Confronting the ethics, myths, and legends of *restrictive covenants* in the era of the contract surgeon

by William C. Cirocco, MD, FACS

More and more physicians are opting for salary-structured hospital or institutional employment.[1] A number of economic factors have contributed to this trend. For young physicians, these positions more frequently offer loan repayment, benefits, and/or enticing signing bonuses.[2] Older, established physicians may transition from private practice to employed positions due to concerns about reimbursement. Indeed, according to a 2010 Medical Group Management Association survey, 65 percent of established physicians were hired into hospital-owned practices in 2009.[1]

Surgeons and other physicians who are considering making the shift into employed status need to have the negotiation and decision-making skills necessary to arrive at equitable contractual agreements with their employers. In particular, an understanding of restrictive covenants (RCs), which may be contained within these contracts, is not only relevant, but perhaps even critical for surgeons who are involved in these discussions.

ASCRS survey

To determine the effects of RCs on surgeons, in 2003, the American Society of Colon and Rectal Surgeons' (ASCRS) Young Surgeons Committee (YSC) electronically surveyed individuals who had completed their colorectal surgery residency training programs in the last decade to determine their experience with contracts and RCs (see Table 1, this page).[3] Of the 157 returned surveys, 132 respondents (84 percent) had signed a contract, and 53 percent of these contracts contained a RC. Of the 24 respondents (35 percent) who had contracts containing a RC and subsequently changed employment, 15 (63 percent) stated the RC was enforced—with an adverse effect noted by eight of the 15 (see Table 2, this page). The demographics of seven of the eight respondents are displayed in Table 3, page 31, and vignettes from these seven respondents are summarized in Table 4, page 31. The remaining seven out of 15 respondents who faced enforcement of the RC did not experience an adverse effect because three respondents voluntarily moved out of state (apparently without regret), another respondent noted resolution when the former employer retired, and still another had the foresight to stipulate in the original RC that upon leaving the group, she could continue her practice of colorectal surgery and merely discontinue doing general surgery cases.[3]

Case in point

The most detailed description of the consequences of an enforced RC was provided in vignette number 7. In this case, an enforced RC created a monopoly on the practice of colorectal surgery in a large Midwestern community within a state that had only five active, board-certified colorectal surgeons.

A vice-president and medical director for Blue Cross and Blue Shield (BCBS) testified in court that a lone colorectal surgeon would be unable to serve the needs of this population. More specifically, the testimony indicated that "the covenant's restrictions leave the area with one colorectal surgeon for 700,000 potential patients, a ratio…(he) characterized as dangerous…. Seriously ill patients are faced with long waits for appointments."[4] BCBS routinely monitors the availability of appointments to specialists and nonspecialists. Forcing a patient to wait three to four weeks for an appointment is considered unacceptable

Table 1. ASCRS survey questions

1. Since graduating from your colon and rectal surgery fellowship, have you accepted a job in which you had to sign a contract or written agreement?
2. Did that contract or written agreement contain a restrictive covenant?
3. Have you changed jobs since signing that contract or written agreement?
4. If you changed jobs, was the restrictive covenant enforced?
5. Was there an adverse effect due to the enforcement of the restrictive covenant? Please describe the adverse effect.
6. Demographic data at time of enforcement: Age, sex, marital status, time in practice with restrictive covenant, and type of practice with restrictive covenant: academic, private, other.

Table 2. ASCRS survey responses

	Number	Percent
Total number of surveys sent	630	
Total number of survey respondents	157/630	(25%)
Number that signed a contract	132/157	(84)
Contract contained a RC	67/132	(53)
Change in employment	24/67	(35)
RC enforced	15/24	(63)
"Adverse" effect of RC	8/15	(53)

Table 3. Demographics of 7 of 8 respondents who experienced an "adverse effect" from an enforced RC

Number having an "adverse" effect of enforced RC	8*
Age (mean, range)	36.3 years (range 32–41 years)
Sex (men/women)	5 men/2 women (71% men)
Married	7/7 (100%)
Time in practice before RC enforced (mean, range)	2.9 yrs (range, 1–6 years)
Type of practice (private practice/academic)	6/7 private practice (86%)

*One of the eight respondents did not provide any demographic data or a personal description of the effects of the enforced RC.

Table 4. Vignettes from 7 of 8 respondents experiencing an "adverse effect" from an enforced RC

1. Had to locate office at a distance from original hospital. This resulted in use of another hospital that is now my main place. Years later when I hired a new surgeon and did not have any restrictive covenants, he bolted down the street with my other partner's referrals. We did not even charge him for "good will." I now believe in restrictive covenants to a degree!
2. It cost me $200,000 to get out.
3. Essentially had to move out of town or not practice for two years. The acute cost of moving and the long-term cost of starting all over as an employed salaried MD in a new practice is substantial.
4. Had to move out of state, completely disrupting my family's place in the community that we had lived in for almost five years, selling a house I had built, leaving a teaching position that I loved. Now we are trying to rebuild our "community life" and expect this to take several years again. Otherwise, left an area I loved, but have found work without a problem.
5. A lot of time and money went into fighting it and it was eventually dropped.
6. If I set up practice within a certain limit of miles I would have to pay a very large fee.
7. I was duped into a "handshake" deal, but after leaving an academic position and moving to town (now without leverage) I was forced to sign a contract containing a RC a few months later. After six years building the practice, I was "financially" forced out of the practice (all referrals, therefore all billings, were intercepted by my so-called "associate") and essentially out of the state when I lost a district court decision over the RC which included a 25-mile radius around 12 hospitals (100-mile diameter). Because of this decision (and my removal from the area), the district court had effectively created a monopoly on colorectal surgery in this Midwestern state with only three other board-certified colorectal surgeons—all located 200 miles away. As a matter of public policy, this ruling was overturned by the state Court of Appeals two years later by unanimous decision. My former associate's petition to the state Supreme Court to overturn the appellate court decision was denied six months later. It took nearly three years (and significant expense) to complete the legal proceedings and return to practice without restrictions.[4]

if the patient has colorectal cancer, rectal bleeding, or other acute colorectal disease. "The district court also heard testimony (from the plaintiff) that patients requiring colorectal surgery whose surgeries were performed by general surgeons rather than members of the colorectal subspecialty have higher death rates than patients treated by colorectal surgeons."[4]

The district court ruling upheld the RC in this case, but two years later the decision was overturned on appeal. In the published text of the appellate court decision eliminating the RC was the explanation that a RC "is valid and enforceable if the restraint is reasonable under the circumstances and not adverse to the public welfare."[4]

Considerations and deliberations on RCs

In determining whether a RC is "reasonably necessary," most courts weigh the three factors outlined in the legal treatise known as the Restatement (Second) of Contracts, which are as follows: (1) the employer's need to protect a legitimate business interest; (2) the hardship or injury to the former employee; and (3) the likely injury to the public.[5] The hardship/injury to the former employee is assessed for reasonableness in terms of the geographic, temporal, and activity limitations it imposes. Table 5, page 32, lists typical arguments of public harm to patient interests by RCs as suggested by Sandra S. Benson, JD, an assistant professor of business law.[6]

Physician specialty is another important matter for the courts to consider, including whether a physician is in a "unique specialty," the physician is in a geographic area of physician shortage, or enforce-

ment of a RC creates a monopoly.[7,8] Furthermore, in a state Supreme Court ruling cited by the appellate court in this decision, "it is well settled that only a legitimate business interest may be protected by a noncompetition covenant. If the sole purpose is to avoid ordinary competition, it is unreasonable and unenforceable."[9]

Another factor to consider in these matters is compliance with the federal government regulations established under Stark Law, phase III. If a hospital is paying recruitment monies to guarantee a physician's salary, then it may be argued that imposing a RC would be "unreasonable."[10] In effect, the federal government has negotiated for the new physician and has taken the risk to add the physician (not the medical practice); therefore, the RC may be removed or challenged in court. According to Ms. Benson, "There is virtual certainty that a practice cannot have a noncompete agreement with a new physician who is paid hospital recruitment monies."[11]

In general, the employer must provide a benefit to the employee in exchange for adding a RC to an employment contract. Making a job offer contingent on agreeing to a RC probably satisfies this requirement because the employee is receiving a benefit (a job) in exchange for signing the RC. However, if the new employer did not state that a RC had to be included in the contract until the employee had left previous employment to work for the new employer, or if the employee had previously begun work before signing the contract, the RC may be rendered unenforceable.[12]

The district court ruling in vignette number 7 was overturned by the appellate court based on transgressions of several of the aforementioned criteria. To begin with, terms of the RC "effectively froze the former employee physician out of the entire…metropolitan area and gave the former employer physician a monopoly."[4] Those restrictions, including a "25-mile limitation on office placement and the prohibition of practice in the entire metropolitan…area exceeded reasonable scope," were therefore concluded to be "overbroad," "unenforceable," and "injurious to the public welfare."[4]

Regarding public welfare, the appellate court stated:

> [T]he district judge did not specifically address this factor, concluding generally that enforcement of the noncompetition covenant was not against public policy. He did recognize that [the vice-president and medical director of BCBS] had expressed concern over…[the plaintiff's] ability to handle all of the patients who needed help, but he discounted the testimony because he [the judge] had not heard what ratio of surgeons to potential patients would be adequate…. [The defendant's] argument that he bore no burden to establish such a ratio is correct. It was enough that he demonstrated one doctor was not enough. Two necessarily would be better than one, even if not optimal.[4]

Table 5. Arguments of public harm to patient interests by RCs[6]

- Shortage of physicians of that specialty in the area
- Disruption in continuity of care or quality of care
- Harm to patient's freedom to choose their physician
- Detriment to ability to obtain emergency care
- Inability to be treated at hospital of choice
- Negative impact on hospital, such as teaching facility

Given the dearth of colorectal specialists in this state, together with the plaintiff's own testimony that colorectal surgeons, not general surgeons, should be operating on colorectal disease, "enforcement of the covenant threatens the health" of this community.[4] Upon notification of the appellate court decision, the plaintiff petitioned the state Supreme Court to review the unanimous appellate court decision. This petition was formally denied six months later and the defendant was finally allowed to return to his colorectal practice unencumbered by any restrictions to practice anywhere in the state.

Involvement of the ACS

The issue of RCs was taken up by the ASCRS YSC and the American College of Surgeons (ACS) Committee on Young Surgeons (CYS). The ASCRS executive council deferred any statement on the subject of RCs to the ACS, given the College's superior resources (including legal counsel); however, the College did not, at that time, have an official statement or opinion on RCs.

The only prominent society with an opinion on the subject up until 2004 was the American Medical Association (AMA). In 1933, the AMA published the opinion that RCs were unethical because they interfered with reasonable competition and prevented

the patient's free choice of physicians. However, in 1960, this position changed with the following AMA statement: "There is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood and consistent with local law. Ethically, such agreements are not forbidden."[13]

This statement disregards the effect of RCs on patients, including access to their physician of choice and the consequent disruption of the physician-patient relationship. In 1980, this was acknowledged in an opinion that RCs among physicians were not in the public interest, and as of 1994 the AMA Code of Ethics, developed by the Council on Ethical and Judicial Affairs (CEJA), officially "discourages" any such agreement between physicians that restricts the right of a physician to practice medicine for a specified period of time or in a specific area of medicine after the termination of employment, partnership, or corporate agreement.[14] At least 11 states forbid or severely limit RCs among physicians and 18 states have statutes regarding RCs.[15] In states where RCs are allowed, the courts must weigh business interests versus harm to the public (patients) when deciding these cases. Interestingly, courts typically look to the medical community (state, regional, and national medical societies) for direction in deciding these cases.

The issue was taken to the ACS CYS, which developed a statement on RCs. The CYS Chair Chad Rubin, MD, FACS, presented the statement to the ACS Board of Regents at the College's 90th Annual Clinical Congress in New Orleans, LA, on October 9, 2004. This Statement on Restrictive Covenants was ultimately adopted by the ACS Board of Regents as statement on principles 49 (ST-49) and later published in the February 2005 issue of the *Bulletin*.[16] The ASCRS' executive council adopted this position statement during the 104th Annual ASCRS Convention in Philadelphia, PA, on June 13, 2005. ST-49 reads, in part, "Any restrictive covenant that interferes with the uninterrupted delivery of qualified surgical care to patients is considered unethical," and the ACS "also recommends the review of all contracts with an attorney who is familiar with local laws and precedents prior to signing any contract."[16]

This is sage advice, as the best way to avoid such conflicts is to refuse to sign any contract that contains a RC. Otherwise, any legal battle in a state that allows RCs will be stacked against the employee. S. Allan Adelman, JD, former president of the American Health Lawyers Association, warns that "Noncompetes are getting negotiated out of contracts more than they're being struck down by the courts."[17] He further noted that "Today, doctors are becoming savvier. They're consulting legal counsel, and they're pushing back on some things, including non-competes."[17] There are more RCs challenged in court by physicians than any other profession.[18] However, there may be unintended repercussions from such litigation because "physicians who sue their former employers become very unemployable in the future."[19]

Another important aspect of this litigation that took center stage was the issue of access to "the uninterrupted delivery of qualified surgical care to patients."[16] The ACS has used the access argument effectively over the years to beat back threats to Medicare funding that would have a direct impact on access to physicians (including surgical specialists) for Medicare participants (mainly senior citizens). RCs also threaten access to qualified surgical care but not just for the Medicare population; RCs pose a risk for all age groups in a given community. Moreover, RCs tear apart the surgeon-patient relationship, the basic underpinning of the mission of the ACS.

Directions for the future

Interestingly, RCs are prohibited among lawyers in the U.S. The American Bar Association in 1969 adopted a code of professional conduct that included a disciplinary rule prohibiting RCs between attorneys, using the logic that RCs interfere with the client's freedom to choose a lawyer.[20] In striking down a RC against a physician, the Tennessee Supreme Court cited the prohibitions against RCs in the legal profession and profoundly stated that there was "no practical difference between the practice of law and the practice of medicine," and further determined that a patient's right to choose a physician is fundamental and cannot be denied by a RC.[21] Increased competition improves the quality of medical care and keeps costs affordable. According to Peter M. Sfikas, chief counsel for the American Dental Association and an adjunct professor of law at the Loyola University of Chicago (IL) School of Law, the right to freedom of choice of a physician, the right to continue an ongoing relationship with a physician, and the benefits derived from having an

increased number of physicians practicing in a given community all outweigh the business interests of an employer.[22] In a point/counterpoint regarding the proposition "Noncompete clauses in employment contracts violate a physicist's freedom to practice his or her profession," one conclusion reached was that "competition is American; prohibiting competition is not."[23]

With respect to the ethics of RCs, the legal profession has led the way, leaving the medical profession to play catch-up in eliminating RCs in employment agreements. A return to the AMA's original pre-1960 position that RCs are unethical would be a blow for common sense, preserve the physician-patient bond, and would once again raise the bar of ethics in the medical profession back to the standard set by our colleagues in the legal profession.

Unlike other areas of the law, where the cases tend to be consistent and build on each other over time, RC cases tend to be "inconsistent and scattered."[24] U.S. courts are looking for direction from the medical community in deciding these cases. Strong language against the existence of RCs (rather than the vagaries of current AMA terms, such as "discourages") incorporated into medical society position statements, which comment on "unethical" practices, is necessary. It is noteworthy that the AMA's CEJA uses much stronger, uncompromising language when presenting its opinion regarding RCs and training programs, stating, "It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program."[25]

Furthermore, it has been proposed that if state medical boards were to ban RCs, then the courts in those states would subsequently refuse to enforce RCs, allowing for swift dismissal of lawsuits brought by employers directed against physicians.[26] It is obvious that state legislatures that have banned RCs among physicians have most effectively eliminated any and all litigious issues related to RCs.

A growing problem

Given the trend of surgeons becoming contract employees entering into written agreements with their employers, contractual disputes will become a reality for an increasing number of ACS Fellows. These disputes will trend away from the typical young versus old, inexperienced versus experienced, surgeon versus surgeon cases (as in vignette number 7) and morph into a hospital/institution versus individual surgeon scenario. These cases will be adjudicated based on the prevailing laws of the state of origin of the dispute. In those states that allow physician contracts to include a RC, any and all statements from state/local/national medical societies (as well as surgical societies) commenting on ethical standards regarding the enforcement of RCs will be helpful to the courts assigned to these cases. It should be noted that the appellate court decision in vignette number 7 was a very narrow decision only made possible by the severe lack of surgical specialists serving that particular population of potential patients. The prevailing myth that RCs never hold up in court is obviously erroneous.

Hopefully, all 50 states and U.S. territories will enact legislation to ban RCs in physician contracts, as it seems that we physicians refuse to condemn this unethical behavior as the legal profession did long ago. Physicians must arm themselves with information to avoid these legal traps, lest they find themselves at the mercy of the local judiciary. Other surgical societies should adopt ST-49 (or their own version) and the AMA's CEJA should void their 1960 opinion on RCs and return to their pre-1960 position that contractual provisions that interfere with reasonable competition or prevent the patient's free choice of physician are unethical. Physicians and surgeons should form alliances with patients who want to sustain their right to see their physician of choice. This basic right to health care should trump any and all business concerns, similar to the constitutional right to legal representation. The lawyers had it right all along, although paradoxically they also contribute to this quagmire by typically insisting on the inclusion of RCs in physician contracts that they draw up. The attorneys know (and physicians should recognize) that all practices or practice groups eventually come to an end either through lateral movement, retirement, death, or disability. They've got us coming and going. We should at least spread the word about RCs. We have no one to blame for this mess but ourselves. As the comic-strip character Pogo discovered, "The enemy is us," but we can also be the solution. We can choose ethics and patient rights over business interests.

In a treatise titled "Banish the Restrictive Cov-

enant!" Philip M. Catalano, MD, a dermatologist in private practice, compared RCs to a "financial sword of Damocles" and concluded that "The legacy of restrictive covenants is further diminution of our profession."[27] It is long past time for the demise of the former for the sake of the latter. Ω

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