11.2.3.1 Restrictive Covenants

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

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

Physicians should not enter into covenants that:

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

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

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

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

Background report(s):

CEJA Report 13-A-14 Restrictive covenants

CEJA Report 7-A-97 Covenants not to compete for physicians in training

CEJA Report 6-A-97 Agreements restricting the practice of medicine

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-14

Subject: Restrictive Covenants
(Resolution 9-A-13)

Presented by: Susan Dorr Goold, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Lynn Parry, MD, Chair)

Resolution 9-A-13, "Restrictive Covenants," introduced by the Minnesota Delegation and referred by the House of Delegates, asks that "our American Medical Association conduct an in-depth review of and update" Opinion E-9.02 on restrictive covenants in physician contracts. This report by the Council on Ethical and Judicial Affairs (CEJA) summarizes key ethical and legal issues relating to the use of restrictive covenants in medicine and reviews relevant AMA ethics policy in this area.

INTRODUCTION

In the context of medical services, a restrictive covenant—commonly referred to as a noncompete agreement or a covenant not to compete—is a contractual provision between a physician and his or her employer that limits or prevents a physician's practice of medicine. Generally, the restriction applies to a specific geographic area for a defined period of time following the termination or conclusion of the physician's employment or the sale of the physician's medical practice.[1] Restrictive covenants are often implemented to prohibit a new physician from leaving his or her employer and then establishing a competing practice in that particular vicinity while using information, skills, training, or patient contacts provided by the employer.[2] Likewise, they may be implemented to restrict competition against the purchaser of a physician practice.

The *Code of Medical Ethics* includes several opinions relevant to covenants not to compete. Opinion E-9.02, "Restrictive Covenants and the Practice of Medicine," holds that the restrictive covenants have the potential to restrict competition, disrupt continuity of care, and deprive the public of medical services.[7] Covenants-not-to-compete may be unethical if they are "excessive in geographic scope or duration" or fail to make "reasonable accommodation" of patients' choice of physician. Opinion E-9.021, "Covenants-Not-to-Compete for Physicians in Training," addresses the use of restrictive covenants in the context of medical residency and fellowship programs, and prohibits training institutions from seeking noncompete guarantees in return for fulfilling their education obligations.[8] Finally, Opinion E-6.11, "Competition," encourages competition among physicians and other health care practitioners and identifies key criteria for ethically justifiable competition.[9]

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

TREATMENT OF RESTRICTIVE COVENANTS BY STATE COURTS

Restrictive covenants are strictly a matter of state law. State courts generally view restrictive covenants in employment contracts with considerable skepticism given that these agreements are seen as a potential restraint on trade.[1] Therefore, courts often decline to enforce restrictive covenants against employees unless the employer can demonstrate that the noncompete agreement falls within the parameters established by state law.[2] In assessing whether a restrictive covenant is legally enforceable, courts look at whether the employer has a protectable business interest beyond simply avoiding competition that justifies the use of a restrictive covenant, whether the covenant is reasonable in terms of the time and geographic restrictions it establishes, and whether enforcing the agreement would be otherwise contrary to public policy.[2,6] Even if a restrictive covenant is determined to be legally valid, a court may be hesitant to see this portion of the employment contract implemented for fear the restrictions may impede an employee's ability to work and deprive the public of that employee's skills, all the while providing little if any economic benefit to the employer's economic interests.[6,7] Depending on the law in a particular jurisdiction, some courts may apply a "blue pencil" rule whereby the court may narrow the terms of the covenant to keep the contract in line with applicable state law.[2] Under this type of rule, a judge may use his hypothetical blue pencil to cross out or limit the unreasonable elements of a covenant while leaving the enforceable provisions of the covenant intact.[2]

RESTRICTIVE COVENANTS IN PHYSICIAN EMPLOYMENT CONTRACTS

The use of restrictive covenants in medicine has become more commonplace in recent years because doctors are more likely to change employers than in years past.[10] Prior to 1990, it was estimated that less than two percent of physicians changed jobs during their lifetime.[10] More recent estimates show that approximately ten percent of physicians change their jobs annually.[11] Further, doctors are increasingly seeking employment with large hospitals and health care systems instead of pursuing careers in solo practice.[12] Given the movement toward bigger health care systems where physicians enter into contractual relationships for employment, restrictive covenants have become a ubiquitous component of employment agreements where employers seek to protect their investments in the training and employing of physicians.[13]

Courts usually recognize two primary business interests with respect to restrictive covenants involving physicians: the employer's investment in specialized training provided to the physician, and protecting a practice's patient base.[2] Where the employer has been able to demonstrate it has provided valuable medical training that was key to physician's current marketability and earning potential restrictive covenants have been upheld.[14,15] In like manner, courts in several states have recognized that access to a practice's "customer" contacts is a protectable interest under a noncompete agreement.[16,17,18]

Courts have determined what qualify as "reasonable" geographic and time limitations on a case-by-case basis. For example, the Supreme Court of New Jersey found that restricting a physician's practice within a thirty-mile radius of his former employer to be excessive, but changing the radius to thirteen miles would be a reasonable geographic limitation.[14] And in Florida, the state statute on employment noncompete restrictions holds that any restrictive covenant that imposes restrictions of less than six months is reasonable, but a limitation of more than two years is unreasonable.[19]

While many state courts have held physician restrictive covenants to be ethically justifiable when found to not be injurious to the public,[20] and that they can even have a positive impact on patient care,[21] other states do not enforce noncompete agreements for physicians. Delaware and Massachusetts—two states that allow noncompete agreements in employment contracts—do not enforce them against physicians.[2] States such as Virginia, Tennessee, and Texas, however, are simply more critical of physician restrictive covenants than they are of other employment noncompete agreements.[2]

ETHICAL CONSIDERATIONS

A chief concern in the use of restrictive covenants in physician contracts is their impact on patient-physician relationships. Patients have the right to choose their physician (within certain constraints).[22] They are also entitled to continuity of care,[23] and to the extent that restrictive covenants may disrupt continuity, such agreements can be ethically problematic.[24] While a patient may be able to secure care from a different physician in the area or even within the same practice, the trust and confidence established between the patient and his or her original physician may no longer be present.[25] If a noncompete agreement restricts the ability of a physician to enter or leave a market and restricts the scope of the physician's practice, this can erode the number of physicians in a particular region, causing physician shortages and undermining a patient's choice in care.[25] This type of outcome may adversely affect the quality of care in a region or limit access to health care to populations that are already underserved.[24] In terms of employment, restrictive covenants may not adequately recognize the contributions a departing physician has made to a medical practice with regard to his or her professional skills, reputation, and patient relationships, and may overestimate the employer's investment in education and training of that physician.[25] Finally, a noncompete agreement could delay a physician's exit from the physician's current employer, keeping the physician in an unhealthy employment relationship that will have ramifications that reverberate across the practice.[25]

To be ethically justifiable, restrictive covenants must carefully balance the medical needs of individual patients and communities and the business interests of health care organizations. While covenants not-to-compete may seem counterproductive in the medical realm, such agreements can help protect a practice's relationships with its patients, as well as protect monetary and other investments health care organizations and practices make in physician training and mentoring.[26]

RECOMMENDATION

Given these considerations, the Council on Ethical and Judicial Affairs recommends that Opinions E-9.02, "Restrictive Covenants in the Practice of Medicine," E-9.021, "Covenants-Not-to-Compete for Physicians in Training," and E-6.11, "Competition" be amended by substitution as follows in lieu of Resolution 9-A-13 and the remainder of this report be filed:

> Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.
>
> Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.
>
> Physicians should not enter into covenants that:

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

(b) do not make reasonable accommodation for patients' choice of physician.

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

(Modify HOD/CEJA Policy)

Fiscal Note: less than $500

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APPENDIX

The following opinions are referenced in the report.

E-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 on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (VI, VII)

Issued prior to April 1977; Updated June 1994 and June 1998.

E-9.021 Covenants-Not-to-Compete for Physicians-in-Training
It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training (residents in programs approved by the Accreditation Council for Graduate Medical Education [ACGME], fellows in ACGME-approved fellowship programs, and fellows in programs approved by one of the American Board of Medical Specialties specialty boards) should not be asked to sign covenants-not-to-compete as a condition of their entry into any residency or fellowship program. (III, IV, VI)

Issued December 1997 based on the report "Covenants-Not-to-Compete for Physicians-in-Training," adopted June 1997 (JAMA. 1997; 278: 530).

E-6.11 Competition
Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc, is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care. (VII)

Issued July 1983.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 8-A-07

Subject: Restrictive Covenants

Presented by: Robert M. Sade, MD, Chair

At the 2006 Annual Meeting of the AMA House of Delegates, the Council on Ethical and Judicial Affairs presented Report 5-A-06, "Restrictive Covenants," which set forth revisions to Opinion E-9.02, "Restrictive Covenants and the Practice of Medicine."

The Opinion revisions retained guidelines providing that restrictive covenants are unethical if excessive in geographic scope or duration, or if they fail to make reasonable accommodation of patients' choice of physicians, but clarified the terms restrictive covenant and covenant-not-to-compete. Additionally, the revisions noted that such agreements must not compromise the welfare of patients and that parties should establish equitable terms of severance, in part to facilitate patient choice of physicians. There was much resistance to the proposed amendments to Opinion E-9.02 and the report was referred back to CEJA for further consideration.

After discussion by CEJA, as well as input from interested constituencies, including representatives from the Advisory Committee on Group Practice Physicians, the Council has decided to withdraw the report. Withdrawal of CEJA Report 5-A-06 does not mean that CEJA will not reconsider Opinion E-9.02 in the future, only that the Opinion will remain unchanged at this time.

The Council would like to thank all those providing testimony at the 2006 Annual Meeting, and the constituencies that provided additional comments as CEJA was deliberating on a course of action.

CEJA Report 7 – A-97
Covenants-Not-to-Compete for Physicians-in-Training

BACKGROUND

Covenants-not-to-compete have become increasingly common in medical practice. A physician practice group, hospital, or managed-care organization may request that its newly recruited physician sign an agreement promising that if he or she ever leaves the group, hospital, or plan, he or she will not set up a competing medical practice in the same geographic area for a period of months or years. Hospitals, plans or groups often bear the costs of assisting a new physician in establishing a practice, and of introducing him or her into the community; restrictive covenants assure them that the new physician will not make unfair use of their investment by setting up an independent and competing practice after successfully settling in.

Covenants-not-to-compete are controversial, however. Many state courts will not enforce them, because they limit market competition. The American Bar Association prohibits attorneys from signing them, on grounds that such covenants interfere with clients' free ability to choose between attorneys, or to follow their attorneys if the attorneys move from one firm to another. The Council on Ethical and Judicial Affairs discourages such covenants in the medical context both because they limit patients' choice and because they have the potential to interfere with continuity of patient-care: under such covenants, physicians who are dissatisfied with their practice-partners or managed-care plans can leave their unfortunate circumstances only by leaving their patients behind.

Recently, the practice of signing covenants-not-to-compete has been extended to the educational sphere. Some medical schools and affiliated institutions are requesting that residents and other physicians-in-training sign covenants-not-to-compete as a condition of enrollment in training programs. (For purposes of this report, the term “physicians-in-training” means residents in ACGME-approved residency programs, fellows in ACGME-approved fellowship programs, and fellows in programs approved by one of the ABMS specialty boards.) Covenants in such circumstances are particularly problematic. The decision to seek training in some aspect of medicine is not an arms-length negotiated business decision, like the decision to join a medical practice group or to sign on with a plan. Physicians-in-training lack bargaining power. Moreover, the investment made in their training by teaching institutions is not made in the expectation of return, as in the case of a practice group, which introduces s new physician into a community. It is made as part of the continuing obligation of physicians to pass their knowledge on to one another. It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations.

CONCLUSION

Teaching institutions should not request that a physician-in-training sign any covenant-not-to-compete. While such covenants may sometimes be appropriate in the commercial context of an arms-length agreement between a physician and a practice-group or a managed-care entity, they are never appropriate in the context of the unequal bargaining power, which characterize the relationship of physician-in-training with teaching institution. Such agreements risk cheapening the fiduciary obligation of physician-teachers to pass on their knowledge to new trainees, and raising barriers to specialty medical education.

RECOMMENDATION

It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants-not-to-compete as a condition of their entry into any residency or fellowship program.

A version of this Report was published as “Covenants-Not-To-Compete for Physicians-in-Training (*JAMA*. 1997 Aug. 20; 278(7): 530an.)

This clarification of Opinion 9.02 recognizes that properly tailored restrictive covenants can benefit the public, such as by facilitating the recruitment of new physicians to underserved areas. At the same time, the opinion emphasizes that the interests of patients must always be paramount. In doing so, Opinion 9.02 is consistent with Current Opinion 8.03: Conflicts of Interest: Guidelines, which states that "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients."

For the foregoing reasons, the Council on Ethical and Judicial Affairs issues the following Opinion 9.02:

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 on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician.

7. COVENANTS-NOT-TO-COMPETE FOR PHYSICIANS-IN-TRAINING

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

BACKGROUND

Covenants-not-to-compete have become increasingly common in medical practice. A physician practice group, hospital, or managed-care organization may request that its newly recruited physician sign an agreement promising that if he or she ever leaves the group, hospital, or plan, he or she will not set up a competing medical practice in the same geographic area for a period of months or years. Hospitals, plans or groups often bear the costs of assisting a new physician in establishing a practice, and of introducing him or her into the community; restrictive covenants assure them that the new physician will not make unfair use of their investment by setting up an independent and competing practice after successfully settling in.

Covenants-not-to-compete are controversial, however. Many state courts will not enforce them, because they limit market competition. The American Bar Association prohibits attorneys from signing them, on grounds that such covenants interfere with clients' free ability to choose between attorneys, or to follow their attorneys if the attorneys move from one firm to another. The Council on Ethical and Judicial Affairs discourages such covenants in the medical context both because they limit patients' choice and because they have the potential to interfere with continuity of patient-care: under such covenants, physicians who are dissatisfied with their practice-partners or managed-care plans can leave their unfortunate circumstances only by leaving their patients behind.

Recently, the practice of signing covenants-not-to-compete has been extended to the educational sphere. Some medical schools and affiliated institutions are requesting that residents and other physicians-in-training sign covenants-not-to-compete as a condition of enrollment in training programs. (For purposes of this report, the term "physicians-in-training" means residents in ACGME-approved residency programs, fellows in ACGME-approved fellowship programs, and fellows in programs approved by one of the ABMS specialty boards.) Covenants in such circumstances are particularly problematic. The decision to seek training in some aspect of medicine is not an arms-length negotiated business decision, like the decision to join a medical practice group or to sign on with a plan. Physicians-in-training lack bargaining power. Moreover, the investment made in their training by teaching institutions is not made in the expectation of return, as in the case of a practice group which introduces a new physician

into a community. It is made as part of the continuing obligation of physicians to pass their knowledge on to one another. It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations.

CONCLUSION

Teaching institutions should not request that a physician-in-training sign any covenant-not-to-compete. While such covenants may sometimes be appropriate in the commercial context of an arms-length agreement between a physician and a practice-group or a managed-care entity, they are never appropriate in the context of the unequal bargaining power which characterize the relationship of physician-in-training with teaching institution. Such agreements risk cheapening the fiduciary obligation of physician-teachers to pass on their knowledge to new trainees, and raising barriers to specialty medical education.

RECOMMENDATION

It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants-not-to-compete as a condition of their entry into any residency or fellowship program.

8. RESTRICTIONS ON DISCLOSURE IN MANAGED CARE CONTRACTS

HOUSE ACTION: FILED

At the 1996 Annual Meeting, the House of Delegates reviewed and approved Council on Ethical and Judicial Affairs Report 1-A-96 concerning contract clauses that inhibit the ability of physicians to disclose relevant medical information. In this informational report, the Council issues its Opinion derived from the conclusions of Council on Ethical and Judicial Affairs Report 1-A-97. The following Opinion will appear in the next revised edition of the Code of Medical Ethics:

> 8.137: RESTRICTIONS ON DISCLOSURE IN MANAGED CARE CONTRACTS
>
> Managed care organizations have the right to protect proprietary information as long as such protection does not inhibit physicians from disclosing relevant information to patients. Contract clauses which could be applied to prevent physicians from raising or discussing matters relevant to patients' medical care are unethical and should be removed to safeguard the health of plan subscribers.

9. THE USE OF PLACEBO CONTROLS IN CLINICAL TRIALS

HOUSE ACTION: FILED

At the 1996 Annual Meeting, the House of Delegates reviewed and approved Council on Ethical and Judicial Affairs Report 2-A-96 concerning the appropriate use of placebo controls in clinical trials for conditions with existing and available therapies. In this informational report, the Council issues its Opinion derived from the conclusions and recommendations of CEJA Report 2-A-96. The following Opinion will appear in the next revised edition of the Code of Medical Ethics:

5. Health care facilities honor, and physicians use, a range of orders on the Doctor's Order Sheet to indicate patient wishes regarding avoidable treatments that might otherwise be given on an emergency basis or by a covering physician with less knowledge of the patient's wishes.

(References pertaining to Report 5 of the Council on Ethical and Judicial Affairs are available from the Ethical Standards Division Office.)

6. AGREEMENTS RESTRICTING THE PRACTICE OF MEDICINE (RESOLUTIONS 6 AND 11, A-96)

HOUSE ACTION: FILED

At the Annual Meeting in 1996, the Board of Trustees referred Resolutions 6 and 11 to the Council on Ethical and Judicial Affairs. Resolution 6, which was introduced by the Illinois Delegation, stated:

> Resolved, That, in order to strengthen Council on Ethical and Judicial Affairs Opinion 9.02, our American Medical Association adopt as policy that physicians, singly and in organized groups, shall not be a party to or participate in a corporate, partnership or employment agreement with another physician or organization that restricts the right of the physician to practice medicine after termination of a relationship created by the agreement, and that reasonable cost-based payments that are part of a separation agreement are not unprofessional, unethical restrictions on the right to practice medicine or on professional autonomy or on patient access; and be it further
>
> Resolved, That our AMA develop model state legislation that abolishes employment, partnership or corporate agreements that restrict the right of physicians to practice medicine, the intent of such legislation to be similar in its effect to the enforcement of the comparable ethical standard of the legal profession by the State and U. S. Supreme Courts.

Resolution 11, introduced by the Resident Physician Section, stated:

> Resolved, That the American Medical Association study the development of model state legislation to effect changes in contract law that will preclude "no compete" clauses for physicians; and be it further
>
> Resolved, That the AMA make a formal statement against these types of contracts which border on antitrust activity.

The Council on Ethical and Judicial Affairs (CEJA) long ago issued Current Opinion 9.02: Agreements Restricting the Practice of Medicine. As presently formulated, Opinion 9.02 discourages, but does not prohibit, the use of restrictive covenants in the practice of medicine generally. (A separate CEJA report before the House at this meeting does prohibit the use of restrictive covenants by residency and fellowship programs).

The Council on Ethical and Judicial Affairs has received a large volume of inquiries over the years about the scope of Opinion 9.02, and it has been interpreted in a variety of ways by the courts. CEJA therefore recognized the need to issue a new Opinion 9.02 which clarifies its meaning. In this new opinion, CEJA generally discourages the use of restrictive covenants in the practice of medicine because of their potentially adverse effect on the patient-physician relationship. However, CEJA considers restrictive covenants to be unethical only 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.

This clarification of Opinion 9.02 recognizes that properly tailored restrictive covenants can benefit the public, such as by facilitating the recruitment of new physicians to underserved areas. At the same time, the opinion emphasizes that the interests of patients must always be paramount. In doing so, Opinion 9.02 is consistent with Current Opinion 8.03: Conflicts of Interest: Guidelines, which states that "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients."

For the foregoing reasons, the Council on Ethical and Judicial Affairs issues the following Opinion 9.02:

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 on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician.

7. COVENANTS-NOT-TO-COMPETE FOR PHYSICIANS-IN-TRAINING

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

BACKGROUND

Covenants-not-to-compete have become increasingly common in medical practice. A physician practice group, hospital, or managed-care organization may request that its newly recruited physician sign an agreement promising that if he or she ever leaves the group, hospital, or plan, he or she will not set up a competing medical practice in the same geographic area for a period of months or years. Hospitals, plans or groups often bear the costs of assisting a new physician in establishing a practice, and of introducing him or her into the community; restrictive covenants assure them that the new physician will not make unfair use of their investment by setting up an independent and competing practice after successfully settling in.

Covenants-not-to-compete are controversial, however. Many state courts will not enforce them, because they limit market competition. The American Bar Association prohibits attorneys from signing them, on grounds that such covenants interfere with clients' free ability to choose between attorneys, or to follow their attorneys if the attorneys move from one firm to another. The Council on Ethical and Judicial Affairs discourages such covenants in the medical context both because they limit patients' choice and because they have the potential to interfere with continuity of patient-care: under such covenants, physicians who are dissatisfied with their practice-partners or managed-care plans can leave their unfortunate circumstances only by leaving their patients behind.

Recently, the practice of signing covenants-not-to-compete has been extended to the educational sphere. Some medical schools and affiliated institutions are requesting that residents and other physicians-in-training sign covenants-not-to-compete as a condition of enrollment in training programs. (For purposes of this report, the term "physicians-in-training" means residents in ACGME-approved residency programs, fellows in ACGME-approved fellowship programs, and fellows in programs approved by one of the ABMS specialty boards.) Covenants in such circumstances are particularly problematic. The decision to seek training in some aspect of medicine is not an arms-length negotiated business decision, like the decision to join a medical practice group or to sign on with a plan. Physicians-in-training lack bargaining power. Moreover, the investment made in their training by teaching institutions is not made in the expectation of return, as in the case of a practice group which introduces a new physician