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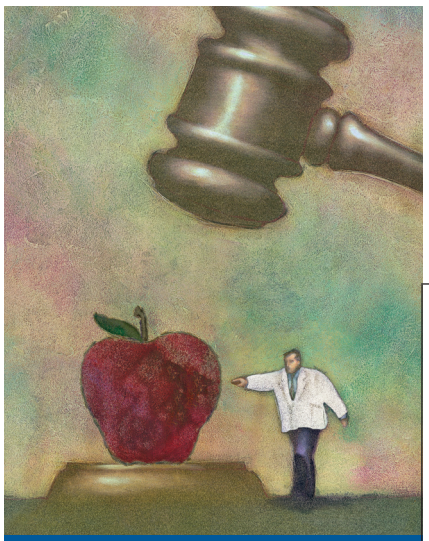

On the Cover

It has been a widely accepted and long-standing practice for hospitals to provide financial benefits to recruit physicians to their communities, notwithstanding that it raises a variety of legal issues. The article, "Physician Recruitment: New Stark Regulations Upset the Applecart," written by Charles B. Oppenheim, examines the final Stark II, Phase II regulations with respect to physician recruitment.

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Hospitals, Their Physicians, And Their Non-Competes: Breaking Up—Should Be Hard To Do

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I. INTRODUCTION

Courts have traditionally looked favorably on doctors seeking relief from non-competition agreements, and analysis has focused primarily on the acknowledged need of every community for more quality healthcare. We believe, however, that this customary view of physicians and their agreements can be shortsighted when applied to covenants not to compete between doctors and their hospital employers.

The traditional view of physicians and their contracts can be particularly narrow when looking at specialty doctors and their regional practices. In considering the need for medical specialization, one must recognize that nearly every community outside the ambit of the country's academic medical centers is underserved. Focusing only on the doctor and the community to the exclusion of the hospital employer does not provide a balanced analysis. The public interest in supporting those hospitals willing to make the financial commitment, take the economic risk, and extend the physical and time-consuming effort necessary to establish a medical specialty practice from scratch should also be considered. The affected hospitals are left with no adequate remedy. Dollars alone cannot compensate the loss of a physician recruited, nurtured, and promoted as the centerpiece of a regional specialty practice.

Traditionally, a hospital plaintiff seeking to enforce a non-competition agreement bears the burden of demonstrating the reasonableness of the limitation, while giving deference to the community need for the precluded service. The hospital must show that the covenant: (1) relates to the contract for employment; (2) is supported by adequate consideration; and (3) is reasonably limited in both duration of time and geographical extent. A plaintiff seeking enforcement must also show that enforcement of the covenant will not be a detriment to the availability and quality of healthcare services in the underserved area. Understandably, courts attach great weight to this additional public policy prong.

While one can never be in favor of a detriment to healthcare—consideration must be given to how the issue is framed. A too narrow view of the public interest leads to a rule of per se invalidity of non-competition agreements involving specialty physicians geographically removed from the country's academic medical centers.

The current emphasis on underserved communities discourages hospitals from investing in and building sophisticated specialty practices for fear of having their physicians and resources cherry picked by their competitors. By definition, regional medical practices often serve areas within the boundaries of expansive restrictive covenants. Patients seeking a qualified specialist regularly drive some distance to receive the best medical care.

As things now stand, there are few, if any, negative consequences for those who leave their hospital employer taking with them their training, patients, and staff. They are free to market themselves to a high bidder who can afford to pay more because start up risks and costs have been avoided. It is noteworthy that there is often no deterrence to the acquiring hospital/or practice. The contract between the nurturing institution and its physician usually contains "protective" language that defines the relationship as "priceless"—incapable of calculating damages from the irreparable harm of divorce. In any event, no liquidated damages clause can protect against the actions of an outside third party.

Courts must shift the balance of their public policy considerations in weighing whether to enforce non-competition agreements involving physicians. A more balanced analysis would be to take the measure of the public's interest in a not-for-profit hospital's investment in the establishment of a sophisticated, regional medical practice versus the loss of a single physician to a community. Special consideration must be given to the circumstances under which the physician's employment was terminated. A recent New Jersey case, *Community Hospital Group, Inc. v. More,*[1] espoused a more expansive view of the public interest. This paper compares the traditional approach with that taken in the *More* decision.

A. Pennsylvania—The Traditional View

Pennsylvania's courts have taken the traditional path in evaluating the enforceability of non-competition agreements involving physicians. Two Pennsylvania cases, *New Castle Orthopedic Associates v. Burns*[2] and *West Penn Specialty MSO, Inc. v. Nolan,*[3] set the bounds for the traditional view. In Pennsylvania, a plaintiff seeking to enforce such a covenant must show: (1) the covenant relates to the contract for employment; (2) the covenant is supported by adequate consideration; and (3) the covenant is reasonably limited in both duration of time and geographical distance.[4] A plaintiff seeking enforcement must also demonstrate that the court's protection will not detrimentally impact the availability of healthcare services in the restricted area.[5] The *Burns* court emphasized that it attached great weight to this additional public policy prong.[6]

B. Burns and Nolan—The Framework of a Quantitative Public Interest Analysis

In *Burns*, the court refused to enforce a non-competition agreement against the defendant orthopedist.[7] The covenant prohibited the defendant from practicing medicine, in any form, within his employer's county for a period of two years, after the termination of his employment.[8] In assessing the validity of the covenant, the court stated that because the availability and costs of healthcare are national concerns, the law must weigh the impact of enforcement of such agreements upon that larger problem.[9] It stressed that "paramount to the respective rights of the parties to the covenant must be its effect on the consumer who is in need of the service."[10] The *Burns* court's focus on the availability of orthopods was restricted to that immediate need.[11]

Almost twenty-one years later, in *West Penn Specialty MSO, Inc. v. Nolan*, the Pennsylvania Superior Court applied the *Burns* public policy analysis when it enforced a non-competition agreement against a defendant oncologist.[12] The *Nolan* restrictive covenant prohibited the defendant from practicing medicine within ten miles of the hospital where she conducted her primary practice.[13] The covenant was held enforceable for the remainder of Nolan's five-year employment contract, plus one additional year.[14]

The *Nolan* court refused to look beyond the *Burns* standard in determining its enforceability.[15] *Nolan* resorted to the notion of the public interest as the "quantitative sufficiency of physicians practicing in the restricted area."[16] Having taken the census of oncologists in Allegheny County, the court concluded that the quantity of comparable specialists in the area justified enforcement of the covenant.[17]

C. The Inherent Limitations of a One-Dimensional Public Interest Analysis

In *Nolan*, the center of the restricted radius was Allegheny County, an area well served by respected academic medical centers.[18] The availability of physicians was apparently of less concern. The court enforced the non-competition agreement.[19] Conversely, in *Burns*, the restricted area was Lawrence County, a rural area, apparently suffering from a shortage of orthopods.[20] The *Burns* court

refused to enforce the non-competition agreement, with an eye to the detrimental impact caused by the loss of a single physician.[21]

It is respectfully submitted that measuring public interest by the impact on quantity of comparable healthcare in the restricted area based on the addition or subtraction of a *single doctor* is, at best, a one-dimensional analysis. This approach fails to consider the impact on available healthcare where hospitals are discouraged from incurring the costly risk of developing a specialty practice. It can lead to inconsistent and inequitable results based on geography and physician count. If the covenant covers an area of high physician availability—escape is difficult. If there is a perceived need for a particular physician specialty—the opposite is true. But what about the underserved medical center that is doing its best to establish a well rounded program?

A public interest test based primarily on a physician count leads to a per se rule of unenforceability in all underserved areas. Those hospitals in physician-dry areas that take the initiative should be afforded the protection provided by the agreements they are able to negotiate. In most situations only injunctive relief protects against the incalculable loss of a specialty physician to a competitor. When a court refuses to enforce an employer hospital's non-competition agreement, that hospital loses, not only its quantifiable initial investment and patient base, but also, potentially, its ability to provide critical care, recruit top physicians and staff, and capitalize on related opportunities. Such losses are not only incalculable, but irreparable.[22] Outside of all but the most desolate communities, there is no reason for the simplistic formula applied by courts adopting the traditional view. Courts deciding injunctive relief have broad discretion in customizing remedies to best address the specific problem.

The shortcomings of the traditional view employed in Pennsylvania are exposed when considering the approach followed in the recent New Jersey case. *Community Hospital Group, Inc. v. More.*[23]

II. AN EXPANDED VIEW OF THE PUBLIC INTEREST

A. Community Hospital Group, Inc. v. More

In *More*, the court had to deal with the issue of a neurosurgeon who had been nurtured by the plaintiff and after three successive agreements sought relief from his non-compete.[24]

The plaintiff, Community Hospital Group, Inc., operates a not-for-profit neuroscience institute, where the defendant neurosurgeon had been employed.[25] In reaching its decision to enforce the restrictive covenant, the court noted that the Institute had invested approximately $14 million in building its neuroscience program and annually spent approximately $200,000 toward promotion and advertising.[26] It found that the viability of the hospital was "dependant upon its ability to recruit and retain a sufficient number of skilled physicians that [would] enable it to generate the necessary volume of patients to support its services."[27] The defendant had been hired just after completing his residency in another state.[28] He came to the hospital with no practice or patient base.[29]

The hospital promoted the defendant to the public and to other referring physician specialists as an expert in his field.[30] The defendant's practice grew from zero surgeries to thirty-five to forty surgeries within six months and increased every year thereafter.[31] Together, the hospital and the physician built the practice.

Within several months of leaving the hospital, the defendant joined a neurosurgery practice located approximately five miles from plaintiff and had staff privileges at a hospital also within the thirty-mile radius of the plaintiff.[32] The *More* court reversed the trial court and enforced the restrictive covenant.[33] It relied on New Jersey's more expansive view of the public interest set forth in *Karlin v. Weinberg* (the "Karlin Test").[34]

B. Applying the Karlin Test

In *Karlin*, the New Jersey Supreme Court held non-competition agreements will be enforced to the extent such a covenant: (1) protects a legitimate interest of the employer, (2) imposes no undue hardship on the employee, and (3) does not injure the public.[35] While New Jersey's analysis considers the effect of enforcement on the surrounding community, it also places great weight on the importance of protecting the interest of the employer and making sure the employee does not experience undue hardship.[36] In something of a reversal of the law on injunctive relief, it shifts the burden from the party seeking enforcement to the party seeking escape from his or her negotiated agreement.

The facts of the *Karlin* case are significant. The case did not involve a unique medical specialty, it arose from a dispute between two dermatologists who had been partners. The agreement itself was originally a one-year employment contract, executed in July 1973, when Dr. Karlin hired Dr. Harvey Weinberg.[37] The original contract prohibited Dr. Weinberg from competing within ten miles of Dr. Karlin's practice for five years from the date of the termination of Dr. Weinberg's employment, for whatever reason.[38] Within the contractual period, Dr. Karlin and Dr. Weinberg formed a partnership, which was never reduced to writing and was dissolved two and one half years later.[39] Thus, at the time Dr. Weinberg left the practice he was acting as Dr. Karlin's partner and not his employee. The circumstances surrounding this garden variety agreement might have allowed the court to sidestep the issues had it desired to do so. The court need not have found that the original non-compete survived the unwritten partnership agreement.

1. Protecting the Legitimate Interests of the Employer

Karlin first seeks to protect the *legitimate* interests of the employer.[40] The court cited its concern for the employer's interest in preserving ongoing relationships with patients utilizing its practice or services.[41] The employer's ongoing duty to the public it serves was seen as primary.[42]

In *More*, the defendant physician had received a disproportionate benefit as a result of his relationship to the hospital. The hospital had made a significant investment in the community's welfare and the doctor's practice.[43] It had spent ten years growing the Institute and building the physician's patient base and reputation.[44] The defendant was the beneficiary of the continuing promotion of his practice.[45]

Failure to enforce such agreements provides an undiluted incentive to those who would follow suit. To fail to take sufficient account of the employer/investor's stake in healthcare is to encourage the worst sort of competition with specialty doctors going to the highest bidder.

2. No Undue Hardship on the Employee

In *Karlin,* the court held that, in order to be enforceable, a non-competition agreement involving physicians must not pose an undue hardship on the employee.[46] The court enumerated considerations in making that determination. Most important were the likelihood of the defendant finding employment outside the restricted area and the reason and circumstances surrounding the termination of the employment relationship.[47] The court distinguished between inconvenience and hardship.[48] The need to find a position outside the agreed upon area of restriction is not necessarily a hardship; neither is a long commute.[49] While the circumstances surrounding the termination of any given employment arrangement will vary widely, the *Karlin* court specified where the employee physician terminates the employment relationship courts should be hesitant to find that undue hardship exists.[50] If an inconvenience is created, it is self-imposed.[51]

In *More*, the defendant chose to leave the Institute because he had outgrown its practice model.[52] He failed to pursue employment opportunities outside of the thirty-mile radius. The defendant had agreed to the restriction in three separate agreements.[53] The court enforced the restriction, finding the doctor's personal dissatisfaction no equal to hardship.[54]

3. Enforcement Will Not Injure the Public

The third factor applied by the *Karlin* court requires that enforcement of a non-competition agreement is not "injurious to the public."[55] This factor matches the public interest prong employed by Pennsylvania and many other courts. The difference is that this aspect of the public interest is the third consideration and not the first. The court scrutinizes how enforcement of the non-competition agreement will impact the availability and quality of healthcare in the affected community.[56] Are there other physicians in the same area practicing the same specialty? Could there be? Could the defendant's patients follow him to an office location outside the boundaries of the non-compete? Does the presence or absence of a single physician really affect the public interest? Are the limitations of the non-compete unnecessarily burdensome? In *More*, the court noted that patient inconvenience is not, by itself, injurious to the public.[57] Specialty practices often draw patients from over long distances.[58]

III. WHY A MULTI-DIMENSIONAL PUBLIC INTEREST ANALYSIS WILL BETTER SERVE THE COMMUNITY AND PRODUCE MORE EQUITABLE RESULTS

A. Encouraging Widespread Growth in the Availability of Specialty Healthcare

A comparison of the *More/*New Jersey approach to the narrow analysis favored by the Pennsylvania courts demonstrates the limitations of simply equating the public interest with a snapshot count of specialty physicians practicing within the restricted area.

The burdens on hospitals attempting to provide quality healthcare have multiplied over the past several years. It is not enough to keep pace with the progress of medical science. Declining levels of reimbursement, the scarcity of trained technicians, shifting patient populations, and numerous other factors combine to make the operation of a financially viable institution extremely difficult. Given these conditions, the establishment of a new specialty department requires a major commitment of time, money, effort, and acceptance of risk. Hospitals have a right to protect their investment through their contractual negotiations with staff physicians. Hospitals have a right to protect themselves against bidding wars for established practices during the period that their physicians continue to be bound by contractual terms. Mere scarcity of physician specialties outside the draw of academic medical centers is simply one factor in an equity court's calculus of irreparable harm. It should not be dispositive.

An analysis that examines not only the impact of enforcement on the surrounding community, but that also places great weight on the importance of protecting the interest of the employer and notes the circumstances surrounding the termination of the employment relationship provides the best way of improving the widespread availability of quality healthcare.

B. Customizing a Remedy—The Court's Equitable Powers

The use of a multi-dimensional public interest analysis is consistent with the trial court perfectly fulfilling its responsibility as a court of equity having the power to customize remedies based on the factual nuances of each case.[59] Temporal and/or geographic limitations must be molded to meet the needs of the doctor, hospital, and community. Once a court analyzes a non-competition agreement by considering the impact of enforcement on the surrounding community, the protectable interests of the employer, and the circumstances surrounding the termination of the employment relationship, it is in the best position to fashion the most appropriate remedy, modifying the agreement where it deems appropriate.

IV. CONCLUSION

The availability of specialty healthcare has become an issue of increasing importance. Hospitals must be encouraged to assume the risk and responsibilities of expanding their fields of care. For their part, courts must give more weight to that aspect of the public interest in determining how their decision impacts access to specialty healthcare.

In short, courts deciding the enforceability of non-competition agreements must be willing to do something more than count doctors.

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We invite those with a different view of this issue to submit an analysis of equal length for publication in a future Health Lawyers News or a 250 word letter to the editor that will be published in the edition following receipt of the letter.

END NOTES

1 838 A.2d 472 (N.J. Super. Ct. App. Div. 2003).
2 392 A.2d 1383 (Pa. 1978).
3 737 A.2d 295 (Pa. Super. Ct. 1999).
4 *See Medical Wellness Assoc. P.C. v. Heithaus*, 51 D&C 4th 1, 23 (C.C.P. Westmoreland 2001).
5 *Burns*, 392 A.2d at 1387.
6 *Id.* at 1385.
7 *See id.*
8 *Id.* at 1384.
9 *Id.* at 1387.
10 *Id.*
11 *Burns*, 392 A.2d at 1388.
12 737 A.2d 295.
13 *Id.* at 297.
14 *Id.* at 302.
15 *Id.* at 301.
16 *Id.*
17 *Id.*
18 *Nolan*, 737 A.2d at 297.
19 *See Id.* Personal behavior of the physicians also influenced both decisions. In *Burns*, the escaping physician had taken steps to protect the interests of his former employer. *Nolan* had taken a more conciliatory approach toward his former employer. Both cases involved physicians leaving for-profit hospitals.
20 *Burns*, 392 A.2d 1383.
21 *See id.*
22 *See Nolan*, 737 A.2d at 299 (damage is irreparable where "it will cause damage which can be estimated only by conjecture and not by an accurate pecuniary standard"); *see also John G. Bryant Co., Inc. v. Sling Testing and Repair, Inc.*, 369 A.2d 1164, 1167 ("[i]ts not the initial breach of the covenant which necessarily establishes the existence of irreparable harm but rather the unbridled threat of the continuation of the violation and an incumbent disruption of the employer's customer relationships").
23 838 A.2d 472 (N.J. Super. Ct. App. Div. 2003).
24 *See id.*
25 *Id.* at 474.
26 *Id.* at 475.
27 *Id.*
28 *Id.*
29 *More*, 838 A.2d at 475.
30 *Id.* at 477.
31 *Id.*
32 *Id.*
33 *Id.* at 489.
34 *See More*, 838 A.2d 472 (relying on a test first annunciated in *Solari Idus., Inc. v. Malady*, 264 A.2d 53 (N.J. 1970), and applied to non-competition agreements between physicians and their employers by *Karlin v. Weinberg*, 390 A.2d 1161 (N.J. 1978)).
35 *Karlin*, 390 A.2d at 1163.
36 *Id.* at 1166.
37 *Id.* at 1163.
38 *Id.* at 1163-64.
39 *Id.* at 1164.
40 *Id.* at 1166.
41 *Karlin*, 390 A.2d at 1169.
42 *Id.* at 1168-69.
43 *More*, 838 A.2d at 475.
44 *See id.*
45 *See id.* at 477 (in addition to its initial expenditures, the hospital incurred extensive costs associated with enhancing and maintaining the defendant's practice, including: costs associated with defendant's continuing education, keeping his license current, tuition reimbursement, business travel, subscriptions to medical journals, medical society dues and annual medical malpractice insurance premiums).
46 *Karlin*, 390 A.2d at 1163.
47 *Id.* at 1169.
48 *Id.*
49 *Id.* at 1169.
50 *Id.*
51 *Id.*
52 *More*, 838 A.2d at 484.
53 *Id.*
54 *See id.*
55 *Karlin*, 390 A.2d at 1163.
56 *Id.* 1169-70.
57 *More*, 838 A.2d at 487.
58 *Id.*
59 *Karlin*, 77 N.J. at 421 n. 4; s*ee also Thermo-Guard, Inc. v. Cochran*, 408 Pa. Super. 54, 65 n. 9 (1990) (citing *Sidco Paper Co. v. Aaron*, 465 Pa. 586, 594-95 (1976)); *Jacobson & Co. v. International Entl. Corp.*, 427 Pa. 429 (1967)).