Missouri Law Review

Volume 74
Issue 4 *Fall 2009*

Article 5

Fall 2009

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I. INTRODUCTION

In its model rules, the American Bar Association (ABA) adopted a restriction on an attorney's ability to enter into non-compete clauses. The American Medical Association (AMA) has no such restriction. This Article discusses the history, case law, and justifications for this restriction in a lawyer's practice; details the reasons why the AMA has failed to implement such a restriction for doctors, despite the AMA's position in favor of the policy; and argues that the AMA should adopt a policy against restrictive covenants that is similar to the ABA's policy.

The U.S. Constitution states, "No State shall . . . pass any Law impairing the Obligation of Contracts. . . . No State shall . . . deprive any person of life, liberty, or property, without due process of law."[1] Pursuant thereto, in *Lochner v. New York*, the Supreme Court ruled unconstitutional a New York statute that prohibited bakers from working more than ten hours per day.[2] In that seminal case, the Court held,

> The statute necessarily interferes with the right of contract between the employer and employees, concerning the number of hours in which the latter may labor in the bakery of the employer. The gen-

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1 U.S. CONST. art. I, § 10, cl. 1; U.S. CONST. amend. XIV, § 1.

2. 198 U.S. 45, 64 (1905).

> eral right to make a contract in relation to his business is part of the liberty of the individual protected by the Fourteenth Amendment of the Federal Constitution. Under that provision no State can deprive any person of life, liberty or property without due process of law. The right to purchase or to sell labor is part of the liberty protected by this amendment, unless there are circumstances which exclude the right.[3]

The short-lived preeminence of *Lochner* represented the apex of American law's recognition of a virtually unfettered right to contract. Even during this time, however, courts recognized an exception to this principle in the context of police powers relating to the safety, health, morals, and general welfare of the public.[4] The Supreme Court stated that "[b]oth property and liberty are held on such reasonable conditions as may be imposed by the governing power of the state in the exercise of those powers, and with such conditions the 14th Amendment was not designed to interfere."[5] As a consequence, "restraints of trade" – contracts in which a party agrees to foreclose the method of engaging in, or opportunity to engage in, a vocation – had been regulated or prohibited under British and American common law for centuries, even during the *Lochner* era. A contemporary court even suggested that "among the most ancient rules of the common law" was that restraints of trade were void – noting their existence as early as 1415 – because of the many negative effects:

> 1. Such contracts injure the parties making them, because they diminish their means of procuring livelihoods and a competency for their families. They tempt improvident persons, for the sake of present gain, to deprive themselves of the power to make future

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3. *Id.* at 53 (citations omitted). Civics courses across the nation – and time – have detailed the events that have come to be known as a "switch in time saves nine," which reversed the Supreme Court's near absolute protection for the unfettered right to contract. Christopher Shea, *Supreme Switch: Did FDR's Threat to "Pack" the Court in 1937 Really Change the Course of Constitutional History?*, BOSTON GLOBE, Dec. 4, 2005, *available at* http://www.boston.com/news/globe/ideas/articles/2005/12/04/supreme_switch/. During the midst of the Depression, President Franklin Delano Roosevelt "pushed his ambitious legislative agenda to revive the economy." *Id.* When the Supreme Court declared unconstitutional key aspects of Roosevelt's legislative proposals, aided by the fact that the Constitution does not set forth the number of Justices that sit on the Supreme Court, Roosevelt warned that he would pack the court. *Id.* As a consequence – perhaps – the Court switched its position on the unfettered right to contract, and in "1937, less than a year after striking down a very similar law, the justices upheld a minimum-wage law . . . in West Coast Hotel Co. v. Parrish [300 U.S. 379, 391, 400 (1937)] . . . . By 1938, the court had largely removed itself as a block to national economic policy." *Id.*

4. *Lochner*, 198 U.S. at 53.

5. *Id.*

> acquisitions. And they expose such persons to imposition and oppression.
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> 2. They tend to deprive the public of the services of men in the employments and capacities in which they may be most useful to the community as well as to themselves.
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> 3. They discourage industry and enterprise, and diminish the products of ingenuity and skill.
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> 4. They prevent competition and enhance prices.
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> 5. They expose the public to all the evils of monopoly. And this especially is applicable to wealthy companies and large corporations which have the means, unless restrained by law, to exclude rivalry, monopolize business, and engross the market. Against evils like these, wise laws protect individuals and the public by declaring all such laws void.[6]

Notwithstanding these strong judicial proclamations eschewing restraints of trade, as early as the seventeenth century courts began to chip away at this limitation on the right to contract.[7] Over time, the common law came to recognize the validity of restraints of trade when limited in time or place.[8] And though *Lochner* recognized the limitation on restraints of trade even while forging a singularly broad view of the rights of privately contracting parties, post-*Lochner* jurisprudence – although far more accepting of limitations on private contracts – somewhat paradoxically accepted the notion that in certain circumstances private parties may elect to employ restraints of trade.

The contemporary version of the law on restraints of trade is aptly reflected in the Second Restatement of Contracts, which sets forth the modern scope and boundaries of these restrictive contracts. Restraints of trade are currently prohibited if they fall into either of two broad categories: (1) "the restraint is greater than is needed to protect the promisee's legitimate interest," or (2) "the promisee's need is outweighed by the hardship to the promisor and the likely injury to the public."[9] Moreover, restraints on competition

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6. Shute v. Heath, 42 S.E. 704, 705 (N.C. 1902).

7. *Id.*

8. *Id.*

9. RESTATEMENT (SECOND) OF CONTRACTS § 188 (1981); *see* Sys. & Software, Inc. v. Barnes, 2005 VT 95, ¶ 4, 178 Vt. 389, 391, 886 A.2d 762, 764 ("Like many other courts, this Court has adopted a position with respect to enforcement of non-competition agreements similar to that set forth in § 188(1) of the Restatement (Second) of Contracts (1981) . . . .").

are enforceable only when part of a broader enforceable contract.[10] Thus, "[i]f a restraint is not ancillary to some transaction or relationship that gives rise to an interest worthy of protection, the promise is necessarily unreasonable."[11]

Doctors generally employ permissible restrictive covenants for restraining trade in their vocation in two contexts: agreements accompanying the sale of a practice and employment or partnership agreements.[12] Agreements accompanying the sale of a practice are implicated when a doctor sells her practice.[13] Employment agreements are typically signed prior to employment and restrict a physician's activities if she leaves the practice.[14] Restrictive covenants used for employment agreements typically are only valid when they apply for a limited time frame, while with the sale of a medical practice courts typically allow restrictive covenants with no time limits.[15]

The common law rules on restraints of trade are often augmented in the context of licensed professionals by mandatory obligations imposed by private or quasi-governmental governing bodies. For lawyers, the American Bar Association (ABA) developed a set of ethical rules that has been adopted, at least in part, by courts in all states – often with legislative ratification. For doctors, the American Medical Association (AMA) provides ethical rules, compliance with which is typically tied to state licensing. The ABA has adopted a comprehensive body of rules governing restrictive covenants for the practice of law. The AMA, however, has not done the same for the medical vocation.

The AMA's failure to do so harms both physicians and patients, because the AMA's inaction prevents many doctors from competing with practices with which they were previously affiliated. Doctors, thus, are forced to remain with existing practices longer than they otherwise would, and, when they depart, they often must leave the geographic location. As a consequence of the AMA's failure to prohibit this rational but predatory behavior by existing medical practices, the AMA reinforces the oligopolistic status quo. This

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10. The Restatement describes three situations in which restraints of trade are seen as part of a broader enforceable contract:

(a) a promise by the seller of a business not to compete with the buyer in such a way as to injure the value of the business sold;

(b) a promise by an employee or other agent not to compete with his employer or other principal;

(c) a promise by a partner not to compete with the partnership.

RESTATEMENT (SECOND) OF CONTRACTS § 188(2).

11. *Id.* at § 188 cmt. b.

12. STANLEY G. ANDEEL, AMERICAN LAW INSTITUTE – AMERICAN BAR ASSOCIATION CONTINUING LEGAL EDUCATION, EMPLOYMENT BUY-SELL AGREEMENTS FOR PHYSICIANS AND OTHER PROFESSIONALS (2000).

13. *Id.*

14. *Id.*

15. *Id.*

reduces both competition and access for patients. Many patients are forced into existing practices and are not offered the opportunity, when those doctors leave their employing practices, to stay with doctors with whom they have developed relationships. The result is that patients and newer doctors suffer economically, while the benefactors are rent-seeking, established practices intent on using protectionist measures for economic gain without increasing productivity.

This Article proposes that the AMA adopt rules governing restrictive covenants for doctors similar to those already adopted by the ABA for attorneys. The ABA's current rules allow for restrictive covenants in a limited number of situations – including restrictive covenants incident to the sale of a law practice – but specifically *prohibit* restrictive covenants as a condition to an employment agreement. The ABA's approach is nuanced and equitable. Both the underlying rationales and practical effects of the ABA's current rules governing non-compete clauses in the legal profession serve as persuasive justifications for adopting the same rules in the medical context. These rules serve to regulate competition among lawyers, while protecting both attorney and client freedom of choice, and would serve similar ends in the medical profession.

Part II will examine restrictive covenants generally and then specifically within the context of medical practitioners. In doing so, it will address the public interest implicated by the physician-patient relationship. After that, Part II will illustrate how limiting restrictive covenants to only those incident to the sale of a medical practice is preferable to the current situation, as the harm to the public of permitting restrictive covenants in that context only is not significant.

Next, the Article, in Part III, will detail the ABA's approach to non-compete clauses as articulated in the ABA's Model Rules of Professional Conduct 5.6 and 1.17. With this as the basis, it will then describe the AMA's current failure to address restrictive covenants concretely. This Part will also detail the AMA's misguided justifications for its current position – describing the AMA's failure to properly understand the Federal Trade Commission's (FTC) current rulings.

Finally, Part IV will demonstrate the AMA's need to adopt a position similar to that of the ABA in order to protect the interests of both physicians and patients. In doing so, the analysis will demonstrate how adopting a variant of the ABA's rule in the context of the medical profession comports with the FTC's most recent applicable rulings and alleviates concerns regarding the public interest in the physician-patient context.

II. RESTRICTIVE COVENANTS AND THE MEDICAL PROFESSION

The two types of restrictive covenants commonly used by doctors for restraining professional trade in the medical practice – employment or partnership agreements and agreements accompanying the sale of a practice – track the genesis and demise (or re-genesis) of doctors' practices. Employment and

partnership agreements with restrictive covenants are those contracts signed by a doctor prior to joining a practice or partnership, designed to restrict the newly entering physician's activities upon later departing the practice.[16] Such agreements protect the market share of the existing practice against competition by departed employees or partners. As discussed below, these agreements are not in the public interest.

Restrictive covenants accompanying the sale of a practice, in contrast, come into play when a doctor sells her practice.[17] These agreements are designed to restrict the departing doctor from competing with her former practice.[18] Such agreements protect the market share of the restructured practice against competition from its former owner upon her departure. These agreements generally benefit society or are, at worst, benign.

Generally, "[a] restrictive covenant will be struck if it is harmful to the public interest. Courts have struck non-competes in contexts where the community needs the physician. This question depends on whether there are sufficient practitioners in the area."[19] Courts have used this "public-interest exception" with arresting variation to uphold or strike down non-compete agreements in the medical context.[20] Most such analyses "focus almost exclusively on the interest of the public at large, rather than also considering the interests of individual patients."[21] As such, courts typically evaluate the total number of doctors in an area in considering the public's interest.[22] A few courts, however, have focused on the individual doctor-patient relationship to afford patients' interests greater weight.[23] In most cases, courts ultimately

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.*

20. S. Elizabeth Wilborn Malloy, *Physician Restrictive Covenants: The Neglect of Incumbent Patient Interests*, 41 WAKE FOREST L. REV. 189, 200-01 (2006). *Compare* Rash v. Toccoa Clinic Med. Assocs., 320 S.E.2d 170, 173-74 (Ga. 1984) (dismissing prong as irrelevant), *and* Bauer v. Sawyer, 126 N.E.2d 844, 851 (Ill. Ct. App. 1955) (finding no public harm from covenant for lack of evidence that enforcement would create shortage of doctors in the area), *with* Valley Med. Specialists v. Farber, 982 P.2d 1277, 1282 (Ariz. 1999) (subjecting restrictive covenants between physicians to close scrutiny because of the "strong public policy implications" involved, including the doctor-patient relationship). Just before this article went to final print, a student note, A. Nicholas Naiser, Note, *Physician Noncompetition Agreements in Kentucky: The Past Discounting of Public Interests and a Proposed Solution*, 47 U. LOUISVILLE L. REV. 195 (2008), was published. (While the note states that its publication is in the Fall 2008 issue of the *Louisville Law Review*, that issue was only published in the Fall of 2009 and only appeared on LexisNexis on October 12, 2009.) The note is interesting and makes points similar to some of those included here.

21. Malloy, *supra* note 20, at 200.

22. *Id.* at 200-01.

23. *Id.* at 201.

balance the factors to allow for the enforcement of such agreements.[24] A few states, though, completely prohibit physician non-compete agreements.[25]

Courts have recognized that the public's interest must be evaluated in light of the private interests that are being protected by enforcing such contracts. Post-employment restraints are usually justified on the grounds that the employer has a rational interest in preventing the employee from appropriating the customer base and using the contacts that the employee doctor developed during her employment.[26] In contrast, since the price paid for the medical practice includes payment for the non-compete, non-competes are permitted in the sale of a medical practice[27] because the buyer is essentially contracting for the goodwill established by the selling doctor.[28] If the seller used her established relationships to draw patients away from the very customer base that she sold with her practice, then the value of that goodwill to the buyer – and the practice itself – would be virtually eliminated.[29]

Thus, the interest protected with post-employment restraints is far more attenuated than in the context of the purchase of a practice. Unlike with the

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24. *Id.* at 200-01.

25. Xan Johnson, *Noncompetition Clauses in Physician Employment Contracts in Oregon*, 76 OR. L. REV. 195, 200 (1997) ("Colorado, Massachusetts, and Delaware statutes specifically void any noncompetition clause of an employment, partnership, or corporate agreement between or among physicians which restricts the right of a physician to practice medicine. However, these statutes declare enforceable all other provisions of such agreements, including provisions which require the payment of damages related to competition."); Mike J. Wyatt, Comment, *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, 721 (2006) ("Representing a minority of jurisdictions, nine states have invalidated non-compete clauses in physician contracts. Courts in six of those nine states rendered the covenants unenforceable per se through application of state antitrust statutes. Delaware, Colorado, and Massachusetts, however, have codified the unenforceability of restrictive covenants in physician employment agreements by including specific anti-restrictive covenant provisions in their antitrust statutes.").

26. RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. b (1981); Malloy, *supra* note 20, at 197-98.

27. ANDEEL, *supra* note 12.

28. *See* RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. f; ANDEEL, *supra* note 12. Goodwill is "[a]n intangible asset [that] provides a competitive advantage, such as a strong brand, reputation, or high employee morale. In an acquisition, goodwill appears on the balance sheet of the acquirer in the amount by which the purchase price exceeds the net tangible assets of the acquired company." InvestorWords.com, Goodwill, http://www.investorwords.com/2212/goodwill.html (last visited Sept. 1, 2009). In the context of the sale of a medical practice, the goodwill generally constitutes both the patient list and their concomitant loyalty.

29. *See* RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. b.

latter, post-employment restraints[30] are not needed for the employer to get the core value of what she contracted for – in effect, the work of the employee.[31] Moreover, "[p]ost-employment restraints are . . . often the product of unequal bargaining power and [] the employee is likely to give scant attention to the hardship he may later suffer through loss of his livelihood."[32] Thus, the issue becomes whether we want to allow employer doctors to protect their goodwill and intellectual business property at the expense of the future employment opportunities of their former-employee doctors elsewhere, coupled with the restriction of access to health care for patients. As a consequence of these concerns, post-employment restrictions become highly suspect because they are unduly harmful to both new entrants to the medical market and patients.

In contrast to post-employment restraints, those in the context of the sale of a practice are at the very core of what is transferred *and* are not significantly harmful to patients. When a doctor buys a practice, she typically buys three factors of value: (1) the customer list, (2) access to the location,[33] and (3) the removal of the seller from the relevant market, which is, most importantly, the elimination of a potential primary competitor.[34] These elements are all intertwined, and the first and third have a particularly tight relationship.

Purchasing a patient list alone has little economic value to a new market entrant if the selling doctor continues to practice, as a doctor entering the new market can achieve virtually the same outcome as purchasing that customer list through traditional competitive practices. For example, a new entrant can achieve similar ends through media advertising, mass mailing, opening an office next to the existing practice, or advertising near the existing doctor's office, among other means. Indeed, in the context of the selling doctor continuing to practice, the value of the list is particularly limited because it generally contains the names of people *not* looking for a new doctor. Thus, not only will the new doctor not be able to benefit from the goodwill that the selling doctor previously established, but she will also have to overcome it.

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30. Such restraints could be viewed as an efficient means to reduce the cost to employers of protecting client lists and other trade secrets, but implementing such procedures in a medical practice seems impracticable.

31. RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. b. That is not to say that over the long term doctors might be more hesitant to hire employees if those employees could later compete in the same market.

32. RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. g.

33. Many doctors rent the space that they use for their practice. Thus, the sale is not necessarily for the land that the practice occupies itself but rather for the leasehold. Of course, in the latter case, the buyer simply acquires the right to continue to pay on the existing rental agreement. This right has value because the purchaser expects that the patients will continue with the new practice.

34. Often the selling doctor will also recommend the purchasing doctor to the former's patients.

Absent the removal of the seller from the market, it would be an unwise business decision to purchase a client list for any significant sum.

In fact, the patient list gains significant value – its true value – through the removal of the seller from the relevant market. In this context, the list of patients now becomes a list of customers in search of a new doctor. Characterizing patients as customers seeking a service demonstrates where the real value of such a transaction rests. When patients are seeking a new doctor, timing becomes a key factor. Once patients find alternative medical care, their "free agent" status disappears. Typically, both the purchasing and selling doctor will notify the patients of the sale of the practice and notify them of the identity of the purchasing doctor. As such, patients are advised of the loss of their current service provider and at the same time are informed of a suitable alternative (with the implicit – if not explicit – endorsement of the selling doctor). This endorsement – coupled with the meticulously choreographed timing – is of significant value to the purchasing doctor, particularly given that "[p]atients, like all humans, are creatures of habit and like to deal with 'knowns.' If the practice is well located and easily accessible, patients will not want to change."[35]

The question that arises, then, is whether the selling doctor should be entitled to capitalize (literally) on the opening in the market that she created. That is, perhaps the remaining doctors in the area should be entitled to compete for the newly "released" patients, and perhaps patients should be able to choose their new doctor(s) freely, rather than allowing the seller and purchaser to "restrict" patient choice. The remaining doctors in the area, however, *are* entitled to compete for the newly "released" patients. Competing doctors are free to employ traditional methods of competition or to purchase the transitioning practice. And patient choice is *not* restricted. The sale of a practice takes place when a doctor is (1) retiring, (2) changing practice specialty, or (3) moving out of the relevant geographic area. As such, the result is *not* a restriction on patient choice because in each of these circumstances the "restriction" – the loss of this doctor from the area – would equally occur irrespective of the sale. Also, patients are not obligated to continue with the new doctor.

To be sure, however, the parties to the contract are exploiting the informational advantages available to them regarding the timing of the opening in the market and the exact makeup of the newly available customers. Thus, the list-purchasing doctor obtains convenient and immediate access to the customer list of newly "released" patients – knowing that many patients prefer the least intrusive transition and that it will take more effort for other doctors' advertisements to reach these patients. Maintaining economic value in this informational advantage – by allowing the participants to transact it – serves patients' desires with only marginal impact on overall competition. Non-

35. *See, e.g.*, Dental-Sales.com, Buying a Dental Practice, http://www.dental-sales.com/index.php?page=buying_dental_practice (last visited Sept. 1, 2009).

participants to the transaction remain free to compete for these patients. Competitors would come to know of the forthcoming opening because the selling doctor would have advertised the opportunity to attract potential buyers. Undoubtedly, however, the value of the informational advantage reflects the fact that the buyer and seller retain some monopoly over this data. Stripping value from the information – by prohibiting the transactions – would result in fewer options for patients. They would not be offered as easy a means by which they could transfer service providers because there would be no economic incentive for the departing doctor to transfer her information to new or existing market competitors. At the same time, there would be no significant competing social value to offset this loss. At best, some undefined notion of "fairness" would be served. The result instead would be that customer lists would lay dormant and patients would be "on their own" to find replacement service.

III. RESTRICTIVE COVENANTS IN THE LEGAL PROFESSION

A. ABA Model Rule 5.6: Post-Employment Restrictions on Practice

Rule 5.6(a) of the Model Rules of Professional Conduct states that "a lawyer shall not participate in offering or making: [] 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."[36] While the language of this rule has changed since its predecessor,[37] its purpose has remained largely similar.[38] The rule bars lawyers from entering into employment agreements that limit their ability to practice law after the agreement has expired.[39]

The ABA Standing Committee on Ethics and Professional Responsibility ("Ethics Committee") justified this rule in Formal Opinion 300 ("FO300"),

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36. MODEL RULES OF PROF'L CONDUCT R. 5.6 (2007).

37. Disciplinary Rule 2-108 of the Code of Professional Responsibility ("Code") was adopted in 1969 by the ABA.

38. MODEL CODE OF PROF'L CONDUCT DR 2-108 (1983). The full text of Disciplinary Rule 2-108 reads as follows:

> (A) A lawyer shall not be a party to or participate in a partnership or employment agreement with another lawyer that restricts the right of a lawyer to practice law after the termination of a relationship created by the agreement, except as a condition to payment of retirement benefits.
> (B) In connection with the settlement of a controversy or suit, a lawyer shall not enter into an agreement that broadly restricts his right to practice law, but he may enter into an agreement not to accept any other representation arising out of a transaction or event embraced in the subject matter of the controversy or suit thus settled.

Id.

39. *Id.*

written eight years before the adoption of the Code. FO300 made it clear that any employment agreement that restricted a lawyer's post-employment practice through geographic or time limitations was unethical.[40]

In Informal Opinion 1072 ("IO1072"), the Ethics Committee extended this prohibition to partnership agreements and reiterated the prohibition, found in FO300, against limiting an attorney's freedom "to practice when and where he will."[41] In addition, IO1072 stated that any limitation on a lawyer's freedom to practice would also restrict a prospective client's "desire to engage [the lawyer's] services."[42] It is this latter justification of unrestricted client choice that most courts use when justifying a decision not to uphold a non-compete clause within an attorney's employment agreement.[43]

According to IO1072, the ban on non-compete agreements is designed to protect, as much as possible, a client's or potential client's freedom to choose her lawyer. This is not to say, however, that there are no restraints on client choice. For example, a lawyer may have a conflict of interest that prevents her from representing a particular client; the client and the lawyer may not be able to come to an agreement with respect to the fee; or there may be myriad other restraints to prevent the attorney-client relationship from forming, such as a lawyer's specialty area (e.g., the client may need a criminal defense lawyer while the lawyer in question specializes in patent law).[44] But the purpose of both IO1072 and FO300 is to prevent the business of law from getting ahead of the ethics of law. That is, economic restraints, such as re-

40. ABA Comm. on Prof'l Ethics, Formal Op. 300 (1961).

41. ABA Comm. on Prof'l Ethics, Informal Op. 1072 (1968).

42. *Id.* ("The attorneys should not engage in an attempt to barter in clients, nor should their practice be restricted. The attorney must remain free to practice when and where he will and to be available to prospective clients who might desire to engage his services."). Both Professors Wilcox and Hillman conclude that the Ethics Committee changed its focus for the justification of prohibitions from a lawyer-centered freedom (i.e., a lawyer should be able to choose where he practices), found in FO300, to a client-centered freedom (i.e., a client should be able to freely choose a lawyer), found in IO1072. *See* Robert M. Wilcox, *Enforcing Lawyer Non-Competition Agreements While Maintaining the Profession: The Role of Conflict of Interest Principles*, 84 MINN. L. REV. 915, 926 (2000); ROBERT W. HILLMAN, HILLMAN ON LAWYER MOBILITY: THE LAW AND ETHICS OF PARTNER WITHDRAWALS AND LAW FIRM BREAKUPS §§ 2:51-52 (Wolters Kluwer 2d ed., 1998 & Supp. 2007).

43. *See, e.g.*, Dwyer v. Jung, 336 A.2d 498, 501 (N.J. Super. Ct. App. Div. 1975), *aff'd*, 348 A.2d 208 (N.J. Super. Ct. App. Div. 1975); Marshall v. Romano, 158 A. 751, 752 (Essex County Ct. 1932); Cohen v. Lord, Day & Lord, 550 N.E.2d 410, 411 (N.Y. 1989); Corti v. Fleischer, 417 N.E.2d 764, 768 (Il. App. Dist. 1 1981). As Professor Wilcox points out, many courts credit FO300 with this rationale even though it is found in IO1072. *See* Wilcox, *supra* note 42, at 927.

44. For an extended discussion on client choice, including a discussion of its foundations in FO300, see Robert W. Hillman, *Client Choice, Contractual Restraints, and the Market for Legal Services*, 36 HOFSTRA L. REV. 65 (2007).

strictive covenants, may not be used to limit the matters or methods undertaken in representation of a client.[45]

In *Dwyer v. Jung*, the court declined to enforce a partnership agreement that assigned particular clients to partners and prohibited "one partner from intruding upon a[n]other's clients for a period of five years,"[46] thereby creating an agreement that directly prohibited the partner from representing those particular clients. The court reasoned that it was against public policy for such agreements to be enforced because "[a] client is always entitled to be represented by counsel of his own choosing."[47] The court concluded that the restrictive covenant is "void as against public policy" because it effectively limits the clients "unlimited choice of counsel."[48]

Beginning with *Cohen v. Lord, Day & Lord*,[49] courts began to ban more indirect methods of limiting a client's choice of counsel, which achieve the same effect as restrictive covenants with respect to partnership agreements, though the application of these types of bans is mixed. In *Cohen*, the agreement between the firm and the leaving partner provided for the forfeiture of the leaving partner's departure compensation if he left to join a competing firm.[50] In contrast to *Dwyer*, the agreement in *Cohen* did not directly prohibit the leaving partner from providing services to clients of the partnership, nor did it prohibit the partner from working in a specific geographic area for a specific time period.[51] Instead, the agreement created an economic disincentive for the partner to work with a competitor upon leaving the firm.[52] The court wrote that the "significant monetary penalty . . . constitutes an impermissible restriction on the practice of law" because of the practical wall created between the lawyer and former clients – effectively interfering with the client's choice of a lawyer.[53] The court then found that a provision that indirectly prohibits a lawyer from representing a client by a system of economic disincentives, thereby affecting client choice, was still too much of a limitation on a client's freedom of choice.[54] As Professor Hillman argues,

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45. *See* Wilcox, *supra* note 42, at 926; HILLMAN, *supra* note 42, at §§ 2:51-52; Hillman, *supra* note 44, at 70-71.

46. *Dwyer*, 336 A.2d at 499.

47. *Id.* at 500. Note that the court cited an earlier New Jersey case, *Marshall v. Romano*, 158 A. at 752, not IO1072, in using client choice as the justification for not enforcing the agreement. *Id.*

48. *Id.* at 501.

49. 550 N.E.2d 410 (N.Y. 1989).

50. *Id. See* Gray v. Martin, 663 P.2d 1285, 1286 (Or. Ct. App. 1983) (invalidating a partnership agreement that required leaving partner to forfeit some compensation if he worked in three-county area).

51. *Cohen*, 550 N.E.2d at 411.

52. *Id.*

53. *Id.*

54. *Id.*

"[T]he client's freedom of choice has been bargained away just as effectively as if the partnership agreement contained a bald restrictive covenant."[55]

Many courts appear to agree with *Cohen* that economic disincentives are equally as burdensome as direct restrictive covenants in the context of the legal profession.[56] However, courts have disagreed as to which disincentives are harmful and which are not. For example, the *Cohen* court makes a distinction between income earned and collected by a firm before the partner in question leaves and income earned but *uncollected* before the partner in question leaves.[57] The *Cohen* court contended that the former is an economic disincentive, which is prohibited, while the latter is not and, therefore, can be employed. Courts since *Cohen* have grappled with various schemes to prevent firms from disincentivizing client choice while still protecting the firm from a leaving partner's appropriation of firm assets. That is, courts have recognized that a departing partner can substantially affect her former firm economically by taking both clients and employees.[58] These courts note that, while it would be improper to prevent a partner from leaving, the potential damaging effects to a firm's assets allow for some form of economic protection for the firms, so long as it does not amount to a disincentive against the departing partner.[59]

In *Jacob v. Norris, McLaughlin & Marcus*,[60] the court provided an extended discussion of the role of economic disincentives in partnership agreements. While the court concluded that the partnership agreement's competition clause, which prevented the leaving partner from receiving compensation she would have otherwise received, unfairly restricted client choice, it recognized the cost to the firm as well.[61] The court said, "[W]e are not unmindful of the potential detrimental effect of the departure of a partner or partners on

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55. HILLMAN, *supra* note 42, at § 2:52.

56. A number of courts agree with *Cohen* that economic disincentives levied against partners leaving to compete against the firm are too great a restriction on client choice. *See* Jacob v. Norris, McLaughlin & Marcus, 607 A.2d 142, 148-49 (N.J. 1992); Anderson v. Aspelmeier, Fisch, Power, Warner & Engberg, 461 N.W.2d 598, 601 (Iowa 1990); Pierce v. Hand, Arendall, Bedsole, Greaves & Johnston, 678 So. 2d 765, 769-70 (Ala. 1996); Spiegel v. Thomas, Mann & Smith, P.C. 811 S.W.2d 528, 530 (Tenn. 1991). For a discussion of the opposing point of view, see Fearnow v. Ridenour, Swenson, Cleere & Evans, P.C., 138 P.3d 723, 729 (Ariz. 2006) (en banc).

57. *Cohen*, 550 N.E.2d at 413. See HILLMAN, *supra* note 42, at § 2:62-71, for an extended discussion.

58. This includes other partners, associates, and paraprofessionals. *See, e.g.*, Jacob v. Norris, McLaughlin & Marcus, 607 A.2d 142, 144 (N.J. 1992) (Two partners and an associate left the firm and took associates, paralegals, and clients, who had generated gross billings of $500,000 annually.).

59. *See, e.g.*, *id.* at 151-52.

60. *Id.*

61. *Id.* at 151.

those remaining."[62] The court recognized that firms can minimize the detrimental effect when "computing a withdrawing partner's equity interest in the former firm, [by] accounting for the effect of the partner's departure on the firm's value."[63] The court concluded that a firm may consider the following when determining the effect a leaving partner has upon a firm's value: total value of the partner's capital accounts, accounts receivable, the value of work in progress, and any appreciation in the true worth of tangible personality over and above book value, together with goodwill.[64]

Other courts have validated this approach or suggested different ways to incorporate the economic loss due to a leaving partner.[65] Still others have favored a case-by-case determination of whether a forfeiture provision is too restrictive.[66] And, finally, a small number of courts, mostly in California, have generally enforced disincentive clauses. The most notable of these cases is *Howard v. Babcock*.[67] In *Howard*, the plaintiffs were former partners of Parker, Stanbury, McGee, Babcock & Combs who left the firm to create a new partnership that competed with the remaining firm; the defendants were the partners that remained with the original firm.[68] The disputed provision in the partnership agreement called for forfeiture of a leaving partner's withdrawal benefits if she were to compete with the firm in that particular geographic region upon leaving.[69]

The court concluded that a financial disincentive *could* be applied to leaving partners in this case.[70] The court reasoned that the legal profession was substantially like other professions – such as medicine and accounting – and should be treated similarly, even though California had adopted an earlier form of Rule 5.6 of the Model Code.[71] The court commented that, while there is a "theoretical freedom" associated with a lawyer's right to represent whomever she wishes and there is such a freedom for a client to choose her

62. *Id.*

63. *Id.* at 152 (citing Stern v. Stern, 331 A.2d 257, 260 (N.J. 1975)).

64. *Id.* (citing Stern v. Stern, 331 A.2d 257, 260-61 (N.J. 1975)). The court elaborates on the nature of goodwill, citing *Dugan v. Dugan*, 457 A.2d 1 (N.J. 1983). *Id.*

65. *See* Hackett v. Milbank, Tweed, Hadley & McCloy, 654 N.E.2d 95, 102 (N.Y. 1995) (validating a disincentive clause that an arbitrator found to be "competition neutral"); *see also* Denburg v. Parker, Chapin, Flattau & Klimpl, 624 N.E.2d 995, 999 (N.Y. 1993) (invalidating a competition forfeiture clause but indicating various factors that might make such a clause valid).

66. *See* Pettingell v. Morrison, Mahoney & Miller, 687 N.E.2d 1237 (Mass. 1997) ("[A]lthough a forfeiture is inappropriate, some reasonable recognition of a law firm's loss due to the departure of a partner should be recognized.").

67. 863 P.2d 150 (Cal. 1993).

68. *Id.* at 151-53.

69. *Id.* at 151.

70. *Id.* at 160.

71. *Id.* at 154-57.

own lawyer, these freedoms are simply that – theoretical.[72] In practice, lawyers are discharged from the firms at which they work against their wishes; lawyers are allowed to terminate their relationship with a client over the client's objections; lawyers can refuse to work for particular clients; and no client, in a civil context, has a right to legal services without ultimate payment. All of these factors curtail the theoretical freedom of both attorneys and clients.[73] The court also claimed that the legal profession had become more like standard business, where competition-limiting contracts were generally enforceable.[74] In conclusion, the court stated that, notwithstanding California's particular adoption of Rule 5.6, certain types of non-compete agreements would remain valid.[75]

Generally, the resulting landscape with respect to the application of Model Rule 5.6 is as follows: blanket prohibitions to compete with respect to particular geographic areas or time periods are invalid, as they violate a client's freedom to choose a lawyer and, to some lesser extent, a lawyer's freedom to practice. Economic disincentives employed in partnership agreements in order to dissuade a leaving partner from competing with her previous firm are generally invalid unless they are devised in such a way as to focus on protecting the firm's financial stability rather than preventing or discouraging moves to competitors. The one exception to the use of disincentives is found in the state of California, where law firms are treated similarly to other businesses and professions. California's approach is not only in the minority but also fails to account adequately for the public's interest when evaluating the legitimacy of restraints of trade.

B. ABA Model Rule 1.17: Restrictive Covenants During the Sale of a Law Practice

Model Rule 1.17[76] of the Model Rules of Professional Conduct (2004) describes the way in which "[a] lawyer or a law firm may sell or purchase a law practice, or an area of law practice, including good will."[77] Rule 1.17 establishes the conditions that must be satisfied prior to the sale of a law practice.[78] As a preliminary matter, the seller must cease to practice in a given geographic area.[79] Other conditions are as follows: a seller must market ei-

72. *Id.* at 158-59.

73. *Id.*

74. *Id.* at 159-60.

75. *Id.* at 160.

76. The only case found to discuss this rule, albeit not in great detail, is *Raphael v. Shapiro*, 587 N.Y.S.2d 68 (N.Y. Sup. Ct. 1992).

77. MODEL RULES OF PROF'L CONDUCT R. 1.17 (2007).

78. *Id.*

79. "The seller ceases to engage in the private practice of law, or in the area of practice that has been sold, [in the geographic area] [in the jurisdiction] (a jurisdiction may elect either version) in which the practice has been conducted." *Id.*

ther the entire practice itself or an area of practice to one or more buyers; the seller must provide written notice to current clients apprising them of the potential sale and notifying them of their right to retain other counsel; and the buyer's fees must remain static.[80] Each of these conditions demonstrates the ABA's efforts to address concerns regarding the sale of a practice – client confidentiality, unrestricted client choice, and conflicts of interest between the seller's motivation for financial gain and the recommendation of a competent successor – while still permitting them.[81]

Model Rule 1.17, first adopted in 1990, exists in stark contrast with the underpinnings of Model Rule 5.6 found in FO300. Before the adoption of Rule 1.17, under a "rule of tradition," attorneys could not sell their practices for any reason.[82] At that time, the Ethics Committee argued that the legal profession was not the same as standard commercial activity in that "[t]he practice of law is not a business [that] can be bought or sold;"[83] instead, said

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The rule reads,

> A lawyer or a law firm may sell or purchase a law practice, or an area of law practice, including good will, if the following conditions are satisfied:
> (a) The seller ceases to engage in the private practice of law, or in the area of practice that has been sold, [in the geographic area] [in the jurisdiction] (a jurisdiction may elect either version) in which the practice has been conducted;
> (b) The entire practice, or the entire area of practice, is sold to one or more lawyers or law firm;
> (c) The seller gives written notice to each of the seller's clients regarding:
> (1) the proposed sale;
> (2) the client's right to retain other counsel or to take possession of the file; and
> (3) the fact that the client's consent to the transfer of the client's file will be presumed if the client does not take any action or does not otherwise object within ninety (90) days of receipt of the notice.
> If a client cannot be given notice, the representation of that client may be transferred to the purchaser only upon entry of an order so authorizing by a court having jurisdiction. The seller may disclose to the court in camera information relating to the representation only to the extent necessary to obtain an order authorizing the transfer of a file.
> (d) The fees charged clients shall not be increased by reason of the sale.

Id.

80. *Id.*

81. For comprehensive discussion of these concerns, see James K. Sterrett, II, *The Sale of a Law Practice*, 121 U. PA. L. REV. 306 (1972). *See also* Stephen E. Kalish, *The Sale of a Law Practice: The Model Rules of Professional Conduct Point in a New Direction*, 39 U. MIAMI L. REV. 471 (1985); Leslie A. Minkus, *The Sale of a Law Practice: Toward a Professionally Responsible Approach*, 12 GOLDEN GATE U. L. REV. 353 (1982).

82. 1 GEOFFREY C. HAZARD, W. WILLIAM HODES & PETER R. JARVIS, ESQ., THE LAW OF LAWYERING § 21.3 (3d ed. 2009).

83. ABA Comm. on Prof'l Ethics, Formal Op. 300 (1961).

the Committee, the practice of law is a professional activity in which lawyers maintain "personal and individual" relationships with their clients by providing services.[84] As the Ethics Committee explained, "Clients are not merchandise. Lawyers are not tradesmen. [Lawyers] have nothing to sell but personal service."[85]

In contrast, however, the authors of Rule 1.17 – while recognizing the singular nature of the practice of law[86] – acknowledged the increasing commercialization of the legal profession.[87] The rule espouses the modern view that "clients are an asset of value, and it permits the lawyer controlling the clients to capture that value in the context of the sale of a law practice."[88]

This view has been aided by a growing recognition of the value of professional goodwill. In general, "when applied to law firms, the term 'goodwill' refers to the 'ability to attract clients as [a] result of [the] firm's name, location, or the reputation of [its] lawyers.'"[89] In *Dawson v. White & Case*, the court acknowledged the "economic realities of the contemporary practice of law" as facilitating the modification of the tradition barring the sale of a law practice and its goodwill.[90] While the facts of *Dawson* confined the court to a holding that goodwill had been properly withheld as an asset upon the firm's dissolution,[91] the court was careful to limit its holding, indicating that it "should not be construed as a prohibition against the valuation, in the appropriate case, of law firm goodwill."[92] Likewise, the court recognized that the "ethical constraints against the sale of a law practice's goodwill by a practicing attorney no longer warrant[ed] a blanket prohibition against the valuation of law firm goodwill when those ethical concerns [were] absent."[93]

Similarly, in *Bodner v. Hoffman & Baron, LLP*, the court indicated that, in its broadest sense, goodwill is an intangible asset consisting of a reputation that would most likely produce future business.[94] In embracing the modern view of goodwill as a valuable component of a law practice, the court ac-

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84. *Id.*

85. *Id.*

86. MODEL RULES OF PROF'L CONDUCT R. 1.17 cmt. [1] (2007) ("The practice of law is a profession, not merely a business. Clients are not commodities that can be purchased and sold at will.").

87. *Id. See also* Kalish, *supra* note 81, at 508.

88. HILLMAN, *supra* note 42, at § 2.5.3.

89. Dawson v. White & Case, 672 N.E.2d 589, 592 (N.Y. 1996) (quoting BLACK'S LAW DICTIONARY 695 (6th ed. 1990)).

90. *Id.* at 593.

91. Here, the partners had expressly excluded goodwill as an asset of the firm in their contractual agreements. *See id.*

92. *Id.*

93. *Id.*

94. Bodner v. Hoffman & Baron, LLP, No. 003790/04, 2005 WL 2428331, at *1 (N.Y. Sup. Ct. Sept. 27, 2005).

knowledged that goodwill, existing incidental to a law firm partnership, was an asset for which accounting was necessary.[95]

Two related policy justifications underlie the change in the rule. First, clients who chose sole practitioners to represent them were "vulnerable in a way that clients of lawyers who left law firms were not" when their lawyers died or retired.[96] Practically, the ban created an inconsistency in an attorney's duty to provide for the best interests of her client because a sole practitioner could satisfy a client's immediate needs but was unable to make any definitive plans for the future of her practice.[97] Second, the ban on the sale of law practices was considered burdensome upon sole practitioners and their estates because the goodwill that they had developed in their practices was valuable but not transferable.[98] Prior to the adoption of Rule 1.17, sole practitioners, or their estates, wishing to realize any value from a practice were limited to one of two solutions in order to avoid the prohibition on the sale of a law practice. One option was for a buyer simply to pretend to purchase only the seller's physical assets while secretly purchasing the firm's goodwill as well.[99] Another alternative was for the buyer and seller to enter into a "quickie" or sham partnership.[100] In this case, the buyer and seller would enter into a partnership, and, after a short amount of time, the seller would retire, leaving the partnership in the buyer's sole control.[101] As one commentator put it, before Rule 1.17, "lawyers resort[ed] to misrepresentation and deception in order to realize the goodwill incident to a solo law practice."[102]

In contrast, attorneys who practiced in large firms had a distinct advantage over sole practitioners. These attorneys, upon retiring from firms, were able to realize the value of their developed practice by securing a share in the firm's future earnings via retirement payments.[103] Rule 1.17 helped to equalize the disparities between sole practitioners and attorneys in firms.[104] With the enactment of Rule 1.17 came the explicit recognition that this new approach departed from Model Rule 5.6.[105]

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95. *Id.*

96. ANNOTATED MODEL RULES OF PROF'L CONDUCT 281 (2003).

97. Minkus, *supra* note 81, at 378.

98. ANNOTATED MODEL RULES OF PROF'L CONDUCT 281 (2003).

99. Kalish, *supra* note 81, at 475-76.

100. *Id.* at 476.

101. *Id.*

102. *Id.*

103. Sterrett, *supra* note 81, at 320.

104. 1 HAZARD, HODES & JARVIS, *supra* note 82, at § 21.

105. When Rule 1.17 was enacted, Rule 5.6 was amended to include a statement indicating that "[t]his Rule does not apply to prohibit restrictions that may be included in the terms of the sale of a law practice pursuant to Rule 1.17." *See* Walter Sinclair & Richard J. Worst, *Enforceability of Non-Competition Clauses Affecting Lawyers*, 62 DEF. COUNS. J. 58, 64 (1995).

From an economic perspective, covenants not to compete allow the purchasing attorneys to fully realize the value of the purchased practice.[106] Indeed, attorneys are known to be risk averse.[107] Thus, practice-purchasing attorneys are particularly sensitive to the risk that the selling attorney may at any time, as the product of unforeseeable circumstances or otherwise, return to the area and resume a competitive practice. As such, by allowing covenants not to compete in the limited context of the sale of a practice, buyers are given a reassuring incentive to purchase while still maintaining the profession's general prohibition on covenants not to compete.

IV. THE AMA'S HESITANCY TO REGULATE NON-COMPETE AGREEMENTS

In order to understand why the AMA has not followed the ABA's lead in regulating restrictive covenants, one must understand the AMA's recent experiences with government regulators' evaluations of the AMA's ethical code. In the late 1970s, the FTC severely curtailed the AMA's use of its ethical code to control its members because the AMA had been using the code to achieve anticompetitive ends inconsistent with the public interest. This FTC action left the AMA reluctant to use its ethical code appropriately to restrict improper behavior. The history of the AMA's relationship with the FTC is enlightening.

A. The "Learned Professions" and the Federal Trade Commission

The year 1975 was a watershed year for the development of antitrust and competition law. In *Goldfarb v. Virginia*,[108] the Supreme Court held that lawyers were not exempt from the requirements of the Sherman Act[109] by a sweeping "learned profession" exclusion, as counsel had unsuccessfully argued.[110]

The facts of the case are instructive. In *Goldfarb*, a married couple contracted to buy a home in Virginia.[111] During the process of securing a loan, they needed to obtain a title examination.[112] In Virginia, only a member of

106. Kalish, *supra* note 81, at 508.

107. Law Department Management, http://www.lawdepartmentmanagementblog.com/law_department_management/2008/08/lawyers-are-oft.html (Aug. 25, 2008, 03:31 PM).

108. 421 U.S. 773 (1975).

109. 15 U.S.C. § 1 (2006).

110. Carl F. Ameringer, *Organized Medicine on Trial: The Federal Trade Commission vs. the American Medical Association*, 12 J. POL'Y HIST. 445, 445 (2000).

111. *Goldfarb*, 421 U.S. at 775.

112. *Id.*

the bar could legally provide that service.[113] None of the three dozen attorneys contacted by the couple agreed to provide that service for less than the amount in the minimum-fee schedule published by the Fairfax County Bar Association.[114] The minimum-fee schedule that the couple paid provided for a fee of 1% of the value of the property involved, regardless of the amount of work required to perform the function.[115] The lawyers were likely not just worried about receiving sufficient payment:

> Although the State Bar ha[d] never taken formal disciplinary action to compel adherence to any fee schedule, it [] published reports condoning fee schedules, and [] issued two ethical opinions indicating that fee schedules cannot be ignored. The most recent opinion state[d] that 'evidence that an attorney *habitually* charges less than the suggested minimum fee . . . raises a presumption that such lawyer is guilty of misconduct . . . .'[116]

After hiring one of the equally priced attorneys, the competition-seeking couple brought a class action against the state and county bar alleging that the minimum-fee schedule constituted price fixing in violation of section 1 of the Sherman Act, seeking injunctive relief and damages.[117] After finding that the fee schedule and the threat of sanction constituted classic price fixing, the Supreme Court analyzed whether lawyers were exempt from the requirements of the antitrust laws.[118]

Citing no explicit exemption or legislative history, the defendant bars posited that Congress never intended to include the "learned professions" within the Sherman Act's definition of "trade or commerce."[119] As such, the defendants argued that they were not subject to antitrust regulation.[120] The Supreme Court resoundingly rejected this extra-legislative interpretation.[121] Similarly, the Court rejected arguments based upon "state action" and a lack of jurisdiction-conferring interstate commerce.[122] And so the groundwork was laid for antitrust regulators to investigate and challenge the anticompeti-

113. *Id.*
114. *Id.* at 776.
115. *Id.*
116. *Id.* at 776-78 (emphasis added).
117. *Id.* at 778.
118. *Id.* at 782-83.
119. *Id.* at 786.
120. *Id.* at 787.
121. *Id.* at 787-88.
122. *Id.* at 783-86, 788-93.

tive activities of other "learned professions."[123] Soon thereafter, the FTC came knocking on the AMA's door.[124]

B. The American Medical Association and the Federal Trade Commission

Historically, the AMA viewed free competition as the antithesis of professionalism.[125] The AMA used ethical restrictions to control this "professionalism."[126] These rules were core components of the AMA's 1957 version of its Principles of Medical Ethics, which were in effect when the FTC targeted the AMA for investigation.[127] These standards arose from nineteenth-century medical practices that were viewed as undermining the quality of medical care.[128] Thereafter, the AMA continued to discourage behavior that emphasized commercialized competition in medicine.[129] In an FTC hearing, Dr. Stephen C. Biering, chairman of the AMA's section on medical schools, testified that "doctors should not compete in the commercial sense under any circumstances."[130]

Because federal authorities largely looked at the practice of organized medicine as local in character with a federal structure, organized medicine largely escaped antitrust scrutiny until the 1970s.[131] Additionally, the relationship between organized medicine's various components "was not unlike that of the legal profession, making it difficult for [] authorities to attack."[132] *Goldfarb* turned this analysis on its head.

Goldfarb helped FTC lawyers structure their case against the AMA.[133] Maynard Thompson of the FTC's Bureau of Competition, in a memorandum to commission members, outlined the basis for a complaint that would meet

123. Ameringer, *supra* note 110, at 454 ("There were some obvious similarities between the situation in *Goldfarb* and that involving the AMA and its component state and local medical societies.").

124. *Id.* at 446 ("When the Supreme Court applied the antitrust laws to the learned professions, it undermined government support for the status quo. The antitrust agencies of the federal government, principally the Federal Trade Commission, subsequently opened the health-care industry to market competition, thereby demonstrating that the legal/administrative process can direct public policy when democratically elected branches of government fail to pursue comprehensive reform.").

125. *Id.* at 447.

126. *Id.* at 447-48.

127. *Id.* at 448.

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.* at 450-51.

132. *Id.* at 451.

133. *Id.* at 455.

the requirements of the Federal Trade Commission Act.[134] Thompson's memorandum revealed that the main contention would be that "the AMA and its component state and local medical societies had engaged in a classic price-fixing scheme designed to curtail competition in the health-care industry."[135] Thompson argued,

> In *Goldfarb* the instrument by which price competition between lawyers was avoided was a minimum fee schedule . . . . In the AMA situation, the instrument for avoiding price competition is the 'ethical' prohibition against *engaging* in effective price competition, through the ban on 'soliciting.' As in *Goldfarb,* the potential stick of professional discipline is reinforced by the carrot of assurance that one's peers will co-operate in eschewing competition.[136]

Moreover, the FTC assumed a new posture of activism in the 1970s, supported by increased funding and ideological vigor.[137] FTC economists actively supported intervention and provided the philosophical underpinnings for action – confirming that it would be in the "public interest."[138] Indeed, Thompson's memorandum had relied heavily on economic theory.[139] He indicated that the AMA quashed competition in the health-care market by preventing doctors from conveying important information to consumers.[140] Thompson's solution "was a frontal assault on the AMA Principles of Medical Ethics by means of adjudication rather than rule making. He reasoned that adjudication would encourage a speedy resolution of the matter because it would avoid some complicated legal issues . . . ."[141]

After a nine-month trial, with three thousand exhibits and fifty-two witnesses, the FTC's Administrative Law Judge found that the AMA had violated the antitrust laws.[142] And in 1979, after reviewing AMA practices, the full Commission issued *In re American Medical Ass'n*, detailing the AMA's enormous market power and a litany of its anticompetitive behavior.[143] The FTC ruling described the AMA as a nonprofit corporation and "the largest medical and professional association in the world;"[144] noted that "[i]n 1976,

134: *Id.*
135. *Id.*
136. *Id.* at 456.
137. *Id.* at 454.
138. *Id.* at 456-57.
139. *Id.* at 457.
140. *Id.*
141. *Id.* at 457.
142. *Id.* at 460.
143. *In re* Am. Med. Ass'n, 94 F.T.C. 701, No. 9064, 1979 FTC LEXIS 181 (Oct. 12, 1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980), 455 U.S. 676 (1982).
144. *Id.* at *19.

AMA had projected annual revenues totaling $55,611,000 and total projected assets of $47,185,000;"[145] and found that the AMA seeks to serve as the medical profession's national representative.[146] The FTC charged that the AMA had been engaging in anticompetitive behavior, in violation of section 5 of the Federal Trade Commission Act, by prohibiting its members from engaging in the following activities: "(A) Soliciting business, by advertising or otherwise; (B) Engaging in price competition; and (C) Otherwise engaging in competitive practices."[147] As a consequence of this behavior by the AMA, the FTC indicated that

> (A) Prices of physician services have been stabilized, fixed, or otherwise interfered with; (B) Competition between medical doctors in the provision of such services has been hindered, restrained, foreclosed and frustrated; and (C) Consumers have been deprived of information pertinent to the selection of a physician and of the benefits of competition.[148]

The FTC's findings and conclusions demonstrated that the AMA actively sought to maximize profits for doctors, restrict access to the profession to keep fees elevated, and engage in other anticompetitive behavior. Specifically, the FTC found that, among other things, the AMA worked to resist competition and distort the market for medical services to protect physicians' earnings.[149]

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145. *Id.* at *18.

146. *Id.* at *88.

147. *Id.* at *4.

148. *Id.* at *4-5.

149. The FTC described a succession of events demonstrating this wrongdoing: (1) the "AMA took an active role in its opposition to federal price controls on physicians' fees;" *id.* at *99; (2) the "AMA has opposed national health insurance proposals harmful to the economic interests of physicians, including those that involve more government scrutiny of physicians' incomes and fees;" *id.* at *101; (3) the "AMA has opposed legislation at both the federal and state levels requiring relicensure, retraining, recertification or continuing medical education by physicians in order for them to continue to practice and earn a living as physicians;" *id.* at *107; (4) the "AMA opposed the initial passage of the Professional Standards Review Organization ("PSRO") Act, . . . [which] pose[d] a substantial economic threat to physicians;" *id.* at *109; (5) the AMA worked to "control the entry of competition [into the market] from salaried National Health Service Corps physicians;" *id.* at *111; (6) the "AMA has pressed for tight restrictions on those FMGs [foreign medical graduates] who try to stay in this country as practicing physicians and, thereby, compete with American physicians;" *id.*; (7) "[i]n the 1930's, believing that there was an excess of physicians, [the] AMA sought to reduce the supply of physicians by limiting medical school enrollments [and the] AMA [continued to] oppose[] legislation conditioning federal capitation grant money to a medical school on the school's agreement to increase its enrollment;" *id.* at *113; (8) the "AMA specifically opposed governmental limitation

The AMA used various devices in order to accomplish its anticompetitive goals.[150] It "made adherence to the AMA Principles of Medical Ethics a condition of membership."[151] The AMA's disciplinary proceedings could result in a reprimand, censure, suspension, or expulsion.[152] Even short of those penalties, there were other possible negative consequences for violations:[153]

> (a) Possible loss of malpractice insurance . . . ;
>
> (b) Withholding of claims reimbursement by health insurance carriers . . . ;
>
> (c) Possible loss of referrals and other patronage . . . [;]
>
> (e) Inability to deliver papers and display exhibits at professional society meetings . . . [;]
>
> (f) Time spent away from practice and attorney expenses . . . ; and,
>
> (g) Professional disgrace, embarrassment and humiliation . . . .[154]

Through the enforcement of its ethical principles, the AMA interfered with free competition by restraining doctors from soliciting business, competing on cost and price, and advertising.[155] For instance, doctors were not per-

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of physicians' revenue margins on the ground that it would impose a ceiling on the maximum dollar amount of the physician's 'profit' from medical practice;" *id.* at *122; and (9) the "AMA [gave] detailed guidance to its members on setting fees, cautioning them that charging fees that are too low will lessen respect for physicians." *Id.* at *130.

150. *See generally id.*

151. *Id.* at *221.

152. *Id.* at *227.

153. *Id.* at *229 ("Actions to enforce AMA's ethical standards may deprive the disciplined physician of valuable rights and affect his or her reputation, professional status or livelihood.").

154. *Id.* at *229-30.

155. *Id.* at *242-43.

> Section[] 5 of the AMA Principles of Medical Ethics states that a physician "should not solicit patients." . . . Opinions 6, 11, 12, 13, 18, 23, and 29 of Section[] 5 in AMA's 1971 Opinions and Reports also contain absolute prohibitions on solicitation of patients or patronage, whether directly or indirectly, by a physician or by groups of physicians . . . . Opinion 6 states, inter alia, "Solicitation of patients, directly or indirectly, by a physician or by groups of physicians, is unethical." . . . Opinion 12 states, inter alia: "The ethical principle remains: No physician may solicit patients.

mitted to solicit business by holding an open house[156] or mailing out previously published articles with the intent to solicit patients.[157] Likewise, by placing general restrictions on the manner in which a physician enters into a contract[158] and disfavoring a physician's ability to accept a salaried position in the emergency room,[159] the AMA and its member societies effectively proscribed contracts under which hospitals, group prepaid health plans, and other lay organizations could employ physicians to care for patients, especially where the physicians were employed for a fixed salary.[160] By doing so, the AMA created barriers to entry into the medical profession that benefited incumbent doctors at the expense of new entrants, as well as consumers (i.e., patients).

Moreover, the FTC detailed numerous instances in which the AMA sought to enforce its ethical rules – particularly when doctors' advertisements sought to compete directly on price.[161] For instance, the AMA characterized

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> A physician may not do indirectly that which he may not do directly. He may not permit others to solicit patients for him."

Id. at *242.

156. *In re* Am. Med. Ass'n, 94 F.T.C. 701, No. 9064, 1979 FTC LEXIS 182, at *25 (Oct. 12, 1979) *aff'd*, 638 F.2d 443 (2d Cir. 1980), 455 U.S. 676 (1982) (citing AMERICAN MEDICAL ASSOCIATION, OPINIONS AND REPORTS § 5, opinion 13 (1971)).

157. *Id.* at *26-27 (citing AMERICAN MEDICAL ASSOCIATION, OPINIONS AND REPORTS § 5, opinion 27 (1971)).

158. *Id.* at *43-44.

> The 1971 AMA Judicial Council's Opinions and Reports provide that an organization's contract with a physician to deliver medical services is 'unfair or unethical' under any of the following conditions:
> (a) When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.
> (b) When the compensation is so low as to make it impossible for competent service to be rendered.
> (c) When there is underbidding by physicians in order to secure the contract.
> (d) When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.
> (e) When there is solicitation of patients directly or indirectly . . . .

Id. at *44.

159. *Id.* at *45 (citing AMERICAN MEDICAL ASSOCIATION, OPINIONS AND REPORTS § 6, opinion 8 (1971)).

160. *Id.* at *51. ("In a number of instances, AMA and its member societies have counseled physicians to refrain from actions contrary to the contract practice ethical restrictions.").

161. *In re* Am. Med. Ass'n, 94 F.T.C. 701, No. 9064, 1979 FTC LEXIS 181, at *248-55 (Oct. 12, 1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980), 455 U.S. 676 (1982) (For example, in 1976, Maryland's medical society published the AMA Principles of Medical Ethics. Citing the AMA as authority, one statement indicated that "[professional]

a proposed letter offering physical exams for civil servants as solicitation.[162] Similarly, the AMA indicated its disapproval of including fee schedules[163] or other references to charges[164] in advertising and brochures.[165] The AMA also placed restrictions on a physician's ability to distribute announcements that contained information relating to cost.[166] Generally, the AMA's policies favored existing medical practices and institutional medical providers.[167] They were anticompetitive.

The FTC's criticisms of the AMA's actions in light of their anticompetitive effects are clear:

> [a]dvertising is the traditional mechanism in a free-market economy for a supplier to inform a potential purchaser of the availability and terms of exchange, [which] performs an indispensable role in the allocation of resources in a free enterprise system . . . [and]

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notices are permissible, provided they do not carry listing of fees or any other material not in keeping with the dignity of the medical profession.").

162. *Id.* at *248-49 (Here, the AMA indicated that such action was prohibited by section 5 of the Principles of Medical Ethics and Opinion 11. Likewise, in numerous instances, physicians were admonished by their local medical societies for sending out brochures and letters that included fee or billing information.).

163. *Id.* at *251 (Responding to a group of doctors seeking to include their fee schedules in a brochure describing their practice designed strictly for current patients, the AMA indicated that this may be seen as solicitation that might cause some to question "[whether] or not such a brochure [was] . . . in keeping with the traditions and ideals of the medical profession.").

164. *Id.* at *252-53 (With respect to an advertisement, the AMA advised a health maintenance organization that it was "not acceptable to include reference to . . . amounts of charges . . . in any sort of publication of this type[.]").

165. *Id.* at *253 (For example, the Santa Clara County (California) Medical Society approved a policy on physician advertising and promotional activities indicating that "[advertising] for the purpose of self-aggrandizement or solicitation of patients is prohibited" when pertaining to statements about cost.).

166. *Id.* at *249-50 (For instance, when a physician was contemplating running a pap smear clinic for one week during which he would reduce his fees, the AMA said, "Ethically you can notify only your own patients. Announcements to the general public should be made only by the medical society.").

167. *Id.* at *283-91 ("[T]he AMA component organization in Phoenix, Arizona . . . , has hindered the marketing efforts of two local HMOs through the application of ethical restrictions based on AMA's 1971 Opinions and Reports . . . . The Society stated that its Committee on Ethics and Discipline had stood firm in its belief that the names of participating physicians should not appear in any advertisements . . . ." Doctors were not prohibited from sending notices of opening or change in office, but these notices were more limited in scope than advertisements.).

serves individual and societal interests in assuring informed and reliable decisionmaking.[168]

The FTC noted that price advertising provides pressure to reduce prices, informs the public about other available prices, and encourages market entry for new and different service providers.[169] In sum, the AMA's ethical restrictions created anticompetitive effects that harmed the public interest.[170]

As a result of these findings and conclusions, the FTC ordered, inter alia, that the AMA *not* (1) restrict doctors' advertising of services, facilities, or prices; (2) limit patients' choice of a physician; (3) impose price floors; or (4) restrict participation by non-physicians in the ownership of medical practices.[171] While broad in scope, the FTC's order specifically and exclusively restricted *anticompetitive* behavior only.

C. The American Medical Association's Approach to Restrictive Covenants

While the AMA, for the past sixty years, has consistently taken the position that non-compete agreements have a negative impact on patient care,[172] it has *not* been consistent in the level of disapprobation that it has applied.[173] In 1933, the AMA declared non-compete clauses unethical.[174] In 1960, however, it backed away from its 1933 position[175] and emphasized the freedom of doctors to contract for employment.[176] The issue arose again in 1971 and 1972, but the AMA adopted no substantive change to its ambivalent position.[177] In 1980, the AMA changed its position and stated "that noncompetition agreements were not 'in the public interest.'"[178] But the AMA refused to take the extra step and declare such agreements unethical.

Today, the AMA Council on Ethical and Medical Affairs, Code of Medical Ethics states,

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168. *In re* Am. Med. Ass'n, 94 F.T.C. 701, No. 9064, 1979 FTC LEXIS 182, at *170 (Oct. 12, 1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980), 455 U.S. 676 (1982).

169. *Id.*

170. *Id.* at *181-82.

171. Am. Med. Ass'n v. F.T.C., 638 F.2d 443, 450 (2d Cir. 1980).

172. Paula Berg, *Judicial Enforcement of Covenants Not to Compete Between Physicians: Protecting Doctors' Interests at Patients' Expense*, 45 RUTGERS L. REV. 1, 6 (1992).

173. Malloy, *supra* note 20, at 217-18.

174. Berg, *supra* note 172, at 6-7.

175. *Id.* at 7.

176. *Id.*

177. *Id.* at 7-8.

178. *Id.* at 9.

> 9.02 Restrictive Covenants and the Practice of Medicine: Covenants not to compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council of Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician.[179]

Thus, notwithstanding the AMA's disapproval of restrictive covenants, it chose not to declare such agreements unethical. The AMA's tepid approach was a direct result of misplaced fears – based on its misreading of *In re the American Medical Ass'n* – that the FTC might find a more emphatic statement anticompetitive.[180] Practically, the result has been that courts are often unwilling to rely on the AMA's halfhearted statement as a basis to interfere with these agreements.

In *Karlin v. Weinberg*[181] and *Ohio Urology, Inc. v. Poll*,[182] the courts compared the application of the outright prohibition on non-compete agreements for attorneys under Rule 5.6 with the less-definitive statement in place for physicians.[183] In both cases, the appellate courts reversed the trial courts' attempts to graft the ABA rules onto the AMA and doctors.[184] The courts, however, each offered distinct reasoning to support their decisions not to follow the ABA's approach.

In *Karlin*, the court indicated its disapproval of the adoption of a per se rule prohibiting post-employment restraints, using precedent to hold that they are valid to protect an employer's economic interests, do not unduly burden an employee, and are not harmful to the public interest.[185] The court indicated that, because the nature of the attorney-client relationship made restriction of client choice a motivating factor in establishing the ABA approach, commercial standards were not an appropriate measure of the "reasonableness of lawyer restrictive covenants."[186] Similarly, the court noted that cases

179. ANDEEL, *supra* note 12. AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS opinion 9.02 (1998), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion902.shtml.

180. Berg, *supra* note 172, at 9.

181. 390 A.2d 1161 (N.J. 1978).

182. 594 N.E.2d 1027 (Ohio Ct. App. 1991).

183. Berg, *supra* note 172, at 39-43.

184. *Id.*

185. *Karlin*, 390 A.2d at 1166.

186. *Id.* at 1167.

like *Dwyer*[187] represented the judiciary's unique, constitutionally mandated role in regulating attorney conduct.[188] In contrast, the court in *Ohio Urology, Inc.* focused on the distinctive language employed by the two regulating bodies as justification for the court's decision to distinguish the prohibition on restrictive covenants for attorneys from the absence of such covenants for physicians.[189] The court recognized that the AMA's language represented only a mere discouragement of restrictive covenants as opposed to the ABA's clear language prohibiting them.[190]

By comparison, in *Valley Medical Specialists v. Farber*,[191] the Supreme Court of Arizona analyzed the AMA rules on non-compete agreements to determine whether such agreements are contrary to the public interest.[192] In this case, the court *invalidated* the non-compete agreement.[193] The court found that, in light of the fact that non-compete agreements between lawyers were illegal, the AMA's discouragement was relevant to the public interest inquiry, even though it was not binding on physicians.[194] In fact, the court used the public interest as a justification to strike down the non-compete despite the AMA's hesitant approach to restrictive covenants. In light of the *Valley Medical Specialists* court's conclusion that some non-compete agreements in the medical profession should be invalidated, it is apparent that courts will employ imprecise judicial evaluations of the public interest in the absence of firm guidance from the AMA. The result is an inconsistent application of restrictive covenants. The difficulty in these cases lies in the AMA's unwillingness to make a definitive statement prohibiting non-compete agreements in those contexts in which they are harmful to both physicians and the public.

D. Properly Applying the FTC's Order to the AMA

While the FTC was highly critical of the AMA's anticompetitive behavior, its reasoning and consequential order demonstrate that the AMA not only could but also should prohibit non-compete clauses in the employment context, like the ABA has done for attorneys. The FTC was concerned that the anticompetitive actions of the AMA had negative ramifications for patients. Just as the ABA Ethics Committee recognized in Informal Opinion 1072 with regard to Rule 5.6, the FTC likely appreciated that any restriction on a profes-

187. Dwyer v. Jung, 336 A.2d 498 (N.J. Super. Ct. Ch. Div. 1975), *aff'd*, 348 A.2d 208 (N.J. Super. Ct. App. Div. 1975).

188. *Karlin*, 390 A.2d at 1167.

189. Ohio Urology, Inc. v. Poll, 594 N.E.2d 1027, 1030-31 (Ohio Ct. App. 1991).

190. *Id.*

191. 982 P.2d 1277 (Ariz. 1999).

192. Malloy, *supra* note 20, at 215.

193. *Id.*

194. *Id.*

sional's right to practice results in a *restriction* on client choice. As the Ethics Committee and later the courts in *Cohen*[195] and *Dwyer*[196] acknowledged, a client's freedom to choose her own counsel was the primary justification to ban restrictive covenants in lawyer-employment agreements. In the same way, the restriction of a physician's right to practice by an employment agreement has the negative effect of restraining patient choice. It is anticompetitive and results in social disutility. As such, the FTC would likely *endorse* the application of the ABA's approach to the AMA.

Indeed, while some have even gone so far as to suggest a total ban on restrictive covenants for physicians,[197] this approach is excessively broad. The ABA approach of prohibiting lawyers from adopting non-compete clauses in post-employment contexts, while allowing for such clauses regarding retirement benefits and incident to the sale of a law practice, is equally appropriate in the context of the medical profession. Whereas non-compete clauses in the physician employment context are anticompetitive and have negative ramifications for patients, including the restriction of a patient's choice of physician, non-competes in the context of the sale of a medical practice are not anticompetitive and do not have negative ramifications for patients.

While post-employment restraints for doctors are rationalized because they prevent the physician employee from appropriating an established customer base and using the contacts the employee doctor developed during his employment,[198] these restraints are not necessary to perform or guarantee the underlying employment contract. The restraints harm new entrants to the medical market and patients by restricting the employment options of the former and the physician options of the latter.[199] Indeed, these agreements reward those with unequal bargaining power[200] and punish those not even involved in the transaction: patients. These restrictive covenants embody the archetype of the evils properly used to justify their prohibition generally. They "injure the parties making them, because they diminish their means of procuring livelihoods and a competency for their families. They tempt improvident persons, for the sake of present gain, to deprive themselves of the power to make future acquisitions, and they expose such persons to imposition and oppression."[201] Equally, such clauses harm patients by "depriv[ing] the public of the services of [doctors] in the employments and capacities in which they may be most useful to the community . . . ."[202] And, finally, "they

195. *See supra* notes 49-55 and accompanying text.

196. *See supra* notes 46-48 and accompanying text.

197. Malloy, *supra* note 20, at 216.

198. *See* RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. b (1981); Malloy, *supra* note 20.

199. *See* RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. b.

200. *See* RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. g.

201. Shute v. Heath, 42 S.E. 704, 705 (N.C. 1902).

202. *Id.*

prevent competition and enhance prices . . . [by] expos[ing] the public to all the evils of monopoly."[203]

The FTC's actions in *In re the American Medical Ass'n* demonstrate that it would neither want to protect employer's goodwill at the expense of the future employment of new entrants to the medical-professional market nor restrict the access to health care for patients. Post-employment restrictive covenants are anticompetitive, and the AMA would be well within its power – and wholly consistent with the FTC's ruling – to prohibit such activities. Accordingly, the AMA should enact a prohibition, similar to that imposed on lawyers, on the use of restrictive covenants that prevent new employee doctors from working in the same geographic area for some time after leaving the initial practice group.

In contrast, for the sale of a medical practice, non-compete clauses are consistent with the FTC's ruling. They restrict neither competition nor access to care for patients. Similar to the situation for the sale of a legal practice, doctors selling their practices are either (1) retiring, (2) changing practice specialty, or (3) moving out of the relevant geographic area. As such, the result is *not* anticompetitive, nor does it restrict patient choice. Because the loss of these doctors from the relevant geographic or practice area would occur regardless of the sale and the concomitant restrictive covenant, there is no loss in competition and no loss in access for patients. In addition, there is no reduction in choice for the patients because they are not obligated to continue with the new doctor who purchased the practice. Thus, the new doctor is only purchasing convenient and immediate access to a customer list. And this is arguably of no effect or has a positive effect on patients because it provides them with some service. While patients are offered a convenient alternative to searching for a new health-care provider on their own, they need not take this moderately option-expanding service. An approach that embraces non-compete clauses only in the context of the sale of a medical practice provides value to the purchasing doctor, as many patients of the selling doctor will use the services of the purchasing doctor.[204] Thus, allowing this covenant is better for doctors, patients, and society than forbidding it.

Finally, the posture of the FTC in *In re the American Medical Ass'n* further supports greater AMA action. "In 1994, the FTC accepted the AMA's final compliance report and notified the AMA that it would take no further action."[205] That is, now that the AMA is out from under what it likely viewed as the oppressive yoke of the FTC, the AMA has greater latitude in revising its ethical rules. Indeed, should the AMA's unjustified fears of FTC action act as an impediment to change, it could assuredly seek guidance from the FTC rather than doing nothing.

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203. *Id.*

204. *See, e.g.*, Dental-Sales.com, Buying a Dental Practice, http://www.dental-sales.com/index.php?page=buying_dental_practice (last visited Sept. 1, 2009).

205. Ameringer, *supra* note 110, at 454.

V. CONCLUSION

The AMA's current relaxed treatment of restrictive covenants in the medical profession impairs both physicians and patients alike. The public interest, long espoused as a key consideration of restrictive covenants in the context of the medical profession, would be best served by the AMA's adoption of ABA-like rules. By adopting restrictions similar to the current ABA rules, which would allow for restrictive covenants incident to the sale of a medical practice but *not* in employment agreements, the AMA would serve the interests of its physicians, prospective patients, and the general public. This approach would allow doctors to leave practices when they see fit without forcing these doctors to flee the location as a consequence of the oligopolistic-reinforcing employment arrangements imposed by established medical practices. Equally, this proposal would allow practice-selling doctors to benefit from the goodwill they established without adversely impacting patient well-being – indeed, possibly improving it. The increased competition and access for patients caused by adopting these proposals would produce better healthcare, and that should be the AMA's paramount goal.