

REPORT 13 OF THE BOARD OF TRUSTEES (A-24)  
Prohibiting Covenants Not-to-Compete (Resolution 237-A-23, Resolve 3)  
Reference Committee B

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 237 entitled, “Prohibiting Covenants Not-to-Compete in Physician Contracts.” Resolution 237 was introduced by California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, and The Society of Thoracic Surgeons.

Resolve 3 of Resolution 237 (Resolve 3) directs that our AMA study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care – such recommendations to include the appropriate regulation or restriction of (1) covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and (2) de facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.

The term “non-compete” in the report refers to an agreement between an employer and an employed physician that prohibits the physician from working within a certain geographic area and for a period of time after the physician’s employment ends.

This report discusses physicians’ recurring concerns about the effect that non-competes have on both physicians and patients. The report also highlights the reasons why an independent physician group may think it necessary to use a reasonable non-compete to protect legitimate business interests (LBIs).

As directed by Resolve 3, this report describes many ways that non-competes can be regulated, restricted, or modified to achieve the purposes of Resolve 3. The report ends with a recommendation that would be new HOD policy. The recommendation calls on the AMA to continue assisting interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA’s state restrictive covenant legislative template.

Following the instructions of the HOD, this report addresses only Resolve 3. As such, this report does not consider non-competes generally, nor does it adjust any AMA policy positions regarding the pros and cons of non-competes as they may exist between physician practices and physician employees.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-24

Subject: Prohibiting Covenants Not-to-Compete  
(Resolution 237-A-23, Resolve 3)

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

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1 INTRODUCTION

2  
3 At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates  
4 (HOD) adopted Resolution 237 entitled, “Prohibiting Covenants Not-to-Compete in Physician  
5 Contracts.” Resolution 237 was introduced by California, American Academy of Family  
6 Physicians, American Association of Neurological Surgeons, American College of Surgeons,  
7 Congress of Neurological Surgeons, and The Society of Thoracic Surgeons. Resolution 237 stated  
8 the following:  
9

10 RESOLVED, That our American Medical Association support policies,  
11 regulations, and legislation that prohibits covenants not-to-compete for all  
12 physicians in clinical practice who hold employment contracts with for-profit or  
13 non-profit hospital, hospital system, or staffing company employers (New HOD  
14 Policy); and be it further  
15

16 RESOLVED, That our AMA oppose the use of restrictive covenants not-to-  
17 compete as a contingency of employment for any physician-in-training, regardless  
18 of the ACGME accreditation status of the residency/fellowship training program  
19 (New HOD Policy); and be it further  
20

21 RESOLVED, That our AMA study and report back on current physician  
22 employment contract terms and trends with recommendations to address balancing  
23 legitimate business interests of physician employers while also protecting  
24 physician employment mobility and advancement, competition, and patient access  
25 to care - such recommendations to include the appropriate regulation or restriction  
26 of 1) Covenants not to compete in physician contracts with independent physician  
27 groups that include time, scope, and geographic restrictions; and 2) De facto non-  
28 compete restrictions that allow employers to recoup recruiting incentives upon  
29 contract termination. (Directive to Take Action)  
30

31 As directed by the HOD, this report addresses only Resolve 3 of Resolution 237 (Resolve 3). As  
32 such, this report does not consider non-competes generally, nor does it adjust any AMA policy  
33 positions regarding the pros and cons of non-competes as they may exist between physician  
34 practices and physician employees.  
35

36 In this report, “non-compete” is defined as “a contractual term between a physician employer, e.g.,  
37 a hospital, and a physician employee that prohibits the employee from working within a certain

1 geographic area and period of time after the physician’s employment ends.” For example, a  
2 restrictive covenant may prohibit the physician from practicing medicine within 10 miles of the  
3 location where he or she treated patients for two years after employment has ended.

4  
5 BACKGROUND

6  
7 Adoption of Resolution 237 made a significant change to the AMA’s policy on non-compete  
8 clauses (a/k/a covenants not-to-compete or non-competes). Prior to Resolution 237, the AMA was  
9 primarily guided by *Ethical Opinion 11.2.3.1, Restrictive Covenants (Ethical Opinion 11.2.3.1)*,  
10 which states that physicians should not enter into unreasonable non-competes.<sup>1</sup>

11  
12 Pursuant to Resolution 237, AMA policy now requires the AMA to “support policies, regulations,  
13 and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who  
14 hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing  
15 company employers.” Resolution 237 does not supplant *Ethical Opinion 11.2.3.1*, which opposes  
16 the use of unreasonable physician non-competes. Thus, while Resolution 237 prohibits covenants  
17 not-to-compete for all physicians in clinical practice who hold employment contracts with for-  
18 profit or non-profit hospital, hospital system, or staffing company employers, *Ethical Opinion*  
19 *11.2.3.1* applies in other contexts, and thus opposes the use of unreasonable non-competes between  
20 physician employers and physician employees.

21  
22 Resolve 3 appears to recognize the negative impact that non-competes – even those used by  
23 physician employers – may have on physicians and patients. Specifically, Resolve 3 asks the AMA  
24 to make recommendations concerning the appropriate regulation or restriction of non-competes in  
25 physician contracts with independent physician groups that include time, scope, and geographic  
26 restrictions. What follows is a brief discussion regarding how non-competes may harm patients and  
27 physicians.

28  
29 *Non-competes Harm Patients*

30  
31 Enforcement of non-competes often harms patients by ending patient-physician relationships, e.g.,  
32 if a non-compete forces a physician out of a community or otherwise makes the physician  
33 geographically inaccessible to patients. Patients may be particularly at risk when the non-compete  
34 severs long-standing patient-physician relationships where the physician has been taking care of  
35 patients with chronic illnesses. Similarly, a non-compete can thwart a patient’s choice of physician.

36  
37 Non-competes may hinder patients’ ability to timely access care. For example, depending on the  
38 geographic area, there may be a few physicians, general practitioners, or specialists available to  
39 serve the patient population. Even if several physicians practice in the community, forcing a  
40 physician to leave the area may reduce the number of available physicians. Although a replacement  
41 physician may ultimately be recruited to the area, recruitment can be a lengthy process. In the  
42 meantime, the absence of the physician subject to the non-compete may frustrate timely patient  
43 access to physician services – assuming the community’s remaining physicians have the capacity to  
44 take on new patients.

45  
46 Non-competes may also harm patients by compromising physician autonomy. For example, most  
47 physician employment agreements allow the employer (and the physician) to end the agreement at  
48 any time, so long as the other party is given advance notice. (This is typically referred to as  
49 “without cause” termination). A physician who knows that an employer can end their employment  
50 at any time, which will in turn trigger a non-compete, may be very reluctant to engage in patient  
51 advocacy, and speak up about matters negatively affecting patient care, clinical decision-making,

1 etc.

2  
3 *Non-competes Harm Physicians*

4  
5 Non-competes can also harm employed physicians by locking them into untenable working  
6 conditions or responsibilities that are detrimental to physicians' mental and/or physical health,  
7 thereby contributing to the physician burnout epidemic. A physician who is practicing medicine in  
8 demoralizing working conditions may feel an urgent need to find a job with a better working  
9 environment and where the employer listens to its physicians' concerns and fosters a workplace  
10 that is more conducive to the practice of medicine. If a competing employer in the community  
11 offers the physician such an opportunity, a non-compete would bar the physician from accepting  
12 the new position. The physician might solve this issue if he or she were willing to work for an  
13 employer outside the non-compete's geographic restrictions. Doing so, however, could not only  
14 force the physician to leave the area, but require the physician to uproot his or her family from a  
15 community where the family has established significant roots. As a practical matter, working  
16 outside of the non-compete's geographic restriction may then be completely out of the question.  
17 Thus, the physician will simply have no option but to stay in a demoralizing employment situation  
18 that continues to put the physician's mental and physical health at risk and increasingly subjects the  
19 physician to burnout.

20  
21 Based on all of the above, we understand that employed physicians have a strong case for wanting  
22 the AMA to adopt policy calling for a complete ban on non-competes. However, while Resolve 3  
23 requires the AMA to support a ban on non-competes in employment contracts with for-profit or  
24 non-profit hospitals, hospital systems, or staffing company employers, Resolve 3 does not call on  
25 the AMA to do the same with respect to non-competes between independent physician groups and  
26 their physicians. Rather, Resolve 3 asks the AMA to study and report back with recommendations  
27 to address balancing legitimate business interests (LBIs) of physician employers while also  
28 protecting physician employment mobility and advancement, competition, and patient access to  
29 care. Thus Resolve 3 appears to recognize that physician employers may feel the need to use  
30 reasonable non-competes to protect LBIs. The next paragraph discusses those interests.

31  
32 *Employer's Reasons for Requiring Restrictive Covenants*

33  
34 Physician employers may feel that reasonable non-competes are essential to protect LBIs, which  
35 may take several forms. For example, an independent physician group may train the physician,  
36 make referral sources and contacts available to the physician, give the physician access to patients  
37 and patient lists, market the physician in the community, and provide the physician with  
38 proprietary practice information to help the physician build up his or her practice. Physician  
39 employers may want to use non-competes to prohibit a physician from leaving and then opening up  
40 their own practice "down the hall," in the same building, or even across the street – after receiving  
41 the benefit of information, training, patient contacts, and other resources provided by the  
42 independent physician group. Non-competes may give the physician employer the freedom and  
43 security to invest significant resources in the employed physician's success, without the employer  
44 having to worry that the physician will later leave after the physician has developed a significant  
45 patient base, taking those patients with him or her.

46  
47 DISCUSSION

48  
49 There are two recent, major developments or trends relating to physician employment contract  
50 terms relating to the potential balancing of the physician employer and their employed physicians  
51 and patient access. These developments are: (1) the Federal Trade Commission's (FTC) proposed

1 rule on non-competes and (2) the ongoing enactment of state legislation dealing with non-  
 2 competes. Because the FTC’s proposed rule bans physician non-competes, except with respect to  
 3 501(c)(3) organizations under the U.S. Internal Revenue Code (which includes at least some  
 4 hospitals and health systems), the proposed rule is not a source of recommendations about how  
 5 physician contracting, regulation, or restrictions to non-competes might modify non-competes  
 6 themselves to achieve the balance described in Resolve 3. The proposed rule does not prohibit the  
 7 use of reasonable confidentiality provisions to protect trade secrets and other confidential  
 8 information or repayment agreements. These types of provisions might, if taken together, be a  
 9 possible means of achieving the kind of balance described by Resolve 3.

10  
 11 *Recommendations Concerning Possible Modifications to Traditional Non-competes*

12  
 13 State legislatures continue to consider bills that address non-competes, and most states have  
 14 enacted statutes that are applicable to non-competes between physician employers and physician  
 15 employees. These laws, as well as court decisions, provide the basis of how non-competes between  
 16 physician employers and physician employees might be regulated. In states where one or more of  
 17 these laws do not apply, the following recommendations could also be considered in contract  
 18 negotiations between physician employers and their employees as a means of trying to achieve the  
 19 balance described in Resolve 3.

- 20  
 21 • **Bases of termination.** Rather than having the non-compete apply regardless of the reason for  
 22 employment termination, the non-compete might be modified so that it is enforceable only if:  
 23 (1) the physician terminated his or her employment without cause; (2) the physician’s license  
 24 to practice medicine, or prescribe or dispense controlled substances, is currently revoked; or (3)  
 25 the physician is currently excluded from participating in Medicare, Medicaid, or any other  
 26 governmental program providing compensation for services rendered to patients.  
 27  
 28 • **Duration.** A non-compete could be drafted so that it has a short duration. It is not unusual for  
 29 physician non-competes to last two years. But, following the direction of several state laws, the  
 30 duration could be reduced to one year, or even six months. For example, Connecticut limits the  
 31 duration of a physician non-compete to no more than one year.<sup>2</sup> In a frequently cited Arizona  
 32 Supreme Court case, the court affirmed a lower court’s ruling that six months, rather than three  
 33 years, was sufficient to protect the legitimate business interests of a physician practice with  
 34 respect to competition from a formerly employed pulmonologist.<sup>3</sup>  
 35  
 36 • **Scope of services.** A non-compete should apply only to services that the employed physician  
 37 provided to the physician employer, and not, for example, broadly restrict the physician from  
 38 “practicing medicine.” For example, a Louisiana court ruled that a non-compete was too broad  
 39 because it prohibited the physician employee from engaging in the practice of medicine, rather  
 40 than being limited to the pain management services that he provided.<sup>4</sup> On the other hand, the  
 41 Illinois Supreme Court upheld a ruling holding that a non-compete prohibiting a physician  
 42 from practicing medicine was not too broad.<sup>5</sup>  
 43  
 44 • **Working for competitors.** A non-compete could be structured so that it prohibits the departing  
 45 physician from working for a competitor, rather than prohibiting the physician from working  
 46 for any employer in the relevant geographic area.<sup>6</sup>  
 47  
 48 • **Tying the geographic scope of the non-compete to a single location.** A non-compete should  
 49 be written so that it is tied to the specific location where the physician provided the majority of  
 50 his or her services, sometimes referred to in state law as the “primary practice site.” A non-

1 compete should not include any geographic area where the physician employer has offices—  
2 since the employer may have several offices in a state or states.<sup>7</sup>

- 3
- 4 • **Reasonable buy-out provision.** A non-compete could be drafted so that the departing  
5 physician could buy his or her way out of the non-compete.<sup>8</sup> The amount of the buyout should  
6 be reasonable based on a predetermined formula to eliminate ambiguity concerning how the  
7 buyout amount will be calculated. However, in some cases, even if there is no dispute  
8 concerning the buyout’s reasonableness, a departing physician may not be able to buy his or  
9 her way out of a non-compete because the amount of the buyout is more than the physician can  
10 pay.
  - 11
  - 12 • **Carve out for specific types of patients.** Some state statutes that do permit the use of non-  
13 competes allow the departing physician to continue to see patients with specific types of  
14 conditions. For example, the Texas statute permits the physician to still treat patients with an  
15 acute illness.<sup>9</sup> The Colorado statute may also serve as an example here. Although the Colorado  
16 law prohibits non-competes in physician employment agreements, it does permit punitive  
17 damages related to competition. However, punitive damages are not recoverable if the formerly  
18 employed physician is treating a patient with a rare disorder.<sup>10</sup>

19

20 *Use of Contractual Provisions that are not Non-competes*

21

22 There are other kinds of post-employment restrictions that may represent other ways of attempting  
23 to achieve the balance described in Resolve 3. A physician employer may, however, be concerned  
24 that these alternatives do not sufficiently protect its LBI. This section describes some of these other  
25 options, which may be used in combination with one another.

26

27 Trade Secrets

28

29 A contract clause obligating the departing physician not to disclose the employer’s trade secrets is  
30 one way that the physician employer could protect its LBI. All states have laws protecting trade  
31 secrets and most states have adopted the Uniform Trade Secrets Act<sup>11</sup> (UTSA) in various forms.  
32 The UTSA defines “trade secret” as information, including a formula, pattern, compilation,  
33 program, device, method, technique, or process, that: (1) derives independent economic value,  
34 actual or potential, from not being generally known to, and not being readily ascertainable by  
35 proper means by, other persons who can obtain economic value from its disclosure or use and  
36 (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

37

38 The UTSA includes a civil cause of action for trade secret misappropriation, which refers to  
39 disclosure or use of a trade secret by a former employee without express or implied consent.  
40 Moreover, the courts have held that trade secrets include patient lists, medical records, and  
41 superbills containing patient addresses, medical diagnoses and treatment codes, and patient  
42 insurance information.<sup>12</sup> AMA policy states, however, that billing records and associated medical  
43 records should not be treated as proprietary or as trade secrets.<sup>13</sup>

44

45 Confidentiality Clauses

46

47 Physician employers may also use confidentiality agreements to protect legitimate business  
48 interests. Confidential information includes, but is not limited to, trade secrets. Some state laws  
49 define “confidential information.” For example, the Georgia non-compete statute defines  
50 “confidential information” in part to mean data and information:

1 Relating to the business of the employer, regardless of whether the data or  
2 information constitutes a trade secret...disclosed to the employee, that has value to  
3 the employer; is not generally known to the employer's competitors; competitors  
4 of the employer; and includes trade secrets, methods of operation, names of  
5 customers, price lists, financial information and projections, route books, personnel  
6 data, and similar information...<sup>14</sup>  
7

8 The employer should require that, upon termination of the physician's employment, that the  
9 departing physician promptly return any confidential information in the physician's possession or  
10 control to the physician employer, including but not limited to, information on electronic devices.  
11 Further, the physician employer should consider requiring the employee to agree to a provision  
12 prohibiting a physician from taking any property, patient lists, or records of the employer with him  
13 or her upon the termination or expiration of the employment agreement.<sup>15</sup>  
14

#### 15 Protecting Trade Secrets and Confidential Information Through Non-disclosure Agreements

16

17 A physician employer can take steps to protect both confidential and trade secrets information by  
18 requiring the employee to sign a non-disclosure agreement (NDA) that applies after the physician  
19 leaves the employer. An NDA needs to be (1) clear about the information that is protected and (2)  
20 specifically tailored to protect that information. Courts may refuse to enforce NDAs that are too  
21 broad, e.g., they apply to information that is not considered to be confidential.  
22

23 In some circumstances an NDA may be so broad that it can function as a de facto non-compete.  
24 One example of an NDA functioning as a de facto non-compete is found in *Brown v. TGS Mgmt.*  
25 *Co., LLC*. In this case, "confidential information" included any information that was "usable in" or  
26 "relates to" the securities industry. A California court refused to enforce the NDA because it  
27 defined confidential information "so broadly as to prevent [the employee] from ever working again  
28 in securities trading" and thus, operated as a de facto non-compete. As a result, the court concluded  
29 that it could not be enforced under California law.<sup>16</sup>  
30

31 While NDAs do not restrict the mobility of physician employees as much as non-competes,  
32 physician employers may be concerned that an NDA is not sufficient to protect its trade secrets and  
33 other confidential information. It may be challenging for the physician employer to detect a breach  
34 of an NDA in comparison with a non-compete. Further, there can be significant litigation  
35 concerning just what damage the breach has caused the employer. Issues with detection and  
36 establishing damage amounts are likely to make enforcement of NDAs more expensive than  
37 enforcement of non-competes. However, in lieu of having to prove damage amounts, the physician  
38 employer might, to the extent permitted by state law, be able to include in the employment contract  
39 a clause entitling the employer to liquidated damages if the physician breaches an NDA, although  
40 the amount of liquidated damages could itself be subject to litigation.  
41

#### 42 Non-solicitation Agreements

43

44 Most states that prohibit non-competes do not disallow the use of non-solicitation agreements  
45 (NSA). For example, the Minnesota non-compete statute does not prohibit an NDA, an agreement  
46 designed to protect trade secrets or confidential information, an NSA, or an agreement restricting  
47 the ability to use client or contact lists or solicit customers of the employer.<sup>17</sup> NSAs can apply to  
48 the physician employer's patients, employees, or both. An NSA should, however, entitle the  
49 physician to notify patients whom they have seen and who wish to continue care with them of their  
50 new location and be advised they may sign a records release to have their records transferred to  
51 their physician of choice.

1 As in the case of NDA, it is likely that an employer will find it more difficult, and thus more  
2 expensive, to detect the breach of an NSA and prove damages, as opposed to a non-compete.  
3 Proving a breach of an NSA may be particularly challenging because employees may want to work  
4 for, and patients may decide to continue their relationship with, the departing physician on their  
5 own initiative without any solicitation from the physician. Again, as in the case of breach of an  
6 NDA, the physician employer might, to the extent permitted by state law, include a liquidated  
7 damages provision in its employment agreement with the physician to remedy a breach of an NSA,  
8 which, as noted above, may also be the subject of litigation.

### 9 10 Repayment Agreements

11  
12 Using a repayment agreement can be another way to attempt to achieve the balance described in  
13 Resolve 3. The main concern here most likely has to do with what costs are covered by the  
14 agreement. Fortunately, some state non-compete statutes address this issue. For example, the New  
15 Mexico non-compete law, which bans non-competes in physician employee contracts, states that  
16 during an initial employment period of less than three years, the physician employer can require  
17 the departing physician to repay all or a portion of: (1) a loan; (2) relocation expenses; (3) a  
18 signing bonus or other remuneration to induce the health care practitioner to relocate or establish a  
19 health care practice in a specified geographic area; or (4) recruiting, education, and training  
20 expenses.<sup>18</sup> The West Virginia non-compete statute, on the other hand, states that a physician  
21 employer may require an employed physician to repay all or a portion of: (1) a loan; (2) location  
22 expenses; (3) a signing bonus; (4) remuneration to induce the physician to relocate or establish a  
23 physician practice in a specific geographic area; or (5) recruiting, education, and training expenses.  
24 (The West Virginia statute does permit the use of physician non-competes lasting no more than  
25 one year). Unlike the New Mexico statute, the repayment obligation appears to have no time  
26 limit.<sup>19</sup>

27  
28 A physician employer must take care that the repayment agreement is fair and is not inflated by  
29 costs that do not reflect actual financial benefits conferred on the employed physician. Notably, the  
30 FTC's proposed non-compete rule states that a repayment agreement may function as a de facto  
31 non-compete if the repayment obligation is not reasonably related to the costs the employer  
32 incurred for training the worker.<sup>20</sup> The abuse of repayment agreements has come under fire from  
33 other quarters as a means of preventing employees from leaving their jobs through debt, and are  
34 being used as a work-around in states where non-competes are banned.<sup>21</sup> If a physician employer is  
35 considering how to structure a repayment agreement and what types of costs ought to be covered,  
36 the cost categories listed in the New Mexico and the West Virginia laws may be useful guides,  
37 keeping in mind that the cost amounts must also be reasonable.

### 38 39 *AMA Educational and Advocacy Resources*

40  
41 The AMA has many educational and advocacy resources concerning non-competes. For example,  
42 the Advocacy Resource Center (ARC) has, pursuant to prior AMA policy, developed a  
43 comprehensive analysis of all state non-compete laws that apply to physicians entitled "Legislative  
44 Template: Covenants not-to-Compete in Physician Contracts." Those interested in this advocacy  
45 resource may obtain it by contacting the ARC at [https://www.ama-assn.org/system/files/rc-](https://www.ama-assn.org/system/files/rc-legislative-template.pdf)  
46 [legislative-template.pdf](https://www.ama-assn.org/system/files/rc-legislative-template.pdf). The AMA Career Planning Resource webpage also has a wealth of  
47 information discussing physician employment issues, which includes information and tips regarding  
48 restrictive covenants. The AMA Career Planning Resource webpage may be accessed at  
49 [https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-](https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts)  
50 [contracts](https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts).



1 RELEVANT AMA POLICY

2  
3 The following AMA policy is relevant to this Board Report:

4  
5 • **Code of Medical Ethics 11.2.3.1 Restrictive Covenants**

6  
7 Competition among physicians is ethically justifiable when it is based on such factors as  
8 quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

9  
10 Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit  
11 access to care.

12  
13 Physicians should not enter into covenants that:

14  
15 (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of  
16 time or in a specified geographic area on termination of a contractual relationship; and

17  
18 (b) Do not make reasonable accommodation for patients' choice of physician.

19  
20 Physicians in training should not be asked to sign covenants not to compete as a condition of  
21 entry into any residency or fellowship program.

22  
23 AMA Principles of Medical Ethics: III, IV, VI, VII

24  
25 • **Restrictive Covenants of Large Health Care Systems D-383.978**

26  
27 Our AMA, through its Organized Medical Staff Section, will educate medical students,  
28 physicians-in-training, and physicians entering into employment contracts with large health  
29 care system employers on the dangers of aggressive restrictive covenants, including but not  
30 limited to the impact on patient choice and access to care.

31  
32 • **Restrictive Covenants in Physician Contracts H-383.987**

33  
34 Our AMA will provide guidance, consultation, and model legislation concerning the  
35 application of restrictive covenants to physicians upon request of state medical associations and  
36 national medical specialty societies.

37  
38 • **Prohibiting Covenants Not-To-Compete in Physician Contracts H-265.988**

39  
40 (1) Our American Medical Association support policies, regulations, and legislation that  
41 prohibits covenants not-to-compete for all physicians in clinical practice who hold employment  
42 contracts with for-profit or non-profit hospital, hospital system, or staffing company  
43 employers.

44  
45 (2) Our AMA will oppose the use of restrictive covenants not-to-compete as a contingency of  
46 employment for any physician-in-training, regardless of the ACGME accreditation status of the  
47 residency/fellowship training program.

48  
49 (3) Our AMA will study and report back on current physician employment contract terms and  
50 trends with recommendations to address balancing legitimate business interests of physician

1 employers while also protecting physician employment mobility and advancement,  
2 competition, and patient access to care - such recommendations to include the appropriate  
3 regulation or restriction of a) Covenants not to compete in physician contracts with  
4 independent physician groups that include time, scope, and geographic restrictions; and b) De  
5 facto non-compete restrictions that allow employers to recoup recruiting incentives upon  
6 contract termination.

7  
8 • **Covenants Not to Compete D-265.988**  
9

10 Our AMA will create a state restrictive covenant legislative template to assist state medical  
11 associations, national medical specialty societies and physician members as they navigate the  
12 intricacies of restrictive covenant policy at the state level.

13  
14 **RECOMMENDATIONS**  
15

16 The Board of Trustees recommends that the following policy be adopted, and the remainder of the  
17 report be filed:

- 18  
19 1. That the American Medical Association (AMA) continue to assist interested state  
20 medical associations in developing fair and reasonable strategies regarding restrictive  
21 covenants between physician employers and physician employees including regularly  
22 updating the AMA's state restrictive covenant legislative template. (New HOD Policy)

Fiscal Note: Less than \$500

## REFERENCES

- <sup>1</sup> See <https://policysearch.ama-assn.org/policyfinder/detail/%2211.2.3.1%20Restrictive%20Covenants%22?uri=%2FAMADoc%2FEthics.xml-E-11.2.3.1.xml>
- <sup>2</sup> Conn. Gen. Stat. § 20-14p
- <sup>3</sup> *Valley Medical Specialists v. Farber*, 982 P.2d 1277, 1281 (Ariz. 1999)
- <sup>4</sup> *Paradigm Health Sys., L.L.C. v. Faust*, 218 So. 3d 1068, 1071 (La.App. 1 Cir. 2017)
- <sup>5</sup> *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill. 2d 52, 77 (2006)
- <sup>6</sup> See e.g., NV Rev Stat § 613.195(6)(a) and (b)
- <sup>7</sup> See e.g., Conn. Gen. Stat. section 20-14p and W. Va. Code § 47-11E-2
- <sup>8</sup> For statutory examples, see IN Code § 25-22.5-5.5 and TX Bus & Com Code § 15.50
- <sup>9</sup> Tex. Bus. & Com. Code § 15.50
- <sup>10</sup> C.R.S. 8-2-113
- <sup>11</sup> See <https://www.uniformlaws.org/committees/community-home/librarydocuments?communitykey=3a2538fb-e030-4e2d-a9e2-90373dc05792&LibraryFolderKey=&DefaultView=&5a583082-7c67-452b-9777-e4bdf7e1c729=eyJsaWJ5YXJ5ZmFkLTRjOGItODk3Yi1jYWE2ZjA4N2U4ZWVifQ%3D%3D>
- <sup>12</sup> See e.g., *Total Care Physicians, P.A. v. O'Hara*, 798 A.2d 1043, 1054 (Del. Super. Ct. 2001)
- <sup>13</sup> Physician Access to Their Medical and Billing Records D-315.971
- <sup>14</sup> O.C.G.A. § 13-8-51
- <sup>15</sup> See e.g., W.Va. Code § 47-11E-3
- <sup>16</sup> *Brown v. TGS Mgmt. Co., LLC*, 57 Cal. App. 5th 303, 306, 319 (Cal. Ct. App. 2020); FTC Proposed Non-compete Rule, 88 F.R. 3482, 3509 (January 19, 2023) <https://www.govinfo.gov/content/pkg/FR-2023-01-19/pdf/2023-00414.pdf>
- <sup>17</sup> Minn. Stat. § 181.988
- <sup>18</sup> N.M. Stat. Ann. § 24-11-3
- <sup>19</sup> W.Va. Code § 47-11E-3
- <sup>20</sup> FTC Proposed Non-compete Rule, 88 F.R. 3482, 3535 (January 19, 2023) <https://www.govinfo.gov/content/pkg/FR-2023-01-19/pdf/2023-00414.pdf>
- <sup>21</sup> See e.g., Harris, Jonathan, *The New Non-compete: The Training Repayment Agreement Provision (TRAP) as a Scheme to Retain Workers through Debt* (November 9, 2022). Northwestern University Law Review Of Note, Nov. 9, 2022, Loyola Law School, Los Angeles Legal Studies Research Paper No. 2022-15, Available at SSRN: <https://ssrn.com/abstract=4273728>