

The Legal Angle

Freedom of contract vs. access to care

Reviewing non-competition provisions and physician employment agreements

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THE MATTER OF RESTRICTIVE COVENANTS and physician employment agreements continues to be fertile ground for litigation in many states across the country.

In hiring a new physician to join a medical practice, there are a variety of concerns for the practice, which typically leads it to seek protection in the form of a restrictive covenant. To be of any value to a practice, information not only must be gathered and developed, but also must be shared with employees and physicians to provide services and to build the practice.

New physicians are exposed to sensitive information, including trade secrets, physician relationships, and patient relationships. That exposure can pose a threat to the practice, particularly when the employer/employee relationship ends.

In that event, the former employee is often in a position to use secrets (e.g., patient lists) to compete with the practice, especially when he or she is privy to essential business information and plans to open his or her own office or join a rival practice. In recent years, however, a number of courts across the country have sought to limit the use of non-compete covenants in the context of profes-

sional services, such as those provided by physicians and lawyers. One such case involved Dr. David Udom, an internist practicing in Murfreesboro, Tenn.

Murfreesboro Medical Clinic, P.A. v. David Udom

The plaintiff, Murfreesboro Medical Clinic ("MMC") was a private medical practice employing approximately 50 physicians. In April 2000, Dr. Udom entered into an employment agreement with MMC in which he agreed to a covenant not to compete provision, which provided for the following:

"Upon any termination of this agreement..., the Employee agrees not to engage in the practice of medicine within a 25-mile radius of the public square of Murfreesboro, Tennessee for a period of 18 months following such termination."

Dr. Udom reviewed the proposed agreement, signed it, and then commenced working for MMC on September 1, 2000. In August 2002, as his initial two-year employment agreement was about to expire, MMC advised Dr. Udom that it would not renew his agreement and that it intended to enforce his covenant not to compete. Dr. Udom inquired as to whether he could seek a position as a hospitalist or work for a local Veteran Administration Medical Center but was told he could not. He was also advised he would have to relinquish his medical staff privileges at the Middle Tennessee Medical Center.

Both the trial court and the Court of Appeals of the State of Tennessee held that the covenant not to compete was enforceable. On appeal, however, the Tennessee Supreme Court disagreed:

"Due to the important public policy considerations implicated by physicians' covenant not to compete, along with the ethical problems raised by them, and our

state legislature's decision not to statutorily validate all such covenants, we conclude that the non-compete agreements, such as the one at issue in the present case, are inimical (harmful) to public policy and unenforceable."

In its opinion, the Court placed great emphasis on two related factors. First, the Court concluded as a matter of public policy that there were community benefits in having greater access to health care, and that the American Medical Association has taken a position discouraging covenants not-to-compete for this reason.

Secondly, the Court concluded that the Tennessee legislature, while allowing covenants not to compete to be enforced, would do so only when such restrictions "are reasonable and not inimical to the public interest."

The Court also drew an analogy to the fact that covenants not to compete between attorneys have been prohibited in Tennessee as well.

Lessons from MMC v. Udom

Several lessons can be learned from *MMC v. Udom*. It is clear that there are a growing number of states that are either strictly construing covenants not to compete, or simply, like Tennessee, refusing to enforce them in the context of physicians, either by court decisions (Tennessee, Arizona, and Ohio) or by statute (California and Colorado). In addition, some states, such as Texas, have recently enacted legislation to require that a physician be provided the opportunity to "buy out" of an otherwise enforceable covenant. Care must be taken, therefore, to clearly analyze each states' law and determine the position of the courts and the legislatures in that state.

Further, it is important to note that the court's decision may have been dif-



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ferent under these circumstances had the covenant not to compete been so broad. For example, the covenant prevented Dr. Udom from practicing medicine in a restricted area rather than limiting the prohibition to his specific specialty. As noted above, the Court cited the fact Udom was prevented from being a hospitalist or working for the Veterans Administration Medical Center. In addition, as noted in the concurring opinion of one court, the 25-mile radius was overly broad and the evidence failed to demonstrate the extent to which MMC and Dr. Udom would compete for patients in that area. Some courts have also indicated that when an issue is raised about the access to a particular specialty, it will par-

ticularly scrutinize the covenants. As this may not have been present in this case, it is an important factor to consider.

Preparing a covenant

When crafting a covenant not to compete provision in those states in which there is no question about its enforceability, there are several ways employers may restrain a former employee. These restrictive covenants generally fall into three categories.

- ▶ non-solicitation of patients and/or employees
- ▶ non-disclosure of confidential information
- ▶ non-competition with the employer, including post-termination

As was discussed in the Udom case, the basic test applied by courts is “whether the covenant is reasonably necessary to protect the employer from improper or unfair competition.” In determining whether a restrictive covenant is “reasonably necessary,” most states use the analysis from the Restatement (Second) of Contracts, which lists three factors.

- ▶ The employer’s need to protect a legitimate business interest
- ▶ The hardship or injury to the former employee
- ▶ The likely injury to the public

Additionally, the reasonableness of a restrictive covenant is generally assessed in terms of the geographic, temporal, and activity limitations it imposes. Given these considerations, it is apparent that determining the reasonableness of restrictive covenants depends upon the facts and circumstances of each case. Not surprisingly, what one court finds reasonable another may not.

Non-solicitation of patients and/or employees

Most agreements will contain a provision preventing a terminated physician from soliciting patients and/or employees following their termination in order to continue to provide services. In most states, a restriction on the solicitation of patients/customer will be enforceable, as in *Abbott-Intervast Corp. v. Harkabus* (1993), and *Curry Eye Center, Ltd. v. Butler* (1999).

In some states, however, such as California, statutory provisions support a strong public policy favoring free competition and prohibit post-employment non-competition covenants. Therefore, in *Kolani v. Gluska*, (1998), a post-termination non-solicitation of patients or customers’ covenant was not upheld.

Non-disclosure of confidential information

The goal of maintaining the confidentiality of information of the medical practice is two-fold: 1) to protect the practice’s patients, and 2) to protect its business. A practice does have a right to maintain the

RPA expands course offerings through Fuqua School of Business

THE RENAL PHYSICIANS ASSOCIATION, IN COOPERATION with the faculty at the Fuqua School of Business at Duke University, has created a new CME course, “Leadership, Negotiations and Operations for the Modern Nephrology Practice.” The first course offering is scheduled for September 7-9 on the Duke University campus. There are no prerequisites to attend this course; it is an independent stand-alone program. Fuqua faculty will use the case study method to illustrate how effective leadership can be applied in the clinical setting to improve nephrology practice. Operations management will be addressed from the perspective of information flows and the integration of automation using electronic health records. The negotiations module will integrate examples of real-life scenarios with which nephrologists are confronted such as medical director contracts, joint ventures, managed care contracts, and employee contracts.

For more information and to download the registration brochure, go to the RPA website at www.renalmd.org, and then select Educational Programs – FUQUA Health Management Course. This program is supported in part by an educational grant from Roche Pharmaceuticals.

The new course is the second one offered by Duke in partnership with the RPA to help physicians manage their practice. The RPA is also offering “Business Management and Leadership for Nephrologists,” on June 29-July 1 at the Duke University campus. This course includes sessions on:

- Understanding the performance metrics of CKD service providers
- Using decision tools to evaluate the delivery of CKD patient care
- Understanding how to develop a customer-focused practice to improve CKD
- Patient care, and strategic approaches to the optimization of CKD patient care.

Case examples are integrated throughout the program. The content for the curriculum was based on numerous interviews and surveys conducted with practicing nephrologists to gain a better understanding about what nephrologists need to know to help them thrive in nephrology practice.

The goal of the program is to help nephrologists understand and integrate business principles into clinical practice and to improve CKD patient care and outcomes. Registration for this program is also available on the RPA website.

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The legal obligation of the plaintiff attorney: Get the cash

As noted, there seems to be an underlying assumption by attorneys who represent and advise physicians that asset protection isn't important—that plaintiffs and their attorneys will not go after physicians' personal assets because it is "distasteful," or for some other reason. But put yourself in the shoes of the plaintiff and the attorney. The plaintiff's attorney has a professional and ethical obligation to represent his or her client with their best interest to the fullest extent of the law. If I represented a plaintiff who had a \$4 million judgment and only \$2 million was paid by insurance, and I knew that the defendant had millions of dollars of assets that were unprotected that I could access in order to get my client paid in full, it would be my obligation to do this. In fact, if I didn't pursue those assets, I would be liable for malpractice to my client, and rightfully so.

Why protect assets?

Statistically, there is a relatively low risk that you will lose personal assets in a malpractice action, regardless of your specialty. However, the point is that asset protection planning can actually benefit you in many ways beyond lawsuit protection. Think of it this way: Consider colon cancer and getting a colonoscopy. Colon cancer, when caught early, is one of the most treatable forms of cancer. In order to detect it, patients simply need to get a colonoscopy performed on a regular basis. The medical field spends time motivating and educating patients about getting a colonoscopy. And even though the chance of cancer might be slight, getting a colonoscopy is the wise thing to do. Nonetheless, many patients still get late-stage colon cancer because they don't get colonoscopies done.

This seems to be the attitude of many physicians about asset protection planning. They think it is going to be expensive and difficult, perhaps even scary and painful. However, when they realize that proper asset protection is not overly complicated, not overly expensive, and often benefits them in many other ways, they will move forward. ♦

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confidentiality of this information and to ensure that it is not used inappropriately by a former employee, and as a result, such a provision has been found to be enforceable by the courts. In order to support the confidentiality of the information, practices should seek limited access of that information which it desires to be confidential. With respect to patient information, this is particularly important, not only because of the patient/physician relationship, but also because of the HIPAA obligation imposed upon medical practices. However, in those courts where access to care has been found to void covenants not to compete, such a provision may be questioned.

Post-termination/non-competition

With respect to the covenants' activity, it should specify the area of specialization of the practice and relate to the services that the physician employee has provided to the practice. Therefore, preventing a nephrologist in a nephrology practice from engaging in the practice of medicine may result in a court determining that the employer does not have a protectable interest in the general practice of medicine, and therefore, refusing to enforce the covenant. In addition, with regard to the reasonableness of the geographic scope and time of the covenant, many courts and state legislatures have addressed these issues.

Geographic scope. What constitutes a reasonable geographic limitation will depend on the facts of a case. For example, a geographic restriction of 30 miles about the Chicago area was found to be unreasonable in *House of Vision, Inc. v. Hiyane* (1967), while a geographic limitation of 250 miles around New York City was found to be reasonable in *Wessel v. Busa* (1975). Generally, a larger geographic limitation will more likely be accepted if the time and/or activity limitations are narrower. The majority of cases state that the lack of a geographical restriction does not in itself render a restrictive covenant

void, but its absence makes the other restrictions more important.

While generalizations are difficult, a territorial restriction will most likely be upheld if it does not extend beyond the area in which the employee worked for his or her employer. Such restrictions are most vulnerable when they extend beyond the area in which the employer conducts its business.

Temporal scope. What constitutes a reasonable temporal limitation should be assessed in light of other relevant facts. Generally, it must not extend beyond the time necessary to protect the employer's legitimate business interest. For example, in *McRand, Inc. v. Beeken* (1985), a two-year time restriction was found reasonable where evidence demonstrated that it took the company one to three years to establish a major account. While there may be a variation from state to state, typically a restrictive covenant's reasonableness is measured by its hardship to the employee, its effect upon the general public, and its reasonableness as to time and territory. Because each state law and the facts and circumstances will dictate the reasonableness, the employer should take care in assessing each new contract that it enters into in order to determine whether under current circumstances, the geographic scope and temporary-scope of the covenant is reasonable.

Conclusion

It is clear that a vast body of law governs physician employee and employer relationships. It is equally clear that the law is changing in some states. As a result, extreme care should be taken 1) in examining state law each time an employment relationship is entered to determine the status of the law; and 2) in crafting an agreement which sets forth the practice's and the employee physician's expectations with regard to their relationship. Experience shows that a carefully and clearly drafted employment agreement helps avoid disputes which can later result in disagreements and potential termination of a relationship. ♦