REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-19

Subject: Restrictive Covenants of Large Health Care Systems

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-383.978, "Restrictive Covenants of Large Health Care Systems," introduced by the Organized Medical Staff Section, which asked:

> 1. Our AMA, through its Organized Medical Staff Section will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.
>
> 2. Our AMA study the impact that restrictive covenants have across all practice settings, including but not limited to the effect on patient access to health care, the patient-physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting.

Testimony noted that this is a significant issue that is rarely looked at, that physicians often are not given a choice but to sign a covenant, and that students are rarely educated on the practice before entering the workforce. Speakers also testified that the practice has negative ramifications for rural medicine, and that physicians can be limited from even volunteering to practice in retirement due to restrictive covenants.

It should be noted that during the 2019 Annual Meeting, the HOD referred Resolution 010 "Covenants not to Compete" to the AMA Board of Trustees. Resolution 010 asked our AMA to consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system. Resolution 010 also asked our AMA to ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community. The AMA Board of Trustees will present the HOD with a report concerning Resolution 010 at the 2020 Annual Meeting.

DISCUSSION

Restrictive covenants, which often are included as part of a physician employment contract, typically prohibit physicians from practicing medicine within a specific geographic area and time after employment. For example, a restrictive covenant may prohibit the physician from practicing

medicine within 10 miles of the location where he or she treated patients for two years after employment has ended. With respect to geographic restrictions, physicians should be mindful that the geographic scope of a restrictive covenant can be greatly expanded if the covenant is tied to multiple locations where the employer furnishes health care services. For example, a restrictive covenant may prohibit the physician from practicing within 10 miles from *any* location where a large health care system provides patient care, regardless of whether the physician actually treated patients at a given location. If a large health care system furnishes health care services in multiple locations, the covenant could force the physician to move out of a city or even a state if he or she wanted to keep practicing medicine, which, in turn, may make the physician inaccessible to former patients.

State law governs covenants, and states can vary widely in how they address them. Some states have statutes that regulate restrictive covenants, and some of those statutes prohibit restrictive covenant enforcement against employed physicians. California, Delaware, Massachusetts, New Hampshire, North Dakota, Oklahoma and Rhode Island, for example, have enacted laws that would prohibit restrictive covenant enforcement against employed physicians.[1] Other states may deal with restrictive covenant issues solely through court cases. Absent a specific statute prohibiting the enforcement of a restrictive covenant, courts in most states will generally allow an employer to enforce a reasonable restrictive covenant against an employed physician, notwithstanding the concerns raised by Policy D-383.978.

Application to all care settings where restrictive covenants are concerned

Policy D-383.978 asks our AMA to "study the impact that restrictive covenants have across all practice settings…." This report primarily addresses restrictive covenant use in the large health care system environment. However, this report's discussion about concerns associated with aggressive restrictive covenant enforcement will be applicable across all care settings, since those concerns may arise whenever an employer utilizes restrictive covenants, regardless of practice setting.

Restrictive covenants to protect legitimate business interests

A court will enforce a reasonable restrictive covenant in a physician employment agreement when it determines that the covenant is necessary to protect an employer's legitimate business interest. With respect to physician employment, the legitimate business interest typically is the investment the employer has made in helping the physician establish his or her practice. A physician employer, e.g., a large health system, may spend thousands of dollars recruiting the physician, covering the physician's relocation costs, training, providing administrative support and marketing the physician. The employer may also give the physician access to community referral sources, patient lists and propriety information. This investment will likely be more significant if the employer is recruiting the physician right out of residency. Given this resource commitment, the employer may think it necessary to protect its investment in the physician through a restrictive covenant that will prevent the physician from leaving and joining a rival health system, or otherwise competing with the former employer. Although aggressive enforcement of restrictive covenants can raise the issues identified in Policy D-383.978, restrictive covenants can benefit employed physicians. For example, a potential employer may be much less willing to make the time and resource commitments that are needed to help physicians succeed in medical practice without a restrictive covenant in place.

Concerns that Policy D-383.978 identifies

As Policy D-383.978 notes, aggressive enforcement of restrictive covenants in physician employment contracts can trigger issues regarding the patient-physician relationship, access to health care, physician autonomy and patient choice. A restrictive covenant's application could, for example, negatively impact patient access to care by severing a long-standing patient-physician relationship, particularly in cases where the physician has been regularly and actively involved in helping the patient manage an ongoing mental or physical condition. If a restrictive covenant requires the physician to leave the area in order to continue practicing medicine, for example, the patient may not as a practical matter be able to continue seeing the physician. The result here would be an end to the patient-physician relationship and further, this could potentially hinder the patient's ability to manage his or her condition. Even assuming a smooth care transition to another physician, a significant amount of time might pass before this new patient-physician relationship enjoys the same level of trust and candor as the first.

Aggressive enforcement of a restrictive covenant could also have negative consequences on patient care outside of a long-term patient-physician relationship. For example, depending on the geographic area, there may be just a few physicians, general practitioners or specialists, available to serve the needs of the patient population. This may be particularly true in rural parts of the country. Even if several physicians practice in the community, requiring a physician to leave the area may reduce the number of available physicians. Although a replacement physician may ultimately be brought to the area, recruitment can be a lengthy process. In fact, it may be quite a while before the replacement physician can start seeing the community's patients. In the meantime, the absence of the physician subject to the restrictive covenant could hinder patient access by increasing patient wait times—assuming the community's remaining physicians have the capacity to take on new patients. The situation could be compounded if the community has only one general practitioner or physician of a needed specialty. In that case, obligating a physician to leave the area could deny the community those medical services until a new physician could commence practice. In the interim, patients may have to decide whether they can travel to other communities to obtain those services, which may not always be practically feasible, or do without for the time being.

As Policy D-383.978 notes, aggressive enforcement of restrictive covenants may also detrimentally impact a patient's choice of physician. Obviously, application of a restrictive covenant can negatively affect patient choice if the covenant obligates the patient's preferred physician to relocate to an area that is beyond the patient's practical reach. But patient choice could still be affected if his or her preferred physician moves to an area that the patient does not regard as geographically inaccessible, e.g., the patient places such a value on continuing the patient-physician relationship that he or she is willing and able to accept inconveniences that the physician's relocation may have created, such as increased travel distance. However, notwithstanding the patient's willingness, relocation may affect the physician's network status with respect to the patient's health insurance coverage or employee benefits plan. If the physician had been out-of-network previously, continued out-of-network status may have little impact on patient choice. But if the physician had been in-network, the increase in the patient's financial obligation to stay with the physician may compel the patient to select another, in-network, physician.

Policy D-383.978 also identifies physician autonomy as a concern raised by aggressive restrictive covenants. AMA policy recognizes the importance of physician autonomy. For example, Policy H-225.950, "AMA Principles for Physician Employment," states in part that "[e]mployed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment." Further, according to

H-225.950, employed physicians should not be considered to have violated their employment agreements or suffer retaliation for exercising their personal and professional judgment. Notwithstanding H-225-950, if a physician knows that the culture of his or her employer is one of aggressive restrictive covenant enforcement, that knowledge may dampen the physician's willingness to freely and fully exercise his or her autonomy in patients' best interests. For example, typically a physician employment agreement will contain a "without cause" termination provision. This provision allows an employer to end the employment agreement so long as the employer gives the physician prior notice, e.g., 90 days. The physician need not have violated his or her agreement to be subject to "without cause" termination.[2] If the physician is concerned that his or her employer may end their employment under a "without cause" provision in retaliation for strong patient advocacy, for example, the physician may be reluctant to serve as a strong advocate. This may be especially true if the "without cause" termination also triggers the application of a restrictive covenant that may require the physician to move out of the community if the physician wanted to continue practicing medicine.

Potential difference between restrictive covenants in large health systems and independent physician practices

Although Resolution 26 addresses aggressive restrictive covenant enforcement by large health system employers, independent physician practices also use restrictive covenants. The concerns identified in Resolution 26 can apply equally across the board regardless of employer. There may, however, be cases where concerns about restrictive covenants may be greater when the employer is a large health system vis-à-vis a physician practice. One difference could be the extent to which a potential physician employee may be able to negotiate the scope and duration of a restrictive covenant. A large health system may be less inclined than, say, a small physician practice to negotiate the terms of a restrictive covenant or other conditions of employment, e.g., due to institutional policies. However, a physician should never be reluctant to voice his or her concerns about the impact that restrictive covenant language may have on physician autonomy or simply assume that a large health system will not negotiate restrictive covenant language to address those concerns. A large health system may, in fact, be amenable to negotiations depending on the circumstances, which may be highly fact-specific.

Further, the culture of restrictive covenant structure and enforcement may differ between a large health system employer and an independent physician practice. Physicians frequently own and control independent practices, and thus decide how restrictive covenants will be drafted and enforced. Since physicians are in control, the structure and enforcement of restrictive covenants may be sensitive to the concerns raised by Policy D-383.978 In contrast, in large health systems, non-physicians may dictate how restrictive covenants are structured and enforced and may not be as cognizant of the issues identified in Policy D-383.978. It must, however, be emphasized that simply because a restrictive covenant is used within the context of a small physician practice does not mean that the scope and enforcement of the covenant does not exceed what is reasonable and does not implicate the concerns raised in Policy D-383.978. Furthermore, use of restrictive covenants by large health system employers may not always negatively impact patient access, choice and/or physician autonomy.

Finally, a large health care system's aggressive enforcement of a restrictive covenant may have adverse consequences on network participation which do not often arise when an independent physician practice is involved. For example, in contrast to most independent physician practices, large health care systems may sponsor clinically integrated networks or accountable care organizations (ACOs). Some have also created affiliated health insurers. The system's aggressive enforcement of a restrictive covenant may trigger issues that Policy D-383.978 identifies if the

covenant would force the physician out of the system's clinically integrated network or ACO, or prohibit the physician from participating in the system's health insurance provider network. In some cases, the prospect of adverse network consequences may, in fact, concern the physician as much as the restrictive covenant itself.

AMA POLICY

Our AMA has several policies that address restrictive covenants. For example, CEJA Ethical Opinion 11.2.3.1, entitled "Restrictive Covenants" states that, "[c]ompetition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms." That Opinion also states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care, and that physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician. The Opinion further adds that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

In addition to the CEJA Opinion, Policy H-310.929, "Principles for Graduate Medical Education," states that restrictive covenants must not be required of residents or applicants for residency education; Policy H-295.910, "Restrictive Covenants During Training," strongly urges residency and fellowship training programs that utilize restrictive covenants to provide written intent to impose such restrictions in advance of the interview process; Policy H-295.901, "Restrictive Covenants in Residency and Fellowship Training Programs," states that 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; Policy H-225.950, "AMA Principles for Physician Employment," discourages physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment; and Policy H-383.987, "Restrictive Covenants in Physician Contracts," states that "[o]ur AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies."

SOME KEY POINTS AND AMA RESOURCES ON RESTRICTIVE COVENANTS

As the prior discussion shows, physicians should very carefully scrutinize any restrictive covenant language in employment contract offers they receive. Obtaining the assistance of an attorney who has experience representing physicians in employment matters can be very helpful in determining whether proposed restrictive covenant language is reasonable and appropriate. Physicians should proactively bring any concerns they have about restrictive covenant language to the potential employer and should not be afraid to ask for changes.

The following are some key points that can help physicians evaluate the reasonableness of restrictive covenant language:

- what triggers the restrictive covenant, e.g., the employer's terminating the agreement for *any* reason as opposed to termination because the physician failed to live up to his or her contact obligations;
- the duration of the covenant, e.g., one year versus three years;

- the covenant's geographic scope, e.g., is it greater than what is necessary to protect the employer:
  - for example, 10 miles might be reasonable in a rural area but may not be in an urban setting;
  - for example, is geographic scope tied to an appropriate site of service, e.g., where the physician actually treated his or her patients or does the scope extend to *any* location where the employer has facilities;
- does the covenant apply only to the services that the physician furnished, or does it prohibit the physician from practicing medicine entirely or from providing administrative services; and
- does the covenant contain a reasonable "buy-out" provision that, if satisfied, would free the employed physician from time and geographic restrictions.

Finally, it ought to be noted that the AMA has many resources that educate medical students, physicians-in-training, and physicians about restrictive covenants. For example:

- The AMA Career Planning Resource webpage has a wealth of information discussing physician employment issues, which includes information and tips regarding restrictive covenants. The AMA Career Planning Resource webpage may be accessed at https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts.
- The AMA also has two model employment agreements that discuss restrictive covenants, the Annotated Model Physician-Hospital Employment Agreement, 2011 edition: E-Book, free for AMA members at https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod1240028&sku_id=sku1240037, and the Annotated Model Physician-Group Practice Employment Agreement: E-Book, free for members at https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2530052&sku_id=sku2530104. These agreements contain model restrictive covenant language for potential physician employees to consider, which may prove useful in the employment negotiation process.
- Finally, staff at the AMA Advocacy Resource Center, the state advocacy unit of the AMA, work extensively on physician employment issues. AMA members are encouraged to contact the Advocacy Resource Center at arc@ama-assn.org, if they would like to obtain more information and resources concerning restrictive covenants.

REFERENCES

[1] See Cal Bus & Prof Code § 16600; 6 Del. C. § 2707 (allows liquidated damages); ALM GL Ch. 112, § 12X; RSA 329:31-a; N.D. Cent. Code, § 9-08-06; 15 Okl. St. § 219A (so long as the employee does not solicit the former employer's customers); R.I. Gen. Laws § 5-37-33.

[2] Frequently the agreement will (and should) contain a reciprocal "without cause" provision, meaning that the physician can also terminate the agreement if he or she gives the employer the same prior notice as the employer is obligated to provide the physician.