NON-COMPETE CLAUSES IN PHYSICIAN EMPLOYMENT CONTRACTS ARE BAD FOR OUR HEALTH

by Hazel G. Beh and H. Ramsey Ross[1]

I. INTRODUCTION

Hawai‘i faces unique challenges in recruiting and retaining physicians -- challenges that may be exacerbated by the inclusion of non-competition clauses in physician employment contracts.[2] In this article, we argue that an outright legislative ban on physician non-compete clauses would be good for the health of Hawai‘i citizens and the vitality of its shrinking[3] medical workforce.

Restrictive covenants[4] in employment contracts describe a class of ancillary agreements between employers and employees whereby the employee agrees not to compete with the employer after termination of the contract. Typically the non-compete clause contains a limit on the duration, scope of activity, and geographic area to which it extends. [5] Nationally, there is widespread criticism of the use of restrictive covenants in physician employment contracts because of the potential harm to the public. Here, we offer medical workforce shortages as yet another reason to discourage non-compete agreements in this context. In Part II of this article, we will describe the national and local shortage. In Part III, we will briefly outline the origin and purpose of restrictive covenants and discuss the state of the law in Hawai‘i. In Part IV we will propose a legislative solution.

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[2] Although we focus on non-competition clauses, we recognize that a variety of provisions may have the same effect, by penalizing mobility in employment and in service provider contracts. These include anti-raiding provisions and clauses providing for liquidated damages on departure. *See* W. Eugene Basanta, *No Hire Clauses in Healthcare Sector Contracts: Their Use and Enforceability,* 39 J. HEALTH L. 451 (2006) (discussing no-hire clauses as another method to protect an employer's manpower interests).

[3] Greg Wiles, Hawaii Reporter, *Hawaii 9-1-1: Doctor Shortage Worse than Recently Reported* (reporting on the Hawai‘i Physician Workforce Assessment), *available at* http://boss.hawaiireporter.com/hawaii-doctor-shortage-worse-than-recently-reported/ (last visited July 2010).

[4] For the purposes of this article, the term "restrictive covenants" will be used interchangeably with covenants-not-to-compete and non-compete clauses.

[5] *See* Elham Roohani, *Covenants Not to Compete in Nevada: A Proposal,* 10 NEV. L. J. 260, 262 (2009).

II. THE NATIONAL AND STATE PHYSICIAL SHORTAGE

Hawai‘i is competing for physicians in a time of increasing national shortage.[6] The American Association of Medical Colleges (AAMC) predicts a national shortage of between 124,000 and 159,300 physicians by the year 2025, projecting that "37% of the shortage will be in primary care, 33% in surgery, 6% in medical specialties, and 23% in other specialties."[7] The national shortage is due in large part to nearly two decades of federal medical education policies premised on faulty projections of a physician surplus.

"The primary determinant of the number of practicing physicians in the U.S. is the number of Graduate Medical Education (GME) positions or training slots[;]" and for many years the number of federally funded slots had been capped to slow growth.[8] Even now, as the number of residency slots has gradually increased, the "increase in physicians trained has been at a rate considerably less than the U.S. population growth."[9] States find themselves competing in a scarce market and facing particularly difficult recruiting challenges in rural areas and inner urban neighborhoods and in primary care and certain specialty practices.

The medical labor market faces two serious problems: distribution and overall shortage. Achieving an optimum distribution of physicians will be challenging. Just increasing the workforce without establishing incentives to fill specific shortage areas will not succeed; there will still be regional and practice area shortages. Adding more physicians overall is not a solution, as "unfettered growth is likely to exacerbate regional inequities" because of individual choices of where and what to practice. [10]

The shortage of physicians is caused, in part, because our population growth is outpacing the number of physicians we produce and, in part, by the increased demand of patients for physician services. The Council on Graduate Medical Education has noted that, "[A]lthough the absolute number of physicians would increase by 24% between 2000 and 2020; the population growth would exceed the rate of growth of physicians, resulting in a decrease in the ratio of . . . physicians per [capita]." Further, the Council predicts that "the demand for physician services will grow as the elderly population increases as a proportion of the total population."[11]

Communities seeking to attract physicians need to consider what factors contribute to a physician's choice of where and what to practice. As to the choice of specializations, "one of the top reasons medical students do not choose a primary care specialty is its low average annual

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[6] Gregory C. Kane, et al., *The Anticipated Physician Shortage: Meeting the Nation's Need for Physician Services*, 122 AM. J. MED. 1067, 1156 (2009).

[7] *Id.* at 1156-57.

[8] *Id.*

[9] Jerris Hedges & Daniel A Handel, *A Practical Approach to the Healthcare Crises: The Current Challenges Facing Hawaii and the Nation (Part 1 of 2)*, 68 HAW. MED. J., 100, 102 (2009).

[10] David C. Goodman, *Physician Workforce Crises? Wrong Diagnosis, Wrong Prescription*, 358 NEW ENG. J. MED. 1658, 1659 (2008) (recommending establishing federal policies to encourage filling areas of medical need).

[11] Kane, *supra,* note 6, at 1157.

income."[12] In addition, studies indicate that medical students "prioritize lifestyle issues in career selection and perceive general internal medicine as a low-satisfaction, low-income, and uncontrollable career."[13]

As to where physicians choose to practice, a robust residency program is vital to a region. "Current data suggests that as many as one half of physicians trained in a specific locale will stay there for their practice careers."[14] Lifestyle factors also contribute to location choices.[15] Rural practice attracts fewer physicians than is needed.[16]

Hawai'i finds itself substantially worse off than even the dire national projections and subject to both shortage and misdistribution. [17] According to a recent study, Hawai'i currently needs 644 more physicians than it has.[18] Even more worrying, four out of every ten physicians in Hawai'i will reach retirement age in the next decade.[19] As many as 40% of Hawai'i's physicians in non-military practice are at least 54 years old.[20] To make matters even worse, Hawai'i's demand on health services is greater than in most states. Hawai'i has a large and growing elderly population that consumes significantly more healthcare than those under 65 years old.[21] The result of the disparity in healthcare supply and demand means that Hawai'i will need at least an additional 1,000 physicians by 2030; or at least 50 new physicians per year, over and above the current number it attracts per year. This estimate may be low, due to the looming but unpredictable potential increase in retirement of current practicing physicians.[22] Currently, about half of the new physicians arrive each year through programs at the John A. Burns School of Medicine (JABSOM).[23] However, even with JABSOM's recent annual admissions increase to 75 students per year,[24] physician supply in Hawai'i will fall dangerously short if the state does not attract and

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[12] Roberto Cardarelli, *The Primary Care Workforce: A Critical Element in Mending the Fractured US Health Care System*, 3 OSTEOPATHIC MED. PRIMARY CARE, 11 (2009).

[13] Kane, *supra,* note 6, at 1157.

[14] Kane, *supra,* note 6, at 1159.

[15] Kane, *supra,* note 6, at 1157.

[16] M. MacDowell et. al, Rural and Remote Health, *A National View of Rural Health Issues in the USA,* 10 (2010), *available at* http://www.rrh.org.au/publishedarticles/article_print_1531.pdf.

[17] *See* Kelley Withy et al., *Hawai'i Island Health Workforce Assessment 2008,* 68 HAW. MED. J. 264, 268 (December 2009).

[18] Wiles, *supra* note 3.

[19] *Id.*

[20] *Id.*

[21] Hedges, *supra* note 9. The population of Hawai'i residents over the age of 65 is projected to increase from 13% to 22% by the year 2030, and as a result, healthcare demand faces massive projected increases. *Id.*

[22] Satoru Izutsu, *Developing Shortage of Physicians*, 69 HAW. MED. J. 32, 49 (2010).

[23] *Id.*

[24] Wiles, *supra* note 3.

retain additional physicians. In short, Hawai‘i has to maintain a competitive and attractive environment to draw and keep physicians here.

In times of national shortage, non-compete clauses are destructive to local markets. Allowing non-compete clauses in medical employment contracts may be viewed as unfriendly to physicians entering the workforce and discourage them from committing to the locality. In addition, when terminating employment, the enforcement of non-compete clauses may force physicians out of the local market.

III. NON-COMPETITION CLAUSES IN CASE LAW

Courts have traditionally shown only begrudging acceptance of non-compete clauses. In the employment context, they have traditionally been permissible only to the extent that they protect the employers' legitimate business interests and are limited to a reasonable scope, duration, and geographic range. However, the traditional narrow approach is fading. Modern courts, including those in Hawai‘i, have abandoned a traditional suspicion of non-compete clauses as anti-competitive in favor of a deferential bias toward enforcement.

A. History

When restrictive covenants first developed in the fifteenth century, English courts regarded them as unnecessary restraints on trade and employment.[25] The scarcity of tradesmen resulting from the black plague may be one reason that early English courts disfavored these restrictions.[26] The plague drastically reduced the working class population of England and fluidity in the limited supply of labor became more valuable to the public than protection of business interests. However, the landmark case of *Mitchel v. Reynolds*,[27] announced a "rule of reason" that validated a non-compete agreement in the context of the sale of a business, so long as the restraint was limited in scope, duration, and geography.

The "rule of reason" approach has endured.[28] In the employment context, a determination of validity requires finding and then balancing legitimate interests of the employer against hardship to the employee and injury to the public.[29]

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[25] Mike J. Wyatt, *Buy Out or Get Out: Why Covenants Not to Compete in Surgeon Employment Contracts Are Truly Bad Medicine [Idbeis V. Wichita Surgical Specialists, P.A., 112 P.3d 81 (Kan. 2005)]* 45 WASHBURN L.J. 715, 715 (2006).

[26] *Id.* at 718 (citing Corbin on Contracts § 80.4 (2003)).

[27] 1 P. Wms. 181, 24 Eng. Rep. 347 (Q.B. 1711) (discussed in Harlan M. Blake, *Employee Agreements Not to Compete,* 73 HARV. L. REV. 625, 629 (1960)).

[28] *See* RESTATEMENT (SECOND) OF CONTRACTS § 188, cmt. a (1981) (noting the "rule of reason" as applied to ancillary restraint on competition clauses requires a provision to be "not greater than necessary to protect [legitimate] interests" and "not outweighed by hardship to the promisor and the likely injury to the public").

[29] *Id.*

B. Non-Compete Clauses in Hawai‘i

In 1976, the Hawai‘i Supreme Court in *Technicolor, Inc. v. Traeger*,[30] first considered a non-compete clause in the context of an employment agreement and allowed a state-wide, three year restriction to stand. Traeger worked as the general manager of Technicolor's photo-finishing-services operation in Hawai‘i and had agreed to a non-compete provision at the time of his employment. In his position, he entertained clients and had knowledge of customer lists and pricing information.[31] The restrictive covenant at issue prohibited Traeger from competing or associating with any of Technicolor's competitors for three years throughout the State of Hawai‘i.[32]

After Traeger's employment ended,[33] he was unsuccessful in finding a job in Hawai‘i. He left his family behind and found work in California, although he was not able to obtain work at his previous salary.[34] Eventually, he returned to Hawai‘i to be with his family, and he found work at a competitor's business, again at a lower salary.[35] Technicolor sought to enjoin Traeger's employment with the competitor and prevailed on a motion for summary judgment as to the validity of the restrictive covenant.[36] On Traeger's interlocutory appeal, the Hawai‘i Supreme Court affirmed.[37]

The Hawai‘i Supreme Court adopted the "rule of reason," explaining that "reasonableness analysis" included the scope of the covenant, the undue hardship on the employee, and whether the benefit to the employer was "outweighed by injury to the public."[38] The court instructed that the factors of reasonableness to be considered included "geographical scope, length of time, and breadth of the restriction placed on a given activity."[39]

Remarkably, the court did not discuss how or why it determined that Technicolor had satisfied its burden, but simply concluded "there [was] ample evidence as to these factors and other facts necessary for the court to have made its 'reasonableness analysis.'"[40] The court did not explain why a three-year, state-wide provision was necessary or reasonable to protect the employer's interests in light of the line of work and confidential information Traeger possessed, or whether the hardship Traeger faced in having to leave the state or leave his field of work was undue.

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[30] *Technicolor, Inc. v. Traeger*, 57 Haw. 113, 551 P.2d 163 (1976).

[31] *Id.* at 115, 551 P.2d at 166.

[32] *Id.* at 115, 551 P.2d 166. When Traeger left the company, under disputed circumstances, he agreed not to compete in the State of Washington as well. *Id.*

[33] Whether Traeger's departure was voluntary or not was disputed. *Id.*

[34] *Id.* at 116, 551 P.2d at 167.

[35] *Id.*

[36] *Id.* at 114, 551 P.2d at 166.

[37] *Id.*

[38] *Id.* at 122, 551 P.2d at 170.

[39] *Id.*

[40] *Id.*

Following *Traeger*, the federal district court, applying Hawai‘i law, validated a two-year provision against two sales representatives selling business forms. Citing *Traeger* and with a similarly impoverished analysis of either the employer's legitimate interests or the reasonableness factors, it observed that the provision was "less restrictive" than the result in *Traeger*.[41]

In 2006, in *7's Enterprises v. Del Rosario*,[42] the Hawai‘i Supreme Court validated a three-year, island-wide non-competition provision against a "briefer," a salesperson who promoted and sold souvenirs and tours to travel agents.[43] The employer alleged that briefers were trained for "several months" and were required to memorize sales scripts provided by the employer and to observe briefing sessions. On the other hand, the employee claimed that the training offered was merely of generalized sales techniques.[44] The court agreed with the lower court that the briefer had training in the employer's unique sales techniques. In recognizing the employer's interests in training, the court held that, "[t]raining that provides skills beyond those of a general nature is a legitimate interest which may be considered in weighing the reasonableness of a non-competition covenant, when combined with other factors . . . such as trade secrets, confidential information, or special customer relationships."[45]

The court also upheld the trial court's conclusion that the "covenant was reasonable in scope and duration under *Traeger* and *UARCO*."[46] As to the three-year duration specifically, the court analyzed three factors: the duration needed to fully protect the employer's legitimate interests; the injury to the employee from enforcement; and the interference with the public's interests. As to the first factor, because the employee had attempted to engage in direct competition targeted at the employer's client, the court concluded that three years was "necessary in its full extent for the protection of the legitimate interests of the employer."[47] Second, as to the injury to the employee, the court noted that the employee "was able to work first as a bus driver, then as a hair and makeup person" and had not provided evidence of "hardship on her or her family."[48] Finally, the court could not "discern an injury to the public" noting that the services were still available to the few commercial enterprises who used these services.[49]

Admittedly, *Del Rosario* provides a more principled framework to analyze non-compete clauses than is provided by *Traeger* and *UARCO*. However, it remains unconvincing as to why three years, rather than two or one, or even six months, was necessary in order to allow the employer to solidify its position in the market.[50] The court noted the employer's position as the

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[41] *UARCO Inc. v. Lam*, 18 F. Supp.2d 1116, 1121-22 (D. Haw. 1998).

[42] *7's Enterprises, Inc. v. Del Rosario*, 111 Hawai'i 484, 143 P.3d 23 (2006).

[43] *Id.*

[44] *Id.* at 490, 143 P.3d at 28.

[45] *Id.* at 493, 143 P.3d at 31.

[46] *Id.* at 488, 143 P.3d at 27.

[47] *Id.* at 497, 143 P.3d at 36.

[48] *Id.*

[49] *Id.*

[50] *Id.* at 486 n. 3, 143 P.3d 25 n. 3.

"first company to offer briefing services" and its investment in its own business.[51] Yet safeguarding the employer's position as the first company and still one of only three in the market is precisely the kind of anti-competitiveness that is not a legitimate interest; after all, enforcement is meant to prevent an "unfair" advantage, not to inhibit ordinary competition.[52]

Tipping the analysis of reasonableness factors in favor of employers is hardly surprising. Hawai'i follows a modern trend among jurisdictions that is deferential to employers and elevates freedom of contract principles above the traditional judicial stance that rendered them suspect.[53]

Hawai'i courts have not examined restrictive covenants specifically within the context of medical professionals. However, in other jurisdictions where these covenants are allowed, many "courts do not analyze noncompetition agreements between physicians any differently than comparable provisions between commercial parties."[54] While it is heartening that *Del Rosario* invited consideration of public harm, it is nevertheless worrisome that Hawai'i courts generally have upheld, with very little inquiry, durations as long as three years and geographical limits as large as the state. These cases have taken a cavalier approach when enforcing contract provisions that force employees to leave the state or change careers altogether. It therefore seems imprudent to leave enforcement of non-competes in the medical professions to the courts.

C. Physician Non-compete clauses

1. Professional Guidance

Unlike the American Bar Association's (ABA) well-established stance against most attorney non-competition clauses,[55] the American Medical Association's (AMA) position is equivocal.[56] Based principally on the view that it is in the public interest to preserve an attorney's professional autonomy and protect a client's freedom to choose his or her attorney, ABA Model Rule 5.6 provides:

A lawyer shall not participate in offering or making:

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[51] *Id.* at 497, 143 P.3d at 36.

[52] Kenneth R. Swift, *Void Agreements, Knocked-Out Terms, and Blue Pencils: Judicial and Legislative Handling of Unreasonable Terms in Noncompete Agreements*, 24 HOFSTRA L.J. 223, 229 (2007) (observing that the legitimate interests commonly include training, trade secrets and goodwill, which if taken would create an unfair advantage, but not an employer's interest in preventing ordinary competition).

[53] Alina Klimkina, *Are Noncompete Contracts Between Physicians Bad Medicine? Advocating in the Affirmative by Drawing a Public Policy Parallel to the Legal Profession*, 98 KY. L.J. 131, 136-36 (2009) (commenting on deferential trend).

[54] Paula Berg, *Judicial Enforcement of Covenants Not to Compete Between Physicians: Protecting Doctors' Interests at Patients' Expense*. 45 RUTGERS L. REV. 1 (1992).

[55] ABA Comm. on Prof'l Ethics, Formal Op. 300 (1961). The ABA Ethics committee deemed restrictions on competition in legal practice unethical in 1961. The opinion noted, "the practice of law . . . is a profession, not a business," and that "clients are not merchandise[.]" *Id.*

[56] Klimkina, *supra* note 53, at 145.

> (a) a partnership, shareholders, operating, employment, or other similar type of agreement that restricts the right of a lawyer to practice after termination of the relationship, except an agreement concerning benefits upon retirement; or
> (b) an agreement in which a restriction on the lawyer's right to practice is part of the settlement of a client controversy. [57]

The AMA takes a less definitive position, for a variety of reasons.[58] The AMA takes the position that restrictive covenants have negative effects on healthcare but does not prohibit these provisions.[59] The AMA has not been able to persuade its various constituencies that these contract provisions are unethical and should be banned altogether.[60] In part, efforts to adopt an outright ban on restrictive covenants have failed out of concern that such a ban might run afoul of a Federal Trade Commission order on practices that were unrelated to non-compete clauses that "compelled the AMA to cease and desist from declaring certain contractual practices among physicians to be unethical."[61]

Nevertheless, the AMA Code of Ethics does discourage non-compete clauses, commenting, "Covenants-not-to-compete . . . disrupt continuity of care, and potentially deprive the public of medical services. . . . 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."[62] At the very least, the AMA's position should make these provisions in employee contracts suspect and subject to heightened scrutiny in the courts.

2. Judicial Approaches

Whether to enforce non-competition clauses in physician employment contracts implicates substantial public policy tensions. Medical employers regard non-competes as essential to protect their investment in physicians and in their businesses, including recruiting, referral relationships, goodwill, and training.[63] On the other hand, departing physicians oppose enforcement because they claim it places an unfair burden on the physician's ability to practice or fails to recognize the physician's own investment in his or her education and development of his or her own skill and

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[57] MODEL RULES OF PROF'L CONDUCT R.5.6 cmt. 3 (2010).

[58] From 1933 to 1960, the AMA's position was that non-compete clauses were unethical. In 1960, the AMA Judicial Council retreated from that position and recognized that reasonable provisions could be ethical. Since then, attempts to declare restrictive covenants unethical have failed. Berg, *supra* note 54, at 7.

[59] AMA CODE OF MEDICAL ETHICS, § E-9.02 (2010); *see also* Berg, *supra* note 54 at 7-8.

[60] Berg, *supra* note 54, at 7-8.

[61] Berg, *supra* note 54, at 9 (citing *In re American Medical Ass'n*, 99 F.T.C. 1 (1982)).

[62] AMA Code of Medical Ethics, § E-9.02 (2010).

[63] *See, e.g.*, *Idbeis v. Wichita Surgical Specialists*, 279 Kan. 755, 112 P.3d 81 (Kan. 2005) (upholding two-year non-compete clause against surgeons, determining that protecting the employer's establishment of referral relationships was a legitimate interest).

reputation.[64] Moreover, analysis of public injury is most certainly appropriate, including consideration of the patient's interest in retaining and/or choosing one's physician and the public's interest in preserving community access to specialized health care and retention of its medical workforce.[65]

Courts considering non-compete clauses that limit medical practice generally adopt one of three approaches. The first is to apply the rule of reason, with the same deference to the employer as the general modern trend.[66] This approach regards an employer's interest in preserving its referral systems, retaining established patients, and protecting goodwill as legitimate business interests.[67] Under this approach, for example, a Kansas court upheld a three-year, countywide provision against a family physician who had practiced in that community and at that clinic for twelve years.[68] The provision also called for liquidated damages of 25% on all earnings if the clause were violated.[69] Remarkably, the court concluded that the physician had a choice; "the covenant gave Dr. Louis the option of practicing in the area and paying liquidated damages [of 25% of net earnings]. . . . Or she could refrain from practicing in Sedgwick County [for three years.]"[70] The court gave short shrift to public harm considerations, citing with approval an earlier case that had upheld a non-compete with the rationale that the city affected "is not more in need of further doctors and surgeons than many other communities."[71] This comment suggests a judicial attitude that physicians are fungible and that during a pandemic shortage of physicians, a particular community's need is not as compelling as the employer's interests.

The second approach applies the rule of reason, but also subjects the provision to heightened scrutiny, because of the public policies implicated by health care access. *Valley Medical Specialists v. Farber*[72] illustrates the heightened scrutiny approach. There, the court declined to enforce a three-year, five-mile covenant not to compete against a pulmonologist providing specialized services to cancer and AIDS patients. With satellite clinics, the five-mile provision actually extended 235 square miles. In light of the "significant interests of individual patients," the court explained that "[a] court must evaluate the extent to which enforcing the covenant would foreclose patients from seeing the departing physician if they desire to do so."[73] Although agreeing the employer held a "protectable interest in its referral sources"[74] and not

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[64] Wyatt, *supra* note 25, at 732-33.

[65] *See* Klimkina, *supra* note 53, at 149-50.

[66] *See, e.g.*, *Wichita Clinic v. Louis*, 39 Kan. App.2d 848, 185 P.3d 946 (2008).

[67] *Id.* at 858, 185 P.3d at 954.

[68] *Id.* at 849, 185 P.3d at 949.

[69] *Id.* at 861, 195 P.3d at 955.

[70] *Id.* at 860, 185 P.3d at 955.

[71] *Id.* at 860, 185 P.3d at 955.

[72] *Valley Med. Spec. v. Farber*, 194 Ariz. 363, 368, 982 P.2d 1277, 1282 (1999).

[73] *Id.* at 371, 982 P.2d at 1285.

[74] *Id.* at 370, 982 P.2d at 1284.

imposing an outright ban on all physician non-competes, the court upheld the lower court conclusion that the covenant was too broad in time, scope, and geography as well as harmful to the "personal nature of the doctor-patient relationship."[75] Notably, the court also declined to rewrite the provision in order to discourage overreaching.

A third judicial approach is to prohibit physician non-compete clauses in the interests of public policy. In *Murfreesboro Medical Clinic v. Udom*,[76] the Supreme Court of Tennessee held:

> Due to the important public policy considerations implicated by physicians' covenants not to compete, along with the ethical problems raised by them, and our legislatures' decision not to statutorily validate all such covenants, we conclude that non-compete agreements such as the one at issue in the present case are inimical to public policy and unenforceable.[77]

While this latter approach is correct in our view, Hawai'i courts have not signaled what approach it might follow. Yet in the meantime, the uncertainty surrounding how a court would treat a non-compete clause in the medical profession has its own ill effect. The inclusion of overbroad and onerous clauses within these employment relationships has an *in terrorem* effect, as departing employees abide by the terms without testing their legality. As one commentator noted, "[t]he harm of such overreaching typically falls on parties not before the court, which renders myopic the judicial focus on doing justice to the parties to the contract that happen to be before the court."[78]

IV. LEGISLATIVE APPROACHES

Although determining the validity of non-compete clauses in Hawai'i is primarily a judicial function, HRS § 480-4 is where the inquiry actually begins. The statute generally prohibits contracts in restraint of trade,[79] but carves out certain exceptions, including employer-employee agreements to protect the employer's trade secrets by prohibiting their use by the employee during or after employment as may be reasonably necessary without "imposing undue hardship."[80] Although the statute only authorizes limited agreements to protect trade secrets, in *Traeger*, the court held that the narrow statutory exceptions "were not meant to be exclusive in their respective fields."[81] Instead, it viewed the statute as inviting judicial review of non-compete clauses under the rule of reason. Thus it necessarily falls to the legislature to declare physician non-compete clauses unenforceable specifically. Should Hawai'i follow this path, it will join a minority of states that

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[75] *Id.* at 372, 982 P.2d at 1285.

[76] *Murfreesboro Med. Clinic v. Udom*, 166 S.W.3d 674 (Tenn. 2005). *Udom* was abrogated by statute in 2008. *See* TENN. CODE ANN. § 63-1-148 (2010). The statute allows non-competes in health care provider contracts of up to two years, the greater of ten miles or county-wide. They are unenforceable once the employee has remained with the original employer for six years or more. *Id.*

[77] *Id.* at 683.

[78] Charles A. Sullivan, *The Puzzling Persistence of Unenforceable Contract Terms*, 70 OHIO ST. L.J. 1127, 1177 (2009).

[79] HRS § 480-4 (a) (2010).

[80] HRS § 480-4 (c) (4).

[81] *Traeger*, 57 Haw. at 121, 551 P.2d at 169.

statutorily have prohibited restrictive covenants in physician employment contracts or more generally in all employment contracts.[82]

There are many compelling reasons to consider an outright prohibition on these restrictive covenants. First, to enforce them is unfair because doing so does not adequately recognize the departing physician's contributions to the practice. In protecting the employer's referral sources, patient base, training, and goodwill, these cases discount the value created by departing physician's contributions, including the professional skills, reputation, and patient relationships he or she brought to the practice. The cases overestimate the employer's investment in training and mentorship and underestimate investments the departing physician has made in his or her own medical education, residency, and specialization. Moreover, residency training is highly subsidized by federal dollars, and that public investment is eroded by overprotecting employers. Second, in examining public harm, enforcement undervalues the patient's need for continuity of care and the community's need for an adequate workforce that allows for patient choice. By assuming a patient is not harmed because replacement care is available, these cases fail to recognize that doctor-patient relationships are not fungible, but rather based upon a special bond, built on trust and confidence and established over time. And in light of state shortages, retaining every physician is essential to the state. Finally, non-compete clauses have insidious unintended negative consequences. The physician must choose to remain in an unhealthy employment relationship that has run its course, bear the price of litigation, or flee the area.

An employer's investment in recruitment deserves protection, particularly if the physician departs shortly after being recruited and before the employer has enjoyed any significant financial benefit from the employment. After all, the employer's expense in attracting a physician to the community benefits everyone. However, recruitment costs and other initial investments can be reimbursable if the physician leaves prematurely without discouraging competition and limiting a departing physician's ability to practice within a community.

Eliminating non-compete clauses could benefit Hawai'i in unanticipated ways. Scholars theorize that the dynamic success and innovation that defined Silicon Valley was due in part to California's prohibition of non-compete clauses in employment contracts.[83] When employees enjoy mobility and fluidity within the labor market, a competitive market for personal capital thrives.[84] That same mobility and fluidity within Hawai'i's physician workforce will strengthen health care in Hawai'i.

V. CONCLUSION

Under existing Hawai'i law, physicians and their employers alike face considerable uncertainty as to the viability of restrictive covenants. Current law generally favors employers'

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[82] See Mike Kraeger, *The Physician's Right in § 15.50(B) to Buy Out A Covenant Not To Compete in Texas*, 61 Baylor L. Rev. 357, 370-71 (2009); Berg *supra* note 55, at 11; Wyatt, *supra* note 25, at 721; Roohani, *supra* note 5, at 267-68 (each characterizing and tallying state laws). Several states have taken novel middle ground approaches. For example, Texas requires physician non-compete clauses to allow a buy-out instead. Colorado and Delaware prohibit injunctive relief and instead allow for money damages. Kraeger, *supra*, at 370-71.

[83] Richard C. Schragger, *Rethinking the Theory and Practice of Local Economic Development*, 77 U. CHI. L. REV., 311, 334 (2010). See also Roohani, supra note 5, at 282.

[84] *Id.* at 285.

interests and allows restrictive covenants as long as they meet a permissive construction of the rule of reason. There has been no guidance as to whether courts would treat a physician employment contract differently, or whether physician contracts would or should be granted unique considerations necessitated by public policy.

Hawai‘i residents have a vital interest in maintaining an adequate physician workforce, particularly in a time of national shortage. A high cost of living, geographic isolation, low wages, and high demand for services make it difficult enough for Hawai‘i to compete. We offer a small positive step to make the health manpower challenges we face a little easier.