Noncompete agreements in health care impede patient access to physicians, deter advocacy for patient safety, limit physicians’ ability to choose their employer, and stifle competition. Despite projected shortages of 37,800 to 124,000 physicians by 2034, health care employers still intentionally restrict physician mobility and workforce participation via noncompete agreements. New federal policy provides hope and momentum for a comprehensive solution to this national health care problem.

In July 2021, President Biden issued Executive Order 14036: Promoting Competition in the American Economy, which outlines federal action to combat anticompetitive behavior in health care, technology, and agriculture. The order asserts that “powerful companies require workers to sign non-compete agreements that restrict their ability to change jobs” and directs the Federal Trade Commission (FTC) to use rulemaking “to curtail the unfair use of non-compete clauses and other clauses or agreements that may unfairly limit worker mobility.” Physicians struggle with noncompete agreements despite having a powerful political voice; while this Viewpoint focuses on health care, the order draws attention to inequities across all industries.

What Is a Noncompete Agreement?

Noncompete agreements are restrictive covenants in employment contracts that limit worker mobility based on time, scope, and distance. A representative example reads as follows: “Upon termination of employment, physician will not practice medicine for two years within a ten-mile radius of all current practice sites.” Restrictions can apply whether the worker resigns or is removed from their job.

Noncompete agreements are enforced through a patchwork of state laws. Twelve states deem noncompete agreements unenforceable and against public policy. The remaining 38 states allow them in some form, judging enforceability on factors including job type, legitimacy of business interests, and reasonableness of duration, scope, and distance. When an employee enters a noncompete agreement and later attempts to work for a new employer, the original employer can sue for an injunction or damages. Some employers intentionally use unenforceable noncompete agreements, knowing that they too have powerful deterrent effects. Few employees have the resources required for litigation and therefore face the restrictive choice of remaining with their employer or leaving their community.

Employers argue that noncompete agreements are voluntary and protect legitimate business interests. A medical practice might argue that it provides training, advertising, and goodwill for physicians, and that noncompete agreements reduce disruptive job-hopping and poaching. While employers suggest that noncompete agreements are negotiable, only 10% of workers actually negotiate them. Most workers entering noncompete agreements believe they are a requirement for employment.

Harm to Patients and Physicians

Despite headlines lamenting health care workforce shortages, physicians often accept employer limitations on their workforce participation. As a representative example, a 2007 survey revealed...
that 45% of primary care physicians sign noncompete agreements.² Physicians have little choice but to sign them when employers can simply offer the job to the next applicant amid health care consolidation that limits the number of potential employers.

Noncompete agreements prevent physicians from practicing medicine in their communities when they want to change jobs—de facto limiting patients’ access to their physicians. In Pittsburgh, Pennsylvania, a practice of 5 obstetricians attempted to change employers but were immediately fired. Four of the 5 were barred by noncompete agreements from practicing in their county for 1 year, severing long-standing physician relationships with pregnant women and their babies.⁴ In Iowa, a prostate cancer survivor’s urologist was fired after a practice dispute and left town due to a 1-year, 35-mile noncompete agreement.⁵ Left without a physician, the patient self-diagnosed and treated his infection with leftover medications. Finally, a family practice physician wanted to care for underserved patients at a federally qualified health center, 70% of which have active vacancies, but instead stopped practicing medicine for 2 years owing to a noncompete agreement.⁶

Noncompete agreements also deter physicians who advocate for patient and worker safety. Senators Warren and Murphy wrote to the FTC in 2020 citing concerns that physicians advocating for COVID-19 protections are threatened with termination and that noncompete agreements induce dangerous silence.⁷

Noncompete agreements by design benefit employers and decrease turnover.² From a public policy standpoint, however, why ensnare a physician if they are unhappy or unable to advocate for patient safety? Why not allow for physician mobility within the community to serve the public interest? A better approach is to ensure a supportive environment where physicians choose to stay rather than being legally induced not to leave.⁶

Health care employers should retain physicians with fair wages, appropriate benefits, and a culture of safety. Market forces, contractual options, the extensive time needed for licensing and credentialing in a new facility, and professional norms already promote retention and deter frequent job changes. Additionally, employers can issue timed contracts, vested benefits, or retention payments and pursue separate legal recourse to limit patient poaching, maintain trade secrets, and protect other business interests.

Professional Societies’ Positions on Noncompete Agreements

The American Medical Association (AMA) states that noncompete agreements “restrict competition, can disrupt continuity of care, and may limit access to care.”⁸ They advise physicians against entering contracts that “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 do not make reasonable accommodation for patients’ choice of physician.”⁸ However, in a 2020 letter the AMA stated that “it may be prudent for the FTC to monitor evolving state legislative developments and case law rather than weighing in on what traditionally has been a state issue.” By citing national harm while still embracing state law variability, the AMA therefore pursues a noncommittal approach.⁸

In contrast, attorneys are ethically barred from signing noncompete agreements. The American Bar Association (ABA) states that a lawyer shall not enter into an agreement “that restricts the right of a lawyer to practice after termination of the relationship,” noting limited exceptions such as sale of a partnership.⁹ This policy protects an individual’s ability to choose their attorney. The ABA ethics rules are ratified by state bars; therefore, attorneys and law firms cannot enter into noncompete agreements.

The AMA cites the harm of noncompete agreements but gives noncommittal advice to physicians and policy makers, while the ABA deems such agreements unquestionably unethical. This difference in approach yields unsurprising results. Physicians commonly sign noncompete agreements, while attorneys never do. The AMA, medical specialty societies, and state medical boards should follow the ABA’s lead and deem noncompete agreements concretely unethical.
Harnessing Momentum for a National Solution

Congress delegated rulemaking authority to the FTC to act against anticompetitive behavior via rules and regulations carrying the weight of law. Current FTC commissioner Lina Khan and prior commissioner Rohit Chopra argued in 2020 that noncompete agreements intentionally stifle competition, with workers relatively powerless to negotiate or legally fight them. Through rulemaking, the FTC can promote a pro-competition legal framework, eliminate inefficient case-by-case evaluations, and ensure that all stakeholders have a participatory voice. President Biden’s executive order is therefore a call to action backed by legal authority and a motivated FTC commissioner. In addition to rulemaking, a powerful but prolonged process, proposed federal legislation, such as the Workforce Mobility Act, offers another potential avenue to preempt state law and uniformly end noncompete agreements.

Health care workforce integrity and mobility is a national problem. Failure to eliminate noncompete agreements allows a continued patchwork of state law to stifle patient access to care and prevent physicians from practicing medicine in their own communities. Physicians must embrace current political momentum to advocate against noncompete agreements and seek a uniform national solution that ensures patient access to physicians, rewards safety advocacy, and promotes competition.

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REFERENCES