Testimony of Elizabeth C. Tippett in support of HB 3227

I offer the following testimony in support of HB 3227 in my personal capacity and not on behalf of the University of Oregon. I am not authorized to speak on behalf of the University.

I am a Professor at the University of Oregon School of Law, where I teach employment law. Prior to joining the faculty in 2012, I was an employment lawyer at the law firm of Wilson Sonsini Goodrich and Rosati. I am a member of the Oregon state bar.

I support the prohibition of non-compete agreements for physicians. My late husband was a radiation oncologist here in Oregon before he passed away from cancer in 2022. He was an employee physician and subject to a non-compete. He attempted to negotiate for the removal of the non-compete provision from his contract before he accepted the job but was unsuccessful in doing so. Although he did not have complaints about the local partnership that employed him, he worried about what would happen if the practice were ever sold to a large corporation.

I have also personally observed the effect of non-compete provisions on the availability of primary care in Eugene following the sale of Oregon Medical Group to Optum. I am one of the many thousands of patients in Eugene who lost their primary care doctor after their physician left Oregon Medical Group.

Below, I provide some context regarding physician non-competes. First, I summarize the research on physician non-competes and their effect on patient care. I then explain why legislation is necessary to fix the problem in Oregon.

(1) Researchers Have Concluded that Physician Non-Competes Harm Access to Care

Researchers overwhelmingly oppose physician non-competes because they limit access to care. As University of Hawaii Professor Hazel Beh observed, "nationally, there is widespread criticism of the use of restrictive covenants in physician employment contracts because of the potential harm to the public."[1] Specifically, researchers conclude that physician non-competes "impede patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, and stifle competition."[2]

[1] Hazel G. Ben & H. Ramsey Ross, *Non-compete Clauses in Physician Employment Contracts are Bad for Our Health*, 14 HAWAII BAR JOURNAL 79, 79 (2011).

[2] Erik B. Smith, *Ending Physician Noncompete Agreements—Time for a National Solution*, 2(12) JAMA HEALTH FORUM 1, 1 (December 3, 2021); Robert Steinbuch, *Why Doctors Shouldn't Practice Law: The American Medical Association's Misdiagnosis of Physician Non-Compete Clauses*, 74 MISSOURI L. REV. 1051, 1055 (2009) (non-compete agreements "reduc[e] both competition and access for patients. Many patients are forced into existing practices and are not offered the opportunity…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."); Paula Berg, *Judicial Enforcement of Covenants not to Compete Between Physicians: Protecting Doctors' Interests at Patients' Expense,* 45 RUTGERS L. REV. 1, 35 (1992) ("restrictive covenants between physicians limit the range of hospital care

In one study, researchers interviewed doctors who had been subject to non-compete litigation. These doctors described the negative effect of the non-compete on access to – and continuity of – medical care.[3] Several doctors reported that their "patients were unable to find them easily or at all after they left the practice" and that "patients inquiring about their physician were often denied information regarding his/her wheareabouts or misled (i.e. told that the doctor is no longer practicing)… [which] often resulted in patients feeling lost/emotional."[4]

Physician non-competes can also impede doctors' ethical duty to assure continuity of care. As Professor Judy Clausen observed, physicians are ethically obligated to notify patients when they leave a practice and to provide patients with the location of their new practices.[5] Non-compete and non-solicitation provisions can often interfere with their ability to notify patients, forcing them to choose between their ethical duties and potential legal liability.[6]

The public harm imposed by physician non-competes will only increase in the coming decades. The Association of American Medical Colleges project physician shortages of 13,500 to 86,000 physicians by 2036.[7] Non-compete agreements will exacerbate these shortages,[8] forcing physicians to relocate or sit on the sidelines while their patients languish on waiting lists.[9]

---

choices available to several distinct groups of patients"; "if a departing physician is the only practitioner of a certain specialty in a small hospital in an isolated area, a restrictive covenant may have devastating consequences…for the community as a whole"); William F. Sherman, et al., *The Impact of a Non-Compete Clause on Patient Care and Orthopaedic Surgeons in the State of Louisiana: Afraid of a Little Competition?* 14(4) ORTHOPEDIC REVIEW 1, 1 (2022) (Survey of orthopaedic surgeons in Louisiana found that the majority "believed that [non-competes] negatively impact patients, including forcing patients to drive long distances to maintain continuity of care (64.4%) and forcing surgeons to abandon their patients if they seek new employment (76.7%).")

[3] Michelle Bednarz Beauchamp et al, *Why the Doctors will NOT See You Now: The Ethics of Enforcing Covenants Not to Compete in Physician Employment Contracts*, 119 J. BUS. ETHICS 381, 388 (2014). *See also* Judy Ann Clausen, Regulate Physician Restrictive Covenants to Improve Healthcare, 108 KENTUCKY L. J. 112, 116 (2019) (arguing that non-competes have served to "disrupt continuity of care, interfere with the doctor-patient relationship, and prevent a doctor from treating a patient.")

[4] Beauchamp et al *supra* note 3 at 388.

[5] Clausen *supra* note 3 at 118. See also AMA Code of Medical Ethics, Opinion 1.1.5, *Terminating a Physician Patient Relationship*, https://code-medical-ethics.ama-assn.org/ethics-opinions/terminating-patient-physician-relationship ("Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients….When considering withdrawing from a case, physicians must: 1. Notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician. 2. Facilitate transfer of care when appropriate.").

[6] Clausen *supra* note 3 at 118-119 ("This potential liability makes departing physicians wary of fulfilling ethical patient notification obligations; they fear a court will later decide that communications the doctor perceived to be patient notification were, in fact, improper solicitation.")

[7] American Association of Medical Colleges, "The Complexities of Physician Supply and Demand: Projections from 2021 to 2036: Summary Report," https://www.aamc.org/media/75231/download?attachment (March 2024).

[8] Clausen *supra* note 3 at 124.

[9] A 2023 study by Professor Christopher Dinkel conducted a nationally-representative survey and found that "the U.S. public prefers that physicians be exempt from noncompetes." *The Future of Work and U.S. Public Opinion on Noncompete Law: Evidence from a Conjoint Experiment*, 60 AMERICAN BUS. L. J. 749, 755 (2023). *See also*, Sherman et al., *supra* note 2 at 1 (2022) ("Perceptions of [non-compete clauses] were overwhelmingly negative among orthopaedic surgeons in Louisiana.").

(2) State Legislation is Necessary to Fix the Problem in Oregon

In 1969, the American Bar Association issued Model Rules of Professional Conduct declaring that it is an ethical violation for lawyers to enter into a non-compete agreement, on the basis that clients should have access to the lawyer of their choice.[10] Since then, the legal ethics codes of all 50 states prohibit attorneys from signing non-compete agreements.[11]

If access to lawyers is critically important to the public, access to a doctor is even more so.[12] We lawyers serve many important public functions, but rarely do we assist in matters of life or death.

Courts, however, have been slow to prohibit physician non-competes of their own initiative.[13] While they acknowledge the critical public interest in access to care, they tend to defer to state legislatures on the question of whether physician non-competes should be banned or severely

---

[10] Berg, *supra* note 2 at 37 (1992); Alina Klimkina, *Are Noncompete Contracts between Physicians Bad Medicine – Advocating in the Affirmative by Drawing a Public Policy Parallel to the Legal Profession*, 98 KY. L.J. 131, 145 (2009-2010); Steinbuch, *supra* note 2 at 1060-1.

[11] Klimkina, *supra* note 10 at 140 - 142.

[12] Many scholars have noted the comparison between lawyers and doctors, and find it puzzling that doctors remain subject to non-competes given the strong public interest in access to care. *See* Klimkina, *supra* note 11 at 149 ("the right of every individual to choose his or her physician is directly synonymous with a client's ability to choose his or her attorney"); Clausen, *supra* note 3 at 895 ("the similarities between the attorney-client and physician-patient relationship are substantial").

[13] Some courts have declined to enforce physician non-competes to preserve access to care. Valley Medical Specialists v. Farber, 982 P.2d 1277, 1285 (Ariz. 1999) (declining to enforce non-compete against pulmonologist, reasoning that "patients' right to see the doctor of their choice is entitled to substantial protection"); Murfreesboro Medical Clinic, P.A. v. Udom, 166 S.W.3d 674, 679,683 (Tenn. 2005), s*uperseded by statute* ("Having a greater number of physicians practicing in a community benefits the public by providing greater access to health care. Increased competition for patients tends to improve quality of care and keep costs affordable. Furthermore, a person has a right to choose his or her physician and to continue an on-going professional relationship with that physician…. Enforcing covenants not to compete against physicians could impair or even deny this right altogether*…. The right of a person to choose the physician that he or she believes is best able to provide treatment is so fundamental that we can not allow it to be denied because of an employer's restrictive covenant.*)"; Community Hospital Group v More, 869 A.2d 884, 900 (N.J. 2005) (declaring a physician non-compete overbroad because "the interests of patients at Somerset who need emergent neurological care come first"); Odess v. Taylor, 211 S.2d 805, 810 (Ala. 1968) ("It is common knowledge that there is now an acute shortage of physicians and surgeons in Alabama, particularly in specialized fields of practice. One needs but to attempt to obtain an appointment with a medical practitioner to have this fact brought home….the public in Jefferson county would suffer by removing a highly trained specialist from practicing his profession in that area.")

restricted.[14] Consequently, most of the states that have banned or severely restricted physician non-competes have done so through the state legislature.[15]

Here in Oregon, the non-compete statute is likewise central to court rulings regarding the enforceability of non-compete agreements.[16] For that reason, the Oregon legislature should use its legislative authority to restrict the enforceability of non-compete agreements for physicians.

(3) Specific comments regarding H.B. 3227

I have a few specific comments regarding Section 2(2) of HB 3227 – the portion of the bill specific to non-compete agreements.

Section 2(2)(b)(A)(ii) includes an exception that permits non-competes in the sale of a medical practice where the doctor owns a 10% interest in the practice. (See Page 3, line 1.) I believe this is a reasonable threshold and support this provision.

Section 2(2)(b)(B)(i) includes an exception for any doctor that "controls an ownership or membership interest" but does not have a minimum ownership threshold. (See Page 3, lines 4-7). This exception applies to doctors that work for practices that do not have a "contract or other

[14] *See e.g.* Skaf v. Wyoming Cardiopulmonary Svcs. 495 P.3d 887, 897 (Wyo. 2021) (overturning arbitration award enforcing non-compete, but declining to declare physician non-competes *per se* unenforceable in the absence of legislative action); Karlin v. Weinberg, 777 N.J. 408, 421 (NJ 1978) (refusing to declare all physician non-competes unenforceable because the legislature and state board of medical examiners could have issued rules "restrict[ing] physicians from entering into restrictive covenants"); Raymundo v. Hammond Clinic Ass'n, 449 N.E.2d 276, 280 (Ind. 1983) ("agreements are not to be held void against public policy, unless they are clearly contrary to what the constitution, the legislature, or the judiciary have declared to be the public policy"); Central Indiana Podiatry, P.C. v. Krueger, 882 NE2d 723 (Ind. 2008) ("Any decision to ban physician noncompetition agreements altogether should be left to the legislature.")

[15] Colo. Rev. Stat. Ann. § 8-2-113(5) (physician non-compete agreements unenforceable in equity); Del. Code Ann. tit. 6, § 2707 (physician non-compete agreements unenforceable in equity); Fla. Stat. Ch. 542.336 (physician non-competes unenforceable if practice has a monopoly on a specialty in a given county); Mass. Gen. Laws Ann. ch. 112, § 12X (physician non-competes unenforceable); New Hampshire Ch. 39 § 329.31-a (physician non-competes unenforceable); New Mexico § 24-1l-2 (health care practitioner non-competes unenforceable); Rhode Island § 5-37-33 (physician non-compete unenforceable except sale of a business); South Dakota Law 53-9-11.1 (prohibits non-competes for physicians, nurses and physician assistants); Idaho Code Ann. §§ 39-6109, 39-6109A (prohibiting non-competes for physicians on a J-1 visa). *See also* California Bus Prof. Code 16600 (prohibits all non-competes except sale of business); North Dakota Cent Code § 9-08-06 (prohibits all non-competes except sale of business and partnership dissolution); Oklahoma Stat. Tit 15, § 217 (prohibits all non-competes except sale of business); Ala. Code § 8-1-190 (prohibiting most non-compete agreements); Mont. Code Ann. § 280-2-703 (prohibits all non-competes except sale of business and dissolution of partnership); Neb. Rev. Stat § 59-801 (prohibits non-competes).

[16] O.R.S. 653.295. Although the Federal Trade Commission attempted to issue regulations banning non-competes under the Biden administration, the rule was enjoined by a federal court and is unlikely to be revived by the Trump administration anytime soon. 16 C.F.R. § 910.1-6; Ryan LLC et al. v. Federal Trade Commission, Memorandum Opinion and Order, Civ. 3:24-CV-00986-E, August 20, 2024 (N.D. Tex. 2024).

arrangement with a management services organization." I gather that this exception was intended to allow non-competes for locally owned medical practices.

The absence of a minimum ownership threshold in Section 2(2)(b)(B)(i) is problematic because it would enable a locally owned specialty practice to offer a tiny, essentially meaningless share of the practice to an employee-physician and require them to sign a non-compete as a condition of employment.

Non-competes harm access to patient care even when the practice is locally owned. For example, a specialist-employee with no meaningful ownership in a locally owned practice could be forced to move away to comply with a non-compete, which may push that doctor's patients onto a waiting list depending on the number of specialists available in that town. For that reason, I recommend imposing a minimum ownership threshold for Section 2(2)(b)(B)(i), or adding an exception for counties in the state where access to specialists is particularly limited. [17]

Notwithstanding the foregoing comments, I support H.B. 3227 because any new statutory restrictions on physician non-competes is preferable to the status quo.

[17] Florida, for example, has a restriction on non-competes providing that medical specialists can't be restrained if one medical practice has an effective monopoly on that specialty in that county. Fla. Stat. Ch. 542.336