Physician, Meet Thy Covenant

Noncompete Agreements in the Medical Profession

By Daniel D. Quick

Introduction

From 1905, Michigan law deemed most noncompetition agreements as "against public policy, illegal and void." However, the repeal of MCL 445.761 in 1985 heralded a new judicial openness to such agreements. In the intervening 22 years, courts have regularly enforced noncompetition agreements that comply with the four basic tests of MCL 445.774a: that the agreement (1) protects a reasonable competitive business interest, (2) is reasonable as to its duration, (3) is reasonable as to its geographical area, and (4) is reasonable as to the type of employment covered.

Despite the widespread use of noncompetition agreements across various industries, the medical field has not historically imposed noncompetition agreements on its members. However, a recent spate of cases addressing the enforceability of such agreements in the medical profession illustrates that this trend is beginning to change, raising the issue of whether the judicial acceptance of noncompetition agreements in other cases will extend to medical noncompetes.

The Michigan Supreme Court has yet to authoritatively weigh in on the issue of noncompetes for physicians and others in the medical field. Given the unique role that physicians play in our society, some states have been loathe to enforce noncompete agreements against physicians. Most recently, the Tennessee Supreme Court held that physician noncompetes are almost per se unenforceable.

While there is a national split of authority as to how physician noncompetes should be viewed by the courts, most jurisdictions enforce them, and Michigan appears to have joined this group in a recent opinion of the court of appeals in *St. Clair Medical PC v Borgiel*.[1] However, the issue is still subject to review by the Supreme Court, and, even under *Borgiel,* attorneys should be sensitive to special circumstances particular to physicians that may play a role in a court's ruling on a physician noncompete.

Noncompetition Agreements in Michigan

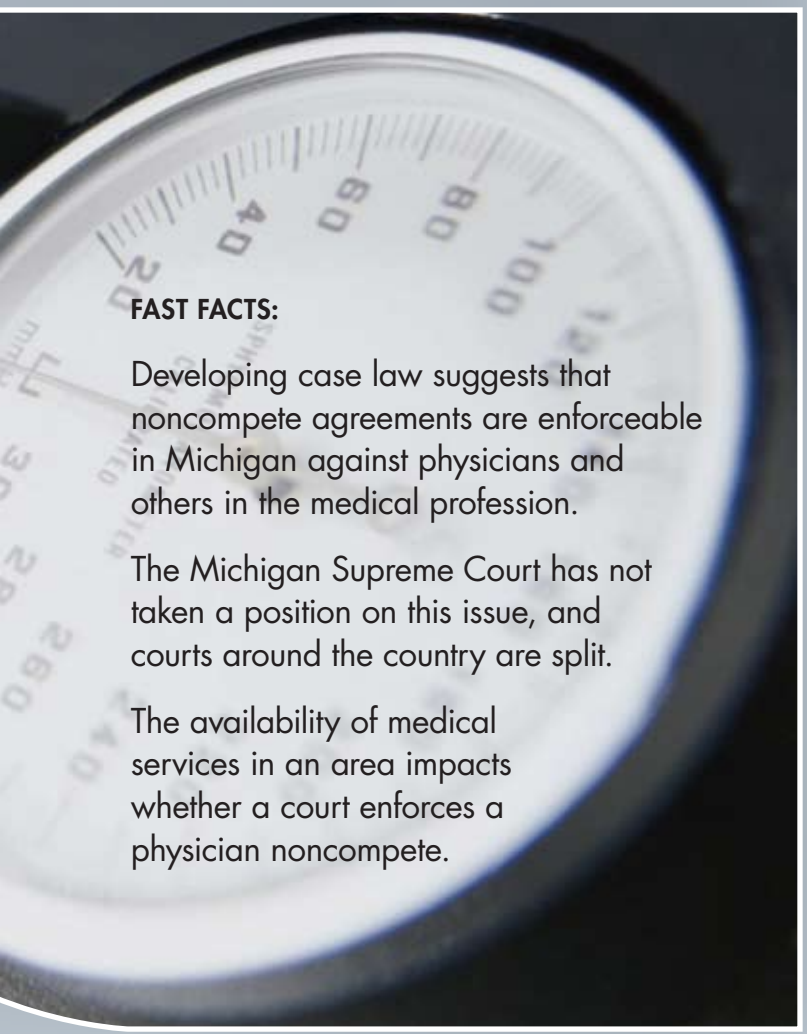
As noted, the four basic requirements for an enforceable noncompete are set forth in MCL 445.774a. Noncompete agreements take two basic forms in the employment context. The most common is an agreement that limits the employee's ability either to work for a competitor or to compete for the former employer's customers for some period of time after separating. Such agreements are normally enforced by injunction. The alternative, which was enforceable in Michigan even before 1985,[2] does not purport to prohibit the conduct, but exacts a price if the former employee does something the agreement prohibits (a so-called liquidated damages or "pay to play" agreement).

Michigan Courts and Medical Profession Noncompetes

The Michigan Supreme Court has not spoken specifically on the issue of noncompetes in the medical profession. Two recent Michigan Court of Appeals opinions, however, suggest the current state of the law in this area.

In *Neocare Health Systems, Inc v Teodoro,*[3] the court enforced a registered nurse's agreement that, for five years postemployment, she would not solicit or render services for plaintiff's patients. Without discussing policy issues, the court considered the nature of the home health-care industry in finding that defendant was in a particularly good position to solicit clients of her former employer.

In *St. Clair Medical PC v Borgiel,* the court engaged in a more thorough review of the issues. The court upheld a $40,000 liquidated damages provision triggered by the defendant physician's violation of a noncompete, holding that "[a] physician who establishes patient contacts and relationships as the result



FAST FACTS:

Developing case law suggests that noncompete agreements are enforceable in Michigan against physicians and others in the medical profession.

The Michigan Supreme Court has not taken a position on this issue, and courts around the country are split.

The availability of medical services in an area impacts whether a court enforces a physician noncompete.

of the goodwill of his employer's medical practice is in a position to unfairly appropriate that goodwill and thus unfairly compete with a former employer upon departure." The court went on to address a live wire in the national debate on physician noncompetes—a statement issued by the American Medical Association (AMA):

> Defendant also argues that the covenant is unreasonable in light of the Principles of Medical Ethics issued by the American Medical Association, which provides:
>
> > Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. [AMA, E-9.02: Restrictive Covenants and the Practice of Medicine.]
>
> We conclude that this standard merely reflects the common law rule of reasonableness and states that restrictive covenants are unethical only if they are excessive in geographical scope or duration.

Borgiel is the first published opinion to squarely address these issues in Michigan.[4] While *Borgiel* is instructive, it only partially reveals the various policy concerns raised by courts regarding these agreements. A fuller appreciation of these issues will help the practitioner foresee and avoid potential pitfalls.

A Brief Glance at National Case Law and Potential Lessons for Michigan

There is a split of authority nationally as to the enforceability of physician noncompete agreements.[5] This article is not an all-encompassing survey, but a brief discussion of a few recent cases illustrates some of the issues with which courts are grappling.

In January 2005, the Tennessee Supreme Court held, under the common law, that physician noncompete agreements were void as against public policy.[6] That ruling relied heavily on the AMA statement discussed by the Michigan Court of Appeals in *Borgiel* and includes a thorough review of the national case law on the issue. The ruling has already come under heavy attack and speculation as to whether it will hold up or be narrowed in subsequent cases.[7]

Other courts opt for a case-by-case analysis that attempts to take all of the contextual facts into account. While obviously more flexible than the absolutist approach of Tennessee, this approach has the disadvantage of rendering nearly every situation sui generis and hence unpredictable and potentially expensive to litigate. In New Jersey, the court considered the following factors, among others:

> Significant here is the demand for the services rendered by the employee and the likelihood that those services could be provided by other physicians already practicing in the area. If enforcement of the covenant would result in a shortage of physicians within the area in question, then the court must determine whether this shortage would be alleviated by new physicians establishing practices in the area. It should examine also the degree to which enforcement of the covenant would foreclose resort to the services of the 'departing' physician by those of his patients who might otherwise desire to seek him out at his new location. If the geographical dimensions of the covenant make it impossible, as a practical matter, for existing patients to continue treatment, then the trial court should consider the advisability of restricting the covenant's geographical scope in light of the number of patients who would be so restricted.[8]

The court then refused to enforce a noncompete, stating that defendant "presented evidence to show that preventing [the physician] from practicing within the thirty-mile radius will be injurious to the public because there is a shortage of neurosurgeons in that area." Similarly, in Idaho, the Supreme Court remanded a case to the trial court for factual findings on a host

of issues, including the "reasonableness" of various elements of the noncompete.[9]

This approach places the burden on litigants to anticipate and present evidence on issues—such as the local availability of particular medical services—generally not required in the "regular" noncompete case. Given that the Michigan Court of Appeals in *Borgiel* seems to be in accord with these decisions, physician noncompete litigation in Michigan can be expected to take on some of these same characteristics.

Tips for Physicians, Employers, and Attorneys

A few tips for all involved:

For physicians:

- Watch what you sign. Before you agree to a noncompete or a pay-to-play agreement, be ready to accept the consequence of its enforcement.
- If you must sign a noncompete, attempt as much as possible to narrow the duration, geographic scope, and other aspects of the agreement (e.g., an exception for involuntary termination). Moreover, during the course of your employment, look for opportunities to eliminate the noncompete or at least further narrow it.
- If you want to challenge your noncompete post-employment, see a lawyer, ideally before you accept employment that would arguably violate the noncompete. You may be able to alter the precise terms of your new employment and avoid the noncompete altogether. At a minimum, you can go into the battle on your terms and with a plan, and not find yourself simply reacting to a lawsuit from your former employer.

For employers:

- Be reasonable. Carefully consider the geographic scope and duration. Limit the agreement to patients of the employee, not all patients of the hospital or clinic. Overreaching can be tempting, but a court might refuse to enforce an agreement and strike the entire provision as overly broad.
- Consider use of a liquidated damages provision rather than a noncompete. While judged under a similar standard, courts may be influenced by the hardship imposed by a noncompete, whereas a liquidated damages provision is less personal.
- Consider using both noncompete and nonsolicitation language in your agreements.
- Identify and protect your trade secrets. While the mere names of patients may not constitute a trade secret, the overall "file," which includes patient history and billing and insurance information, may. See, e.g., *Total Care Physicians PA v O'Hara,*[10] in which a departed physician misappropriated trade secrets by using his former employer's computer system to send out departure notifications, which were, in truth, solicitations for the physician's new practice.

For lawyers:

- Be prepared to address the arguments regarding the AMA statement as well as the underlying policy issues.
- Explore the concerns that someone might reasonably raise—such as whether there is some paucity of this sort of physician within this geographic area—and either demonstrate to the court that it is not a concern or exploit a scarcity to argue that public policy requires that the noncompete either be struck down or at least "blue penciled" (i.e., limited by the court).
- A physician noncompete case may cost more to litigate, especially for an all-important preliminary injunction hearing. For example, consider bringing in experts to testify to the state of the industry in your area.
- Consider alternative theories, such as misappropriation of trade secrets and unjust enrichment.
- If you have a strong case and lose in the trial court, appeal. Given the divergent views on this issue nationally, and the lack of any binding precedent by the Supreme Court, you might just be making new law. ■

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FOOTNOTES

1. *St. Clair Medical PC v Borgiel,* 270 Mich App 260; 715 NW2d 914 (2006).
2. *Follmer, Rudzewicz & Co v Kosco,* 420 Mich 394; 362 NW2d 676 (1984).
3. *Neocare Health Systems, Inc v Teodoro,* 2006 WL 198329 (January 26, 2006).
4. Other reported decisions address physician noncompetes, but none squarely addresses the policy issues discussed in *Borgiel.* See *Compton v Lepak,* 154 Mich App 360; 397 NW2d 311 (1987); *Roland v Kenzie,* 11 Mich App 604; 158 NW2d 72 (1968).
5. See Validity and construction of contractual restrictions on right of medical practitioner to practice, incident to employment agreement, 62 ALR 3d 1014; Wilson, *Location, location, location: The geographic facts about noncompete clauses* (AMEdNews.com, January 2006) <http://www.ama-assn.org/amednews/site/free/prsa0130.htm> (accessed March 12, 2007). Some states have prohibited physician noncompetes by statute, but not pay-to-play provisions. See, e.g., Colorado, Colo Rev Stat Ann 8-2-113(3) (2003).
6. *Murfreesboro Medical Clinic, PA v Udom,* 166 SW3d 674 (Tn, 2005).
7. See, e.g., Schuler, *Knock Out? Supreme Court deals a blow to noncompetes for docs, but this fight is not over,* 41-DEC Tenn B J 16 (December 2005); *Intermountain Eye and Laser Centers, PLLC v Miller,* 142 Idaho 218; 127 P3d 121 (2005).
8. *Community Hosp Group, Inc v More,* 183 NJ 36; 869 A2d 884, 898 (2005) (quotation omitted).
9. *Intermountain Eye and Laser Centers, PLLC,* 127 P3d at 128–133.
10. *Total Care Physicians PA v O'Hara,* 2002 WL 31667901 (Del, 2002).