures that set the parameters of enforceable restrictive covenants.⁴ Some states (e.g., Alabama and South Dakota) have even adopted legislation specifically addressing the enforceability of physician restrictive covenants.⁵

¹ D. Loeser, *The Legal, Ethical, and Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign*, 31 J.L. MED. & ETHICS 283, 283-84 (2003) (citing M. Handler and D.E. Lazaroff, *Restraint of Trade and the Restatement (Second) of Contracts*, 57 N.Y.U. L. Rev. 669, 721 (1982)).

² *Id.*

³ *See, e.g., Lawrence v. Kidder & Sweet*, 10 Barb. 641, 647 (1851). One outlier is California, which prohibits restrictive covenants in all but a narrow set of situations. CAL. BUS. & PROF. CODE § 16600.

⁴ *See, e.g.,* ARK. CODE ANN. § 4-75-101 (providing guidelines for covenants not to compete but exempting from this law individuals holding a professional license, including physicians); NEV. REV. STAT. ANN. § 613.195 (specifying limitations on noncompetition covenants); VA. CODE ANN. § 40.1-28.7:8 (prohibiting covenants not to compete for low-wage employees).

⁵ *See, e.g.,* ALA. CODE § 8-1-196 (prohibiting restrictive covenants against professionals including physicians); COLO. REV. STAT. § 8-2-113 (prohibiting physician non-compete covenants in any employment, partnership, or

Whether the applicable law is based on statutes passed by the state legislature or common law developed by courts, the reasonableness of restrictive covenants is generally evaluated based on three prongs: the length of the restriction, the area restricted, and the line of business restricted.⁶ Some states also include consideration of the effect of the covenant on the public interest or public policy.⁷ Although most states have utilized this rough framework, there is significant variation among the states in the outcomes of this analysis.

States differ in the length of a restriction that is reasonable and enforceable generally. However, some states only apply these limitations for medicine or other professional occupations. For example, Utah prohibits non-competes for *any* employees that span more than one year.⁸ However, Connecticut has adopted a one-year limitation on non-competes for physicians but has set no bright line standard for the length of a reasonable restrictive covenant for most other professions.⁹ Similarly, Tennessee looks to its court-developed common law to determine if a restrictive covenant should be enforced for most occupations but has a two (2) year cap on non-competes for physicians, dentists, and other healthcare providers.¹⁰

For many states, an enforceable geographic scope will often depend on the footprint of the employer and the area serviced by the employee.¹¹ Other states provide specific

corporate agreement between physicians, but not prohibiting damage provisions relating to competition); S.D. CODIFIED LAWS § 53-9-11.1 (prohibiting restricting the right of health care providers, including physicians, to practice although this prohibition does not apply to a contract in connection with the sale and purchase of a practice).

⁶ See 62 A.L.R.3d 1014, at *2.

⁷ *Home Paramount Pest Control Cos. v. Shaffer*, 282 Va. 412, 415-16, 718 S.E.2d 762, 763-64 (2011).

⁸ UTAH CODE ANN. § 34-51-201.

⁹ CONN. GEN. STAT. § 20-14p(b)(2); *United Rentals, Inc. v. Frey*, 2011 U.S. Dist. LEXIS 16375, at *17 (D. Conn. Feb. 17, 2011).

¹⁰ TENN. CODE ANN. § 63-1-148; *Dominion Enters. v. Dataium, LLC*, 2013 Tenn. App. LEXIS 840, at *1 (Ct. App. Dec. 27, 2013).

¹¹ *Hopper v. All Pet Animal Clinic*, 861 P.2d 531, 544 (Wyo. 1993) (“Reasonable geographic restraints are generally limited to the area in which the former employee actually worked or from which clients were drawn.”); *Wood v.*

geographic limits that are permissible—particularly when the covenant seeks to limit the practice of physicians.¹²

As to the third common consideration, the line of business restricted, some states apply what is occasionally referred to as the “janitor rule.” This rule considers a restrictive covenant unreasonable if it prohibits an individual from working for a competing firm in *any* capacity, rather than the capacity in which the individual actually worked for their prior employer.¹³ As an example, a cardiology practice in a state applying the janitor rule may be able to restrict its physicians from working as a cardiologist at a competing practice, but a non-compete that seeks to prevent the physicians from working at the competitor in any capacity would likely be found overbroad.

Finally, courts gauging the reasonableness of restrictive covenants often look closely at the effect on the public interest of enforcing the provisions. For example, Arizona courts have held that covenants not to compete regarding physicians should be strictly construed for reasonableness because such restrictive agreements are not in the public interest.¹⁴

The states have also diverged on the consequences for the employer in the event of a finding that a restrictive covenant is unreasonable. Judges in many states are empowered to “blue pencil” overbroad restrictive covenants. In these states, judges may modify the offending covenant to render it reasonable.¹⁵ Even among these “blue pencil” states, the scope of the

May, 73 Wash. 2d 307, 313, 438 P.2d 587, 591 (1968) (noting that there is good reason not to enforce a non-compete when an employer whose business and good will do not extend beyond the city limits of a specific locality requires an employee to promise not to open a competing business anywhere within the entire state).

¹² See, e.g., CONN. GEN. STAT. § 20-14p(b)(2) (limiting physician non-compete agreements to a geographic region of fifteen (15) miles from the primary site where the physician practices); W. VA. CODE § 47-11E-2 (allowing physician covenants not to compete if the contract is limited to not more than thirty (30) miles from the physician’s primary place of practice with the employer).

¹³ *Medix Staffing Sols., Inc. v. Dumrauf*, 2018 U.S. Dist. LEXIS 64813, at *6-7 (N.D. Ill. Apr. 17, 2018).

¹⁴ *Valley Med. Specialists v. Farber*, 194 Ariz. 363, 367, 982 P.2d 1277, 1281 (1999).

¹⁵ See, e.g., IDAHO CODE § 44-2703; *Hess v. Gebhard & Co.*, 570 Pa. 148, 162, 808 A.2d 912, 920 (2002).

court's authority to change the terms of the restrictive covenant can vary widely. For states that do not blue pencil restrictive covenants, courts often simply will decline to enforce a restrictive covenant found to be unreasonable.¹⁶

State law relating to restrictive covenants continues to evolve. But to the extent a trend is discernible, policymakers are becoming more skeptical of these restrictions. The number of states banning non-competes for lower wage workers has sharply increased in recent years.¹⁷ In 2020, the District of Columbia passed legislation banning non-competes altogether. D.C. Code § 32-581.02.

Additionally, in early 2016, a court in Rhode Island considered a case for injunctive relief brought by a health care facility against a physician who had violated his non-compete agreement. The court declined to grant injunctive relief noting that strong public interest in allowing individuals to retain health care providers of their choice outweighed the professional benefits derived from a restrictive covenant but allowed the health care facility leave to seek compensation for its injuries.¹⁸ Later that same year, Rhode Island passed legislation prohibiting restrictive covenants for physicians except with regard to the sale and purchase of a physician practice.¹⁹

In addition to recent legislative interest in restrictive covenants, there has been some indications of disfavor of the restrictions by state executive agencies. For example, in 2021 an

¹⁶ See, e.g., *H & R Block Tax Servs. v. Circle A Enters.*, 269 Neb. 411, 416-17, 603 N.W.2d 548, 552-53 (2005); *Star Direct Inc. v. Dal Pra*, 319 Wis. 2d 274, 767 N.W.2d 898 (2009).

¹⁷ See, e.g., MD. CODE ANN., LAB. & EMPL. § 3-716 (effective in 2019, prohibits non-competes for employees earning less than or equal to \$15 per hour); OR. REV. STAT. ANN. § 653.295 (effective in 2020, prohibits non-competes for employees earning less than or equal to median family income for a four person family); WASH. REV. CODE §§ 49.62.005–900 (effective in 2020, prohibits non-competes for employees earning less than or equal to \$100,000 per year).

¹⁸ *Med. & Long Term Care Assocs., LLC v. Khurshid*, No. PC-2015-0458, 2016 R.I. Super. LEXIS 39, at *6 (Super. Ct. Mar. 29, 2016).

¹⁹ R.I. GEN. LAWS § 5-37-33.

anesthesia group in Washington State entered an antitrust consent order with the State after an investigation into the group's non-compete agreements and the group's alleged "illegal dominance" of the health care market in the area.²⁰ The group was effectively the exclusive provider of anesthesia services in its service area. Prior to a change in Washington's laws limiting an employer's use of non-compete agreements, the group had required three (3)-year non-competes for all doctors, whether employed or a shareholder. After the enactment of the State's non-compete law, which instructed courts to presume a covenant not to compete exceeding eighteen (18) months after termination of employment was unreasonable and unenforceable, the group reduced the restriction to eighteen (18) months for employed doctors but not shareholders. The consent order required the group to modify existing non-competes to include a term no longer than nine (9) months for employed physicians and twelve (12) months for shareholders.²¹ The group was also required to pay the State \$110,000 in costs and fees.

Perhaps most unexpected is the Biden Administration's decision to take unprecedented action in the area of restrictive covenants. The Administration has adopted an aggressive enforcement posture with respect to health care antitrust issues in general and non-compete agreements in particular. Indeed, the Administration's stance with respect to non-compete agreements suggests that the federal antitrust enforcement agencies may adopt new rules prohibiting non-compete agreements or initiate antitrust enforcement actions targeting non-compete agreements. President Biden's July 2021 executive order to promote competition in the American economy encouraged the Federal Trade Commission (FTC) to exercise its statutory rulemaking authority "to curtail the unfair use of non-compete clauses and other

²⁰ WASH. STATE, OFFICE OF ATTY. GEN., BELLINGHAM MEDICAL PROVIDERS MUST END ILLEGAL NON-COMPETE CONTRACTS, PAY \$110K AS A RESULT OF AG FERGUSON CONSENT DECREE (Aug. 26, 2021), <https://www.atg.wa.gov/news/news-releases/bellingham-medical-providers-must-end-illegal-non-compete-contracts-pay-110k>.

²¹ *State of Washington v. Bellingham Anesthesia Associates, P.S.*, No. 21-2-00882-37 (Wash. Ct. Aug. 25, 2021).

clauses or agreements that may unfairly limit worker mobility.”²² The press release announcing the executive order was even more blunt and indicated that the FTC should ban or limit employee non-compete arrangements.²³ As a result, the FTC and Antitrust Division of the U.S. Department of Justice are likely to scrutinize and potentially challenge non-compete agreements or other restrictive covenants limiting worker mobility that come to their attention. While a federal ban on restrictive covenants is unlikely anytime soon, health care entities and their employees, as well as medical professional societies should monitor this continually evolving area of the law.

Current state of Restrictive Covenants (see Appendix 1 for table of State by State comparisons)

Restrictive covenants and non-compete clauses are currently governed solely by State laws. The current state of restrictive covenants is variable across the country. Few states have significant restriction on using restrictive covenants, but most states have some restrictions on them. Most of the reasons raised about the need to have restrictive covenants include loss of trade secrets and patient loss and are designed to protect the legitimate interests of the employer. In some States healthcare non-compete statutes define the law while others are demarcated by the legal decisions of cases tried.

Restrictive covenants tied solely to employment are generally not permitted by statute in a few states like North Dakota, Oklahoma and California.

²² THE WHITE HOUSE, EXECUTIVE ORDER ON PROMOTING COMPETITION IN THE AMERICAN ECONOMY § 5(g) (July 9, 2021), <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/>.

²³ THE WHITE HOUSE, FACT SHEET: EXECUTIVE ORDER ON PROMOTING COMPETITION IN THE AMERICAN ECONOMY (July 9, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/07/09/fact-sheet-executive-order-on-promoting-competition-in-the-american-economy/>.

There is significant restriction by statute for physician non-competes in other states like Alabama, Illinois, Massachusetts, New Hampshire, and Rhode Island. There is limited restriction for non-competes in other states like Arizona (must be based on a legitimate protectable business interest and must not be outweighed by the patient's interest in seeing the doctor), Colorado (damages not barred (require the payment of damages in an amount "reasonably related to the injury suffered")), Connecticut, Delaware (require payment of damages related to competition), Florida (explained in more detail below), Idaho (non-key employees cannot be restricted, and covenants must not be more restrictive than necessary to protect a legitimate business interest), New Mexico (no non-compete for clinical health care services. However, it does not apply to a covered medical professional if shareholder/ owner/ partner/ director of a health care practice. It also allows the recovery of relocation expenses and signing bonuses, authorizes the enforcement of non-solicitation provisions and allows the recovery of reasonable liquidated damages). Courts in North Carolina (addressing restrictive covenants for physicians in underserved areas), Tennessee, and Texas have restriction in certain circumstances.

Many states have established laws relating to non-competes that are not specific to physicians or healthcare providers. These states include, but are not limited to: Louisiana, Mississippi, Missouri, North Carolina, Virginia, Washington, and Utah. Each state has a number of nuanced requirements, exemptions, provisions and case law. A few of these subtleties are highlighted below.

In Louisiana non-competes are disfavored and cannot be for more than 2 years. In Mississippi, "reasonable" non-competes in some cases have been found enforceable for up to 5 years with a five-mile radius for general practitioners. More recently this decision was called into question in *Field v. Wayne T. Lamar, M.D., P.A.*, 822 so. 2d 893, 899-900 (Miss. 2002) with urgings that Mississippi exempt non-competes as is the case for attorneys. In Missouri, a non-compete of

up to 50 miles for 1 year was not ruled as overly broad. *Washington Cty. Mem'l Hosp. v. Sidebotton*, 7S.W.3d 542, 546 (Mo. Ct. App. 1999). In North Carolina, courts are reluctant to enforce non-competes if the court determines it harms the public. This decision considered the shortage of specialists in the field, the impact of establishing a monopoly on fees, lack of availability of a physician in an emergency, and the public ability to have physician choice. *Calhoun v. WHA Med. Clinic, PLLC*, 632 S.E.2d 563, 572 (N.C. Ct. App. 2006). In Virginia, "reasonable" non-competes are generally enforceable. In Washington, reasonable physician non-competes may be enforced depending on the facts. *Emerick v. Cardiac Study Ctr., Inc., P.S.*, 357 P.3d 696, 705 (Wash. Ct. App. 2015). In Utah, beginning May 10, 2016, the general non-compete limits the provision for no longer than one year after the employee is terminated.

Alabama, Massachusetts, Tennessee, Texas, and West Virginia have statutes specifically for physicians. In Alabama, there are no non-competes for physicians and the same is true for attorneys. In Tennessee, emergency room physicians are exempt from non-competes and all other non-competes have a 2-year term and a radius tied to specific mileage or the county of practice by statute. In Texas, non-competes are enforceable but must allow physicians access to a list of their patients seen within the last year, must provide copies of medical records for a reasonable fee, and must provide for a buy-out option agreeable to both parties. Additionally, "the covenant must provide that the physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during the course of an acute illness even after the contract or employment has been terminated." Tex. Bus. & Com. Code Ann. § 15.50(b)(3). In West Virginia, contracts entered into or renewed on or after July 1, 2017, must be limited to one year and 30 road miles from the physician's primary place of practice by the employer.

Similar to the above 3 States, Florida has specific laws for physicians but only in circumstances where monopolies control specialists in an entire county. In counties where all physicians, in a specific medical specialty, work for the same healthcare entity or its affiliates and there are no competing entities hiring that specific medical specialty, restrictive covenants/non-competes, are void. This applies to new non-competes as well as existing ones under these specific “monopoly” circumstances. Three years after a new, second entity comes into a county and hires specific medical specialists, where previously only one entity had those specific medical specialists, then non-competes become enforceable. Fla. Stat. § 542.336.

In Georgia, Kentucky, and South Carolina there are no statutes that govern physician non-competes, only legal precedents. In Georgia, restrictive covenants are permitted “so long as such restrictions are reasonable in time, geographic area, and scope of prohibited activities.” O.C.G.A. § 13-8-53(a). Specifically, Georgia allows for a time period of 2 years or less. O.C.G.A. § 13-8-53(c)(2). Courts in Kentucky may enforce physician non-competes when they are reasonable in scope and purpose. For example, a Kentucky court of appeals upheld a physician non-compete that extended 1 year for a 50-mile radius. *Hall v. Willard & Woolsey, P. S. C.*, 471 S.W.2d 316 (Ky. 1971). In South Carolina, courts may enforce physician non-competes requiring repayments or forfeiture for violation of provisions in one case of a cardiologist for one year and a 20-mile radius. *Baugh v. Columbia Heart Clinic, P.A.*, 738 S.E.2d 480 (S.C. Ct. App. 2013).

IV. Reasons to Retain Restrictive Covenants

Why Cardiologists May Benefit from Restrictive Covenants

Restrictive covenants (RC's) impose limitations upon cardiologists as a way to protect the legitimate business interests of the employer and are common in a variety of industries. Under the right circumstances, non-compete clauses may serve a rational purpose and can serve a legitimate role for physicians⁵. Cardiologists in healthcare systems may wish to ensure that their group is protected, and that new or established partners don't break away and start their own group, thereby harming the established group and drawing referrals outside the system. Similarly, a large cardiology group contracted to a hospital would not want members of their group spinning off and starting another group, potentially harming the contract agreements already in place with a health system and raising the prospect of competing within the same system. Cardiologists in established independent groups, wishing to protect themselves from partners that may break off and use the established reputation of their group to enhance their own prospects, also seem to have a legitimate interest to protect.

Summary of Why Restrictive Covenants May Be Important for Cardiologists:

1. Protect the Clinical Practice and Allow for Expansion: Spin off groups may take patients, new referrals or hospital contracts away from the cardiologists who have worked to establish the group over the years, even if employed. This creates new challenges to the cardiologists who choose not to leave, or who may be looking to join a group. With the assurance that physician employees will not leave and take a portion of the employer's patient base, employers can freely expand their medical practices (and assist physician employees in doing the same), with the knowledge and comfort that their investment in such expansion is contractually protected from future competition by current employees. Hospitals and health systems in particular may be more willing to

invest in new services or technologies (e.g., building and equipping a new EP Lab) knowing that the capital and personnel investments are protected Non-competes may thus improve access and potentially better align long-term financial and career incentives⁶.

2. Protect the Business: A practice might have developed proprietary business techniques, such as billing or payment methods, or clinical capabilities, such as structural heart, that it wants to protect from use or disclosure if the physician goes elsewhere to compete against them in their service area, especially if the physician has been involved in managing the practice⁶.
3. Foster Training and Mentorship: A practice might wish to protect its investment in the professional training it provides, especially to physicians hired directly out of fellowship with little or no prior experience in a private practice⁶ or in specific healthcare systems.

Additional Points to Consider

The American Medical Association's (AMA's) Code of Medical Ethics disfavors non-compete agreements, stating that they restrict competition, disrupt continuity of care, and potentially deprive the public of access to medical care. The AMA does not state that non-compete agreements are per se unethical, but instead concludes that they are unethical if they "fail to make reasonable accommodation of patients' choice of physician."

Even where states have no broad rules governing enforcement of physician non-competes, the same factors may weigh in a public policy analysis in the overall determination of whether an individual restriction is reasonable. Such factors might include: (1) whether enforcement of the restriction will create an effective monopoly on medical services (either with respect to the area of specialty or the provision of healthcare services generally) within the restricted area; (2) whether the restriction would prevent the area from having a physician available at all times to

handle medical emergencies; (3) whether patients will be able to continue a course of treatment without disruption; (4) whether the physician's termination was caused by the employer or by the physician; (5) whether the employer seeks to gain an unfair competitive advantage by enforcement of the restriction; and (6) whether employment opportunities for the physician exist outside the restricted area⁶

We also need to consider the changing landscape of cardiology practice, and the possibility that the pendulum will shift back away from the employed setting. There is little to suggest that employed cardiologists are happier, have more career satisfaction or are better served than private practice or self-employed cardiologists. Burn out is currently at an all-time high and employed cardiologists are not necessarily just allowed to focus on clinical practice, receiving system leadership roles, or have the type of job security they were promised. The role of the hospital as the center of the health care delivery system is also changing. While inpatient activity still gets much attention, health care is now much more of an ambulatory industry where patient care is mostly handled outside the walls of the hospital, sometimes in nontraditional settings or ways⁷. This trend could easily change the paradigm for how restrictive covenants are perceived at the individual physician level and within groups or systems.

In general, arguing for restrictive covenants in cardiology contracts is a tough hill to climb, though understanding how they might be interpreted by specific ACC members and the cardiology community at large is important. Putting the patient first will guide us as we look to better understand this issue, especially as it pertains to access. Underserved regions, for example, may be significantly impacted if excessive restrictive covenants are enforced, and having a roadmap for members depending on their practice and circumstances may be extremely helpful. Given the diversity in state legislation on restrictive covenants, broad approaches to this issue with tailored resources to guide members may be helpful as a starting

point, with an eye towards creating national standards through appropriate legislative mechanisms.

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V. Arguments in Favor of Eliminating or Limiting Restrictive Covenants

The quadruple aim of medicine is a paradigm in which our health systems strive to provide high quality individual care, improve population health, lower costs, and foster clinician wellness.

This section will examine the negative sequelae of restrictive covenants, designed unilaterally to *protect employer financial loss*, atop a background of a quadruple aim paradigm. Additionally, we articulate the physicians' lost opportunity cost, (at a steeply discounted rate) when a restrictive covenant is enforced. How quadruple aim domains are impacted by a non-compete is essential for physicians, employers, lawmakers, and the legal system. To avoid a myopic view of the employers' fiduciary perspective, we must ascertain a more global understanding of the covenant consequence on the healthcare system; we assume the intent is just and reasonable treatment.

The Restrictive Covenant Target: Limit Employer Financial Loss with Employee Departure

Unfortunately, there is often no direct calculation (or even an equation) to enumerate an actual dollar loss attributable to physician employee departure (at the outset of the contract negotiation, or often at any point). The lack of an understandable dollar amount makes it difficult for any party to understand what fair and reasonable assessment of economic damages would be when creating or enforcing a restrictive covenant. In fact, hospitals may report losing money on their employed physicians because physicians' compensation, plus practice expenses and corporate overhead, significantly exceed the professional collections of the practices. These direct losses are, to a degree, a byproduct of selective accounting practices because hospitals frequently do not attribute any of the "downstream" or associated revenue to employed physician practice income(1).

Financial Stake Holders Considerations Beyond the Employer-Physicians and Government

Health care systems as employers are not the only investors in physician practices. The government invests billions of dollars annually to train physicians. Fifteen billion dollars of graduate medical education was financed by CMS in 2018. In exchange for GME dollars, the government expectation is that physicians provide healthcare for a community at large as well as the individual. Of note, these dollars do not come with an attached restrictive covenant. On an individual physician basis, the average medical school debt is currently \$200,000 – 230,000. Cardiologists would be expected to have similar personal debt, incurred lost income relative to peers (opportunity cost) typically graduating at 32 years of age with training stipends, and delayed contribution to retirement savings. Unlike business expenses, these costs cannot be deducted, depreciated, or distributed.

The financial loss of employment termination to the physician with forced relocation due to a restrictive covenant is amplified when considering not only the immediate loss of revenue but ongoing loss due to school debt service, mortgage loan service (which early in the loan may be entirely interest payments with no equity), and realtor and moving fees. Additional nonmonetary hardships include stress of family relocation and potentially arduous licensing processes and credentialing. As opposed to the large business interests that can distribute and deduct losses, the physician and family/partners will bear a very tangible individual loss.

Why Physicians May Agree to Restrictive Covenants.

Restrictive covenants have, in many instances, become nonnegotiable elements of contracts in mature markets, especially in those controlled by a few employers. This creates a “take it or leave it” approach without ability to negotiate either the geographic details (even more important

in large healthcare systems with wide geographic range and with the advent of remote/telehealth) or time duration of the non-compete. In addition, private practices are reluctant to enter into unique customized agreements with its members, and strongly prefer uniformity related to contractual terms. Generally, younger physicians lack the fiscal and legal resources to effectively challenge restrictive covenants, prospectively or retrospectively. The cost and time requirements to renegotiate restrictive covenants are likely prohibitive, especially when an individual physician is opposed by a fully resourced corporate, legal department. Of concern, successful removal of a non-compete may result in a physician being labeled “non-cooperative” and he or she may then become unwelcome within a future employer community that favors restrictive employee covenants. Alternatives to restrictive covenants do exist in the current marketplace. Some states prohibit restrictive covenants. Additionally, some practices chose to employ a “magnet culture” to attract and retain physicians rather than utilize legal captivation.

Negative Effects of Restrictive Covenants on Physician Wellness

Restrictive covenants may negatively impact competition for better working conditions by promoting an immobile or *captive workforce culture*. It is much easier to enforce clinically unattractive utilization policies and fail to fund or develop clinical programs when physicians have strong non-compete clauses as opposed to physicians who can freely leave and seek employment in systems with more favorable policies or work environments. Systems are under little to no obligation to evolve or renegotiate any portion of the non-compete, no matter how “unreasonable” they may be. The emergence of large multispecialty employed physician groups, which can number thousands of physicians in large national health systems, or hundreds of physicians in regional systems, offer little chance that a physician, group or geographic region can convince the physician organization to make any exceptions. Physicians can try to negotiate for compensation, more support, programmatic investment, or

other important considerations, but have no/limited recourse if these are not met sufficiently and equitably. This can be particularly distressing in systems with administrators who lack relevant clinical experience, training, or curiosity with no financial motivation to innovate. Therefore, physicians in a captive workforce culture, with highly encumbering restrictive covenants, may experience the *moral injury of tolerating lost autonomy versus the significant financial loss of relocation*. This can adversely affect career/family dynamics when physicians are not permitted to remain in a similar geographic location.

Philosophically, physicians should desire to work in their practice and restrictive covenants may force physicians who are disengaged to stay in their current practice, leading to a toxic/negative and less productive culture. Practices and hospitals should *foster retention* through innovation, positive and progressive culture and trust, *rather than a captivity culture* and restrictive covenants.

Restrictive Covenants and Potential Adverse Impact of Restrictive Covenants on Population Health

Access to affordable care is an important foundation for population health. Improved affordability comes from innovative care models. As an example, ambulatory surgical centers that lower cost may not be successful in communities with captive and immobile physician work forces. Physicians disadvantaged by highly limiting RCs may be restricted from ASCs due to competing financial interests of healthcare systems and independent ASCs. If physicians are not permitted to participate, due to their non-competes, then the value proposition of ASCs to the population is diminished.

Potential Adverse Impact of Restrictive Covenants on Patient Experience

Reduced patient access to diversity of caregivers can occur when a patient is unable to find the type of physician (race, gender, ethnicity, expertise or skill set, experience) that “looks like them”

or that they need or desire. If physicians from underrepresented minorities leave their group and they are subject to non-competes, then patients are forced to choose from the remaining physicians who were not necessarily their first choice for caregivers. Patients may select their physician based on clinical skill, acumen, ethnic and gender similarities, and other matters of personal preference. Accountability and outcomes, especially in complex or chronic patient care, are improved with strong longitudinal provider/patient relationship. Physicians who exit health systems with restrictive covenants may leave patients unable to access an established and trusted physician, resulting in loss of care continuity, fragmented care, costly reestablishment with other provider(s), and potentially inability to access clinicians of similar quality. Patients may also suffer due to *system resistance to innovation* fostered by *captive work* culture that may stifle the healthy competition required to spark change in health care. Top rated care systems (for patient and doctor) with better services and offerings should serve as “magnets” and patients should be given the choice of following their physician for the same reason. In this way a physician helps advocate for their patients indirectly and generates the competition that drives innovation.

Non-solicitation and nondisclosure restrictions limit physicians from informing their patients as to their new location or the reason for their departure. Patients have a right to know where their physician went, so that they can make an informed decision about following their physician or not. In some cases, this decision may require patients to change insurance companies/networks and, in some scenarios, physicians are no longer allowed access to the electronic health record for that patient after their departure. RCs should not disenfranchise patients from choice in health care provider, and employers should not overextend non-solicitation to the point of making it appear that the physician has vanished.

Future Considerations:

Medical professional societies and organizations should represent and protect the majority of their members. A recent poll of cardiologists (discussed later) indicated that a large majority opposed non-compete clauses for some or all the reasons mentioned. Similarly, state professional societies should consider polling constituent physicians (who are now predominantly in employed practices) to assess their attitudes towards restrictive covenants.

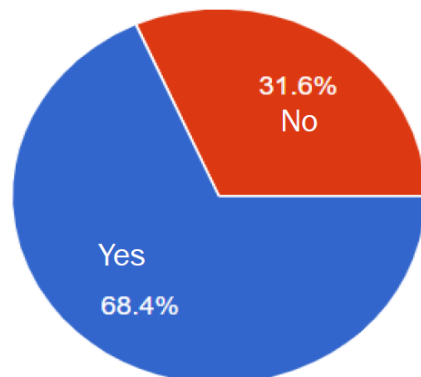
States medical societies should consider sponsoring legislation that prospectively limits or eliminates restrictive covenants and acknowledge the negative impact to patients, populations, and physicians.

VI. Results of Board of Governors and MedAxiom Surveys

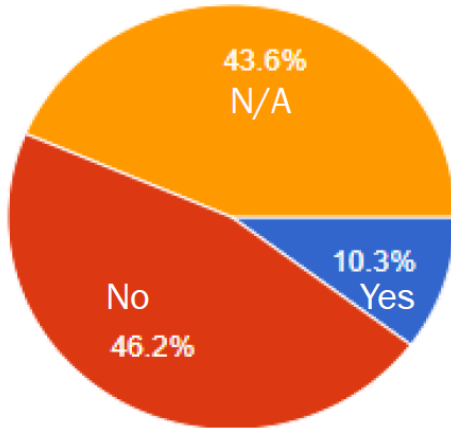
To explore this issue further and to better understand its impact upon those on the “front line”, the BOG Working Group on Restrictive Covenants developed a survey for practicing US cardiologists. The survey was administered to current domestic Governors and Governors-elect serving on the BOG (n=68) for one week in August 2021; 39 responses were received (57%). A slightly modified version of the survey was posted on the MedAxiom physician leads listserv for 2 weeks in September 2021. Sixty responses were received (denominator unknown). The following section reviews the survey responses.

BOG Survey (n=39)

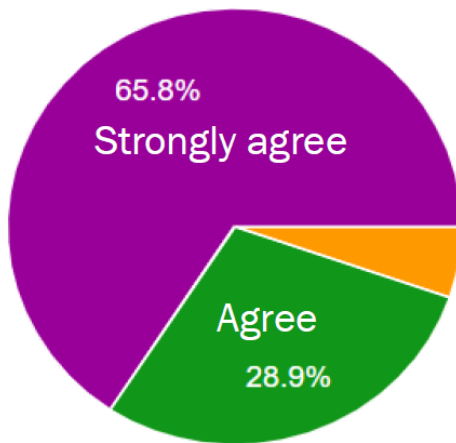
Question 1. *Do you have a restrictive covenant in your current employment contract?*



Question 2. *Have you been successful in modifying the restrictive covenant in your contract through negotiation?*



Question 3. Respond to the statement: ACC Chapters should support legislation that would limit or ban restrictive covenants.



95% Agree or strongly agree

Question 4. I oppose restrictive covenants in physician employment contracts for the following reasons (in rank order of agreement):

1. Health systems have too much power to set terms of the covenant (87%)
2. They limit patient access to care and continuity of care (76%)
3. They are harmful to physician well-being, contributing to physician burnout (74%)
- 4.(tie) They harm the health care system by locking physicians into employment situations in which they are unhappy and disengaged (68%)

4 .(tie) They reduce competition in the healthcare market which ultimately reduces quality of care provided by both health care systems and physicians in a geographic market (68%)

Question 5. *I favor retaining restrictive covenants in physician employment contracts for the following reasons (in rank order of agreement):*

1. They provide stability to the health care system by limiting the movement of physicians between practices (18%)

2. They benefit physician stakeholders in practices by limiting partners and associates' ability to exit (16%)

3. They benefit patients by limiting physician's ability to exit a practice (13%)

3 (tie). They protect the legitimate economic interests of health systems and physician practices (13%)

Verbatim comments:

It's not clear to me that this is a topic that ACC should lead with regards to advocacy as there are so many variations and nuances to it depending on practice, institution and individual. Would advise a lot of caution as we move forward in this space as there is risk of alienating groups and individuals.

Again, we this limits our ability to set our own destinies and gives TREMENDOUS power to health care systems and employers without giving the doctor any incremental job security or protection.

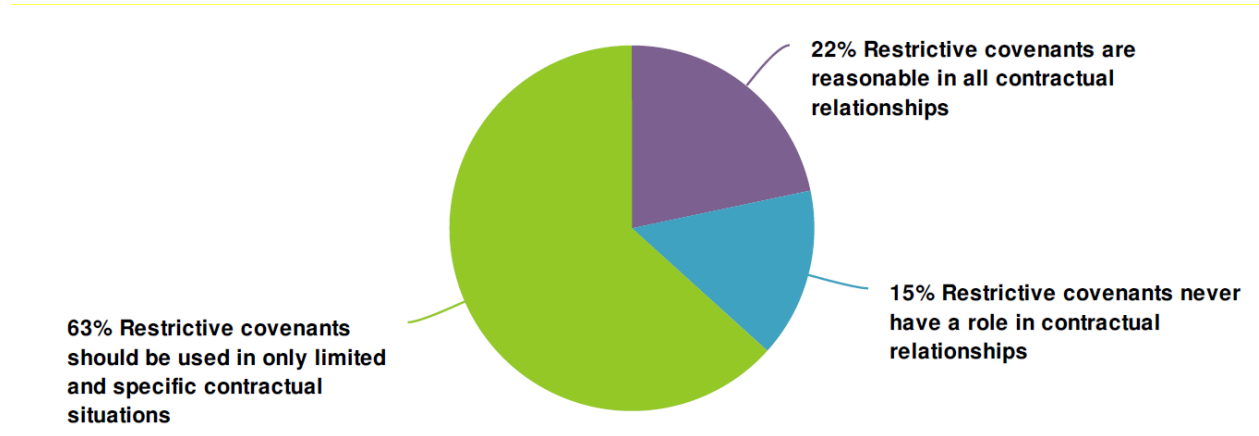
They should be far less restrictive

Restrictive covenants (RC) may have had their place historically in limited small market regions, but since most are employed by larger health care systems and RC are used primarily to limit physician movement from a suboptimal system, to another health care system in the region, that questionable status has definitely expired and needs to be on the dustbins of history.

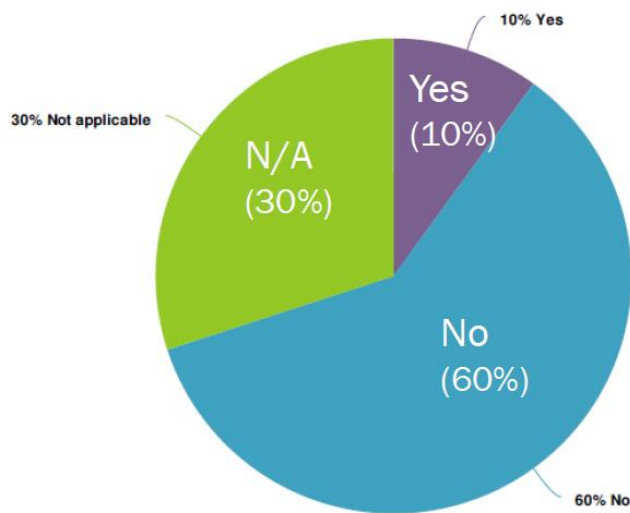
They are considered unenforceable in our state so we don't take them particularly seriously here.

MedAxiom Survey (n=60)

Question 1. *Regarding restrictive covenants in physician employment contracts, which choice best describes your opinion?*

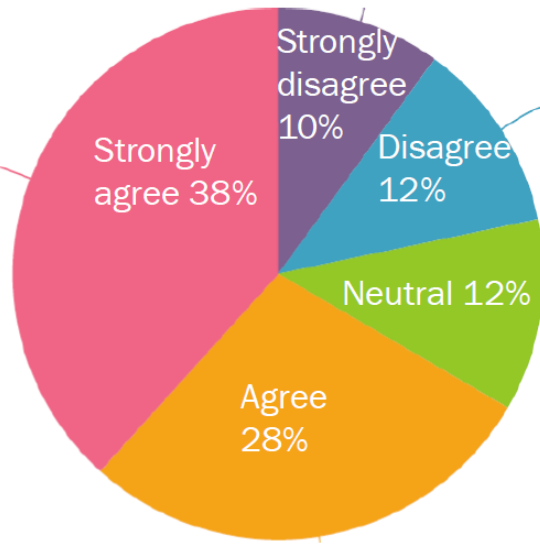


Question 2. *Have you been successful in modifying the restrictive covenant in your contract through negotiation?*

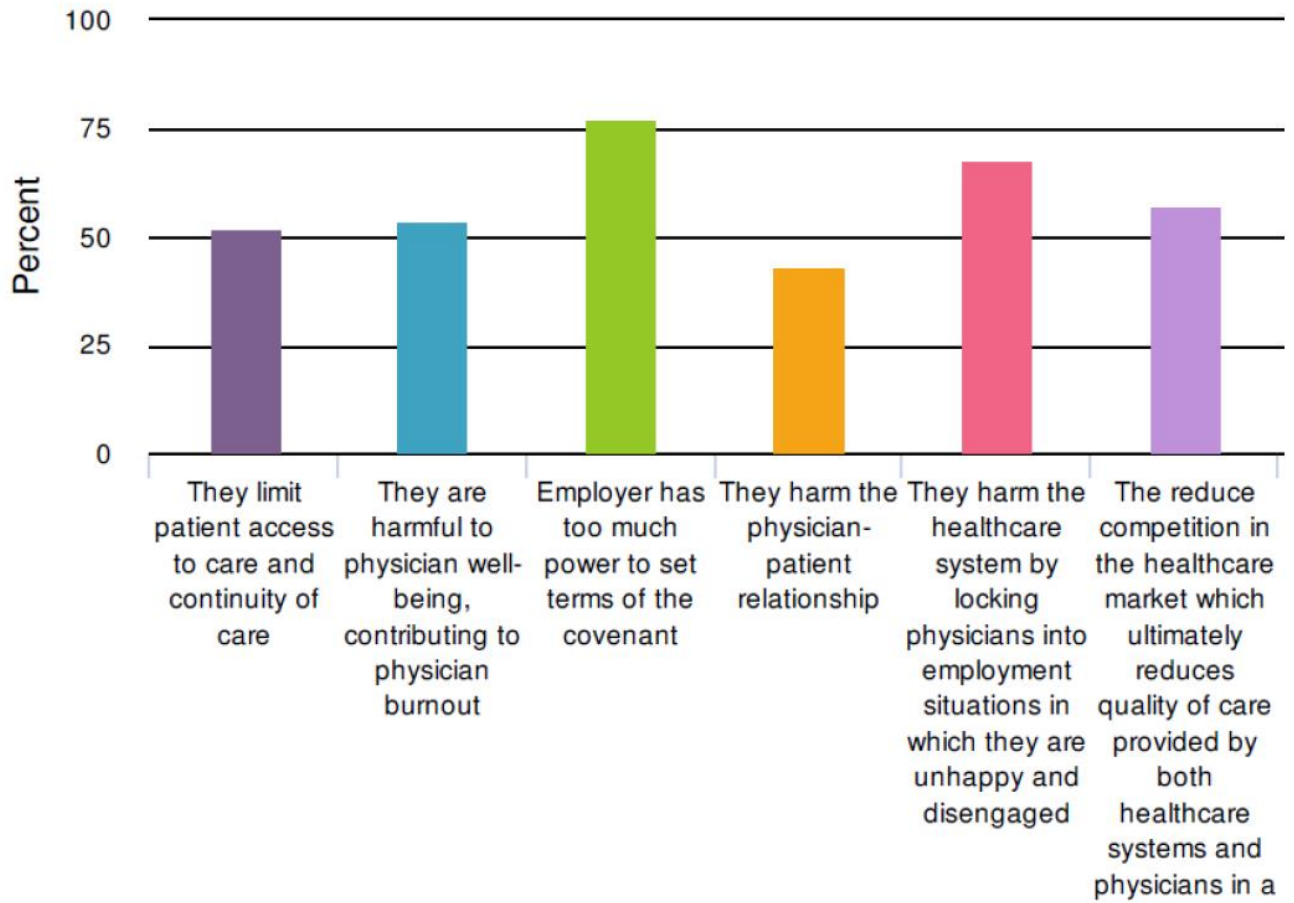


Question 3. *Respond to the statement: ACC Chapters should support legislation that would limit or ban restrictive covenants.*

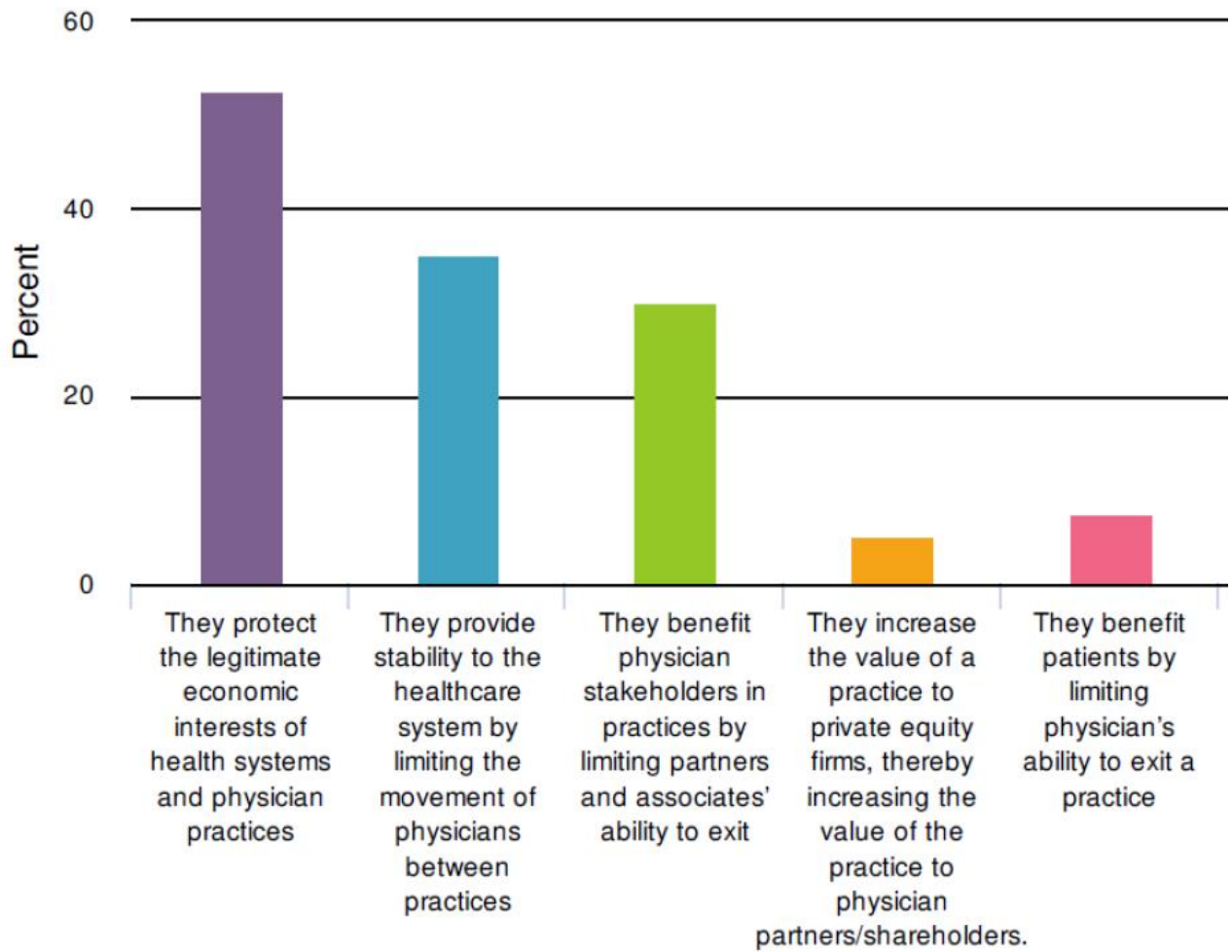
66% Agree or strongly agree



Question 4. *I oppose restrictive covenants in physician employment contracts for the following reasons:*



Question 5. *I favor retaining restrictive covenants in physician employment contracts for the following reasons:*



Verbatim comments:

MedAxiom Comments: Anti- RC

- Do not favor them at all other than very specific niche practices.
- Overly punitive esp. when employer can change the rules of engagement, reimbursement, or admin support.
- Interesting that lawyers are smart enough to make RC unethical because they limit client access to legal counsel. How is the same thing not true for MD-patient?
- Restrictive covenants are too binary. Lower cost penalties could be put in place to reduce the chance that one leaves a practice to compete.
- They are never appropriate in an integrated practice.
- Restrictive covenants are never beneficial to individual physicians

MedAxiom Comments: Pro RC

- As an employer I support continuing restricted covenants if they are reasonable and time and distance
- As a small practice restrictive covenants are important to protect the practice
- In specific situations a group may subsidize the building of a practice, an investment that should be protected
- They can be desirable when recruiting a subspecialist requiring a high initial guarantee with a slow practice ramp up
- If sufficiently limited in scope, restrictive covenants may have a role
- A covenant should be a vehicle that keeps local practice from devolving into the wild West yet still enables physicians and health systems to amicably part ways
- Reasonable RC are critical for the success and sustainability of any business.

Summary of BOG and MedAxiom surveys

Overall, results of the BOG and MedAxiom surveys on cardiologists' attitudes regarding restrictive covenants reflects a shift toward opposition, likely reflecting the substantial move away from independent practice toward employment by academic or private health systems. Sixty-eight percent of BOG respondents noted having a restrictive covenant in their employment contract, but only a small minority (10%) had success in negotiating a modification to this provision, likely reflecting the current market power of large, consolidated health systems. Substantial majorities of BOG (95%) and MedAxiom (66%) respondents agreed that "ACC Chapters should support legislation that would limit or ban restrictive covenants." The lower level of support in the MedAxiom respondents may represent a different pool of subjects that are over-representative of leaders of independent CV practices.

Reasons for supporting limitations to restrictive covenants including noting the market power of consolidated health systems to dictate terms, harm to clinician well-being through restriction of personal and professional choice, reducing healthcare competition and quality of care, and limiting patient access to care. Arguments to retain restrictive covenants (which garnered much less support), included protection of legitimate economic interests of health systems and physician practices, promoting stability in local markets for physician services, and enhancing value for physician stakeholders in remaining independent practices.

Overall, the surveys provide support for ACC and Chapters taking some action to promote reform in the field of restrictive covenants, either opposing their use entirely (as in California (allows for restrictions related to the sale of business goodwill and partnership dissolution or dissociation from a partnership), Alabama, Rhode Island (prohibitions do not apply to the purchase and sale a physician practice if the restrictive covenant is for no more than five

(5) years), Oklahoma (exceptions for the sale of goodwill of a business and covenants not to compete related to the dissolution of a partnership), and a few other states) or limiting their use to more defined time period, geographical region, and other circumstances; and/or allowing other options such as pre-specified buyout terms

Conclusions and Recommendations

Over the last decade, the shift from independent to employed/integrated practice prompted some ACC members to question the BOG about non-competes in their contracts. This issue resonated with a number of BOG members in response to the story of a former Governor who had to leave his state due to a non-compete. In addition, this issue has gained attention from the American Medical Association and the White House.

Large health systems and practices, who may have outgrown the need for protection by non-competes, now employ most of the cardiologists in the US. Cardiologists' concerns and stances range from those who believe that they are obsolete, to those who believe they still serve legitimate business purposes. Those in the middle of the spectrum-of-concern argue that non-competes have become too restrictive and should be legally adjusted by statute or new precedent to balance the power gradient with large health systems or practices. This White Paper addresses: 1) the legal perspectives on restrictive covenants, 2) the current status of restrictive covenants in individual states, 3) reasons to retain restrictive covenants, 4) arguments in favor of eliminating or limiting restrictive covenants, and 5) results of the BOG and MedAxiom physician member surveys, and is the BOG's response to our member's questions and concerns. An additional goal of this White Paper is to initiate a conversation with the ACC Health Affairs Committee (HAC) to consider whether legislative or regulatory action would help our members.

Individual state laws and precedents generally govern non-compete clauses and restrictive covenants, and these laws vary widely from state to state. Some states do not allow physician non-competes. In states with non-competes, some commonalities exist, and states can be grouped into two general categories. They either have: 1) specific statutes that define restrictive covenants, or 2) common law defines restrictive covenants via precedents, based on the length of the restriction, the area restricted, and the line of business restricted. Recently, the Federal Trade Commission (FTC) and President Biden's Executive Order indicate that the federal government may consider new jurisdiction on the unfair use of non-competes that limit patient access to care and impair employee/physician mobility. The sections of this White Paper which cover the legal perspectives on restrictive covenants and the current status of restrictive covenants in individual states, can be used as a resource for ACC members and their Chapters, in conjunction with legal counsel.

There are several reasons why cardiologists may want to retain restrictive covenants. Reasonably written restrictive covenants may facilitate practice expansion into new geographies, protect the clinical and business enterprises of the group or health system, and foster training and mentorship of new partners. Restrictive covenants may also protect the public from the loss of specialty physicians in underserved areas and ensure that physicians are available for emergency cardiac care in specific communities.

Several arguments exist in favor of eliminating or limiting restrictive covenants. In many situations, restrictive covenants have become non-negotiable elements for employed cardiologists and even if non-competes are negotiable, physicians may have little or no negotiating leverage. Restrictive covenants create a captive work culture which may lead to moral injury and impairment of the quadruple aim and physician wellness. Most importantly, executed non-competes can adversely affect our patients and their care. In underrepresented minority groups and in rural areas, where there are fewer cardiologists, the departure of a

cardiologist can lead to reduced patient access and quality of care. Finally, when a cardiologist must relocate to comply with their non-compete, previous employers are not required to share the new location of the departed physician and patient care may be disrupted and harmed. Eliminating or limiting restrictive covenants would avoid these negative outcomes.

The surveys of the BOG and MedAxiom members, while modest in total number (99 responses), provide insight into opinions of our members on the topic of restrictive covenants. The majority of respondents, 95% of the BOG and 66% of MedAxiom, agreed that "ACC Chapters should support legislation that would limit or ban restrictive covenants". While these survey results are not a mandate for action, there are forces at play that have recently changed restrictive covenant statutes in several states and this trend may continue. The BOG respectfully suggests that the HAC should consider further investigation and data gathering on restrictive covenants, entertain the idea of legislative action, and continue to advocate for our members in this important arena.

Appendix 1: Status of Restrictive Covenants by State (July 2022)