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)]

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> *So long as any single man, the humblest and the weakest in the land, may not enter into business or engage in labor such as his means will permit or his inclination determine, just so long is personal liberty an unaccomplished fact*.[1]

I. Introduction

A major disease afflicts the American medical field. Like a vicious, malignant cancer, this ailment has spread to every organ of the medical profession. Virulently jumping from clinic to clinic and hospital to hospital, the malady ravages professionals in the medical community. If not stopped, this outbreak will soon become an epidemic. The disease: covenants not to compete in surgeon employment contracts; the cure: well-reasoned and just decisions by our courts.

Non-competition agreements[2] are routinely included in physician employment contracts.[3] Generally, upon termination of a physician's employment, a covenant operates to restrict, for a certain period of time, the physician's ability to work within a specified geographical location.[4] Medical employers argue that the clauses safeguard their

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1. Justice David J. Brewer, U.S. Supreme Court and Kan. Supreme Court Justice, Independence Day Address: The Liberty of Each Individual (July 4, 1893), *in* INDEPENDENT, July 13, 1893, at 3.

2. Non-competition agreements are also referred to as covenants not to compete, restrictive covenants, and non-compete clauses. Paula Berg, *Judicial Enforcement of Covenants Not to Compete Between Physicians: Protecting Doctors' Interests at Patients' Expense*, 45 RUTGERS L. REV. 1, 2-3 n.9 (1992).

3. *Id.* at 2-3. Today, a new physician's employment contract will likely contain a non-compete clause. Berkeley Rice, *A Win-Win Alternative to Noncompete Clauses: For Both Groups and Their Employed Doctors, There's Now a Fair and Legal Alternative to Restrictive Covenants*, MED. ECON., Aug. 8, 2003, at 56. Non-competition agreements are widely found in employment contracts in American business. Harlan M. Blake, *Employee Agreements Not to Compete*, 73 HARV. L. REV. 625, 625 (1960).

4. Rice, *supra* note 3. The geographical restriction generally depends on the nature and size of the practice. *See* Derek W. Loeser, *The Legal, Ethical, and Practical Implications of Noncompetition Clauses: What Physicians Should Know Before They Sign*, 31 J.L. MED. & ETHICS 283, 284 (2003).

initial investments in hired physicians by preventing the physicians from leaving and becoming competitors.[5] In addition to geographical and temporal restrictions, covenants not to compete often accompany liquidated damages, or "buyout," provisions.[6] These provisions permit a terminated physician to pay a predetermined amount of damages in return for the right to practice within the specified region.[7]

In *Idbeis v. Wichita Surgical Specialists, P.A.*,[8] the Kansas Supreme Court incorrectly enforced a non-competition agreement by holding that referral relationships[9] are legitimate business interests in all physician employment contracts.[10] Because the referral relationships in question were based on the recognition of the surgeons' skills and reputations, not on the goodwill or reputation of the employer, and because the employer fostered a competitive referral scheme that capitalized on the skills and reputations of its surgeons, the employer could not have possessed a legitimate business interest in its surgeons' referral sources. Further, the court in *Idbeis* misapplied prior Kansas case law. Instead of embracing the opportunity to distinguish between the varying degrees of referral interest legitimacy in different medical specialties, the court used overly broad and inapplicable reasoning. As a result of *Idbeis*, future Kansas cases will be wrongly decided, leading to more injustice, less bargaining power for surgeons involved in employment contract negotiations, and higher healthcare costs.

II. Case Description

Dr. Badr Idbeis, a thoracic surgeon, began working for Wichita Surgical Group, P.A., a predecessor of Wichita Surgical Specialists, P.A. (WSS), in 1988.[11] Before beginning employment with WSS, Idbeis signed an employment contract containing a non-compete

5. Am. Med. Ass'n, Restrictive Covenants in Physician Contracts, http://www.ama-assn.org/ama/pub/category/12716.html (last visited Apr. 4, 2006). Such an investment may include recruiting and opportunity costs associated with hiring a physician. *Id.*; *see also* Mark A. Glick et al., *The Law and Economics of Post-Employment Covenants: A Unified Framework*, 11 Geo. Mason L. Rev. 357, 357 (2002) ("Employers regard post-employment restraints as an important if not essential method for protecting their investment in their employees, including not only trade secrets and customer contacts, but also perhaps employee training costs.").

6. Loeser, *supra* note 4.

7. *See* Rice, *supra* note 3. Commentators argue that these buyout provisions are a plausible alternative to restricting a physician's employment because such provisions ensure that a departing physician reimburses the medical group for the expenses associated with his hire, while at the same time permitting the physician to work in the otherwise prohibited geographical area. *See id.*

8. 112 P.3d 81 (Kan. 2005).

9. For purposes of this comment, "referral relationships" are the relationships that exist between a referring physician and a surgeon. "Referring physicians" and "referral sources" will be used in this comment to indicate the physician who referred the patient.

10. *See id.* at 91. The court also ruled that the covenants were not harmful to the public welfare. *Id.* at 93. On appeal, the parties did not contest whether the covenant placed an undue hardship on the employee or whether the time and geographical restrictions were reasonable. *Id.* at 87.

11. *Id.* at 84.

clause.[12] The clause stipulated that if Idbeis ceased working at WSS for any reason, then for two years thereafter he could not

> directly or indirectly engage in the practice of medicine and/or surgery, nor own, manage, operate, control, be employed by, invest in, participate in, advise, consult with, or be connected with the ownership, management, operation or control of any business engaged in the practice of medicine and/or surgery within [seventy-five] miles of the city of Wichita, Kansas.[13]

Idbeis's employment contract also contained a liquidated damages clause.[14] The provision provided that if Idbeis violated the covenant not to compete, then he would be liable for five annual payments equal to twenty percent of his gross earnings for the last year of his employment.[15] Drs. John Rumisek, Gary Benton, and Robert Fleming also joined WSS and signed employment contracts containing similar covenants not to compete; however, only Idbeis's contract contained a liquidated damages provision.[16]

Idbeis began discussing with a local neurosurgeon the possibility of forming a specialty spine hospital.[17] Upon learning of Idbeis's actions, the WSS board of directors voted to terminate his employment.[18] Soon after, the other three doctors resigned from WSS to join Idbeis in forming a new surgical group, Mid-America Surgical Associates.[19] The surgeons, anticipating litigation, initiated an action in the Sedgwick County District Court, seeking to enjoin WSS from enforcing the non-competition agreements.[20]

The trial court primarily relied on the test set forth in *Weber v. Tillman*[21] to evaluate the enforceability of the covenants.[22] Pursuant to the Kansas Supreme Court's holding in *Weber*, the trial court ruled

12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.* at 85. Idbeis's contract contained the liquidated damages provision because he had practiced in Wichita for eight years prior to joining WSS. *Id.* at 84. With the potential to attract referral sources to WSS from his previous practice, Idbeis may have been given the option to pay liquidated damages due to his superior bargaining position. The other three surgeons, however, had not worked in Wichita before joining WSS. *Id.* at 85.
17. Brief of Appellants at 26, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).
18. *Idbeis*, 112 P.3d at 86. Before his termination, the board provided Idbeis with three options: (1) resign from the spine clinic; (2) resign from WSS; or (3) be terminated. *Id.* On February 7, 2002, after the negotiations between Idbeis and WSS failed, WSS shareholders voted 23-22, recommending Idbeis's termination. Brief of Appellants at 27, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).
19. *Idbeis*, 112 P.3d at 86.
20. *See id.* at 83. The plaintiffs also sought a declaration by the court that the restrictive covenants were unenforceable. *Id.*
21. 913 P.2d 84 (Kan. 1996).
22. *Idbeis*, 112 P.3d at 86. In *Weber*, the Kansas Supreme Court upheld a covenant not to compete in a dermatologist's employment contract. *Weber*, 913 P.2d at 87, 96. The *Weber* test establishes four primary questions to consider when determining the enforceability of a covenant not to compete: "(1) Does the covenant protect a legitimate business interest of the employer? (2) Does the covenant create an undue burden on the employee? (3) Is the covenant injurious to the public welfare? (4) Are the time and territorial limitations contained in the covenant reason-

that the covenants protected a "legitimate business interest of WSS."[23] On appeal,[24] the Kansas Supreme Court affirmed the trial court's ruling that WSS had a legitimate business interest that the covenants served to protect.[25] Based on prior precedent, the court concluded that the covenants not to compete were valid and enforceable against the plaintiffs.[26]

III. BACKGROUND

A. *The English Roots of Covenants Not to Compete*

Covenants not to compete date back to the fifteenth century.[27] Early English courts disliked these covenants because they functioned as restraints on trade and employment.[28] At that time, limiting restrictions on employment was an important public policy objective because the plague during the fourteenth century rendered manpower a scarce commodity.[29] With the rise of capitalism three centuries later, however, English courts began recognizing the importance of freedom to contract.[30] Using a new methodology to evaluate the validity of

able?" *Id.* at 90. *Weber* further instructs that "[t]he determination of reasonableness is made on the particular facts and circumstances of each case." *Id.*

The trial court in *Idbeis* began its analysis by deeming reasonable the geographical and temporal limitations of the covenants. *Idbeis*, 112 P.3d at 87. Next, the trial court ruled that an undue burden would not be imposed on the plaintiffs if the court enforced the restrictive covenants. *Id.* Further, the court determined that Idbeis bore a reduced burden because he had the option of paying liquidated damages and, therefore, could continue practicing in Wichita. *Id.* The trial court also held that the covenants in Drs. Benton, Rumisek, and Fleming's contracts were "injurious to the public welfare" because each lacked liquidated damages clauses. *Id.* at 93. To remedy this problem, the court added liquidated damages provisions to the doctors' contracts. *Id.*

23. *Idbeis*, 112 P.3d at 89. The trial court held that, with the new liquidated damages provisions, all four covenants were enforceable. *Id.* at 83-84. The court explained that the plaintiffs benefited from WSS's reputation, already-established customer base, and referral sources. *Id.* at 86. With no prior experience in the Wichita market, the trial court emphasized the extent to which Drs. Rumisek, Benton, and Fleming benefited from their introduction into the Wichita medical community by WSS. *See id.*

24. Pursuant to section 20-3017 of the Kansas Statutes Annotated, the Kansas Supreme Court granted the plaintiffs' motion, transferring the case from the Kansas Court of Appeals. *Idbeis*, 112 P.3d at 84.

25. *See id.* at 94. The court also reversed the trial court's ruling regarding whether the covenant injured the public welfare because "the *Weber* court did *not* hold that the liquidated damages provision in Dr. Tillman's contract prevented the enforcement of the restrictive covenant from being injurious to the public welfare." *Id.* at 92.

26. *Id.* at 94. The Kansas Supreme Court reversed the trial court's addition of the liquidated damages clauses to the other three contracts and only enforced the liquidated damages provision contained in Idbeis's original contract. *Id.*

27. *See* Blake, *supra* note 3, at 635-36. In one early case, for example, the English court considered the enforceability of a restrictive covenant between a dyer and his apprentice. *See id.* (citing *Dyer's Case*, Y.B. 2 Hen. 5, 5, Mich. 26 (C.P. 1414)); 15 GRACE MCLANE GIESEL, CORBIN ON CONTRACTS § 80.4, at 57 (Joseph M. Perillo, ed., rev. ed. 2003) [hereinafter CORBIN]. Although the court never reached the merits of the decision, one of the Lords of the English court indicated that the employee should have demurred the complaint on the grounds that the covenant was illegal. CORBIN, *supra*.

28. *See* Glick, *supra* note 5, at 360.

29. CORBIN, *supra* note 27.

30. *See, e.g.*, Mitchel v. Reynolds, (1711) 24 Eng. Rep. 347, 347-48, 352 (Ch.) (enforcing a covenant not to compete against a bakery employee who operated a competing bakery in the

non-compete agreements, courts weighed the societal harm resulting from enforcement against the benefits conferred on the individuals requesting enforcement.[31] This shift in judicial reasoning was a substantial step in the evolution of the American approach to evaluating the enforceability of covenants not to compete.[32]

B. *The American Approach: The "Rule of Reason"*

The modern approach—also known as the American approach—employs "the rule of reason" to determine the enforceability of covenants not to compete.[33] Only restrictive covenants deemed reasonable are enforceable.[34] To evaluate whether a restraint is reasonable, a court weighs an individual's economic interests against society's interests in free trade.[35] If societal interests greatly outweigh the individual's interests, then the covenant will not be enforced.[36]

Courts consider specific factors when analyzing the reasonableness of a restrictive covenant, including (1) the extent to which the restraint on trade hinders competition;[37] (2) the validity of the underlying transaction;[38] (3) the purpose of the covenant;[39] (4) the scope of time and territorial restrictions;[40] (5) the effect of the covenant on the

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same parish as his former employer); *see also* Brian Kingsley Krumm, *Covenants Not to Compete: Time for Legislative and Judicial Reform in Tennessee*, 35 U. MEM. L. REV. 447, 451 (2005).

31. *See Mitchel*, 24 Eng. Rep. at 348-50, 352; Blake, *supra* note 3, at 632.

32. *See* Maureen B. Callahan, Comment, *Post-Employment Restraint Agreements: A Reassessment*, 52 U. CHI. L. REV. 703, 704 (1985) (noting that American contract law followed the common law of England); Ronald J. Gilson, *The Legal Infrastructure of High Technology Industrial Districts: Silicon Valley, Route 128, and Covenants Not to Compete*, 74 N.Y.U. L. REV. 575, 617 (1999) ("American law generally followed the English pattern . . . .").

33. *See* Gilson, *supra* note 32. The New Jersey Court of Chancery enunciated one version of the test: "whether the restraint is such only as to afford a fair protection to the interest of the party in favor of whom it is given, and not so large as to interfere with the interest of the public." Mandeville v. Harman, 7 A. 37, 39 (N.J. Ch. 1886).

34. CORBIN, *supra* note 27, § 80.4, at 58. One commentator noted, however, that "[u]nfortunately, reasonable and unreasonable restraints do not come so dressed and labeled as to be recognizable at first sight." *Id.*

35. *See id.* §§ 80.4, 80.6, at 57-58, 65.

36. *Id.* § 80.6, at 69; *see also* Iredell Digestive Disease Clinic, P.A. v. Petrozza, 373 S.E.2d 449, 454-55 (N.C. Ct. App. 1988) (noting that the public's interest in access to gastroenterologists is greater than a covenantee's interest).

37. *See, e.g.*, United States v. Trenton Potteries Co., 273 U.S. 392, 397 (1927) ("Whether this type of restraint is reasonable or not must be judged in part at least in the light of its effect on competition . . . ."). Courts scrutinize restrictive covenants that unduly burden the market by limiting competition. *See* CORBIN, *supra* note 27.

38. CORBIN, *supra* note 27, § 80.6, at 64. An invalid contract renders its ancillary restrictive covenant unenforceable. *Id.*

39. *See, e.g.*, Weber v. Tillman, 913 P.2d 84, 89 (Kan. 1996) (noting that the purpose of a covenant determines its enforceability). If the only intention of a person seeking to enforce the covenant is to restrict normal competition, then the covenant cannot be enforced. *Id.*; *see also* Bryceland v. Northey, 772 P.2d 36, 39 (Ariz. Ct. App. 1989) ("An employer may not enforce a post-employment restriction on a former employee simply to eliminate competition *per se*."); Durapin, Inc. v. Am. Prods., Inc., 559 A.2d 1051, 1057 (R.I. 1989) ("[T]he desire to be free from competition, by itself, is not a protectable interest.").

40. Covenants with overly broad territorial restrictions are usually deemed unenforceable. *See*, *e.g.*, Laidlaw, Inc. v. Student Transp. of Am., Inc., 20 F. Supp. 2d 727, 756-57 (D.N.J. 1998) (recognizing that a covenant was not enforceable nine and a half years after it became effective); Stubblefield v. Siloam Springs Newspapers, Inc., 590 F. Supp. 1032, 1036 (W.D. Ark. 1984) (rul-

public availability of the service in question;[41] (6) the employee's right to pursue or continue to work in a specific occupation;[42] and (7) the freedom of contract interests of the individual seeking to enforce the restrictive covenant.[43] In the professional context, courts are likely to give great weight to the public policy concern of promoting unfettered competition.[44] The medical field is one such context.[45]

C. *Covenants Not to Compete in Physician Employment Contracts*

Various jurisdictions treat physician non-competition agreements differently.[46] Some courts believe that non-compete clauses hinder the availability of medical services to the public and refuse to enforce them.[47] Other courts hold that these types of covenants are unenforceable only if they do not pass the reasonableness test used for non-compete agreements in general.[48]

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ing that a covenant restricting competition within the county where a newspaper business was situated was overly broad).

41. *See* Ferdinand S. Tinio, Annotation, *Validity and Construction of Contractual Restrictions on Right of Medical Practitioner to Practice, Incident to Employment Agreement*, 62 A.L.R.3d 1014, 1044 (1975). If a court determines that a covenant not to compete limits an already-scarce service, then it will likely render the covenant invalid. *See, e.g.*, *Petrozza*, 373 S.E.2d at 454-55.

42. *See, e.g.*, Woodfield Group, Inc. v. DeLisle, 693 N.E.2d 464, 466 (Ill. App. Ct. 1998) ("An individual has a fundamental right to pursue a particular occupation . . . ."); Barbe v. A.A. Harmon & Co., 705 So. 2d 1210, 1222 (La. Ct. App. 1998) (explaining that a covenant was unenforceable because it "would deprive [a] fifty-eight year old man . . . of the liberty to earn his living as an accountant").

43. *See, e.g.*, Schott v. Beussink, 950 S.W.2d 621, 625 (Mo. Ct. App. 1997) (noting that the freedom of contract interests of a person seeking enforcement are weighed against public policy concerns).

44. Corbin, *supra* note 27, § 80.6, at 65.

45. *Id.*

46. *See* Berg, *supra* note 2, at 11-14.

47. A minority of states take this approach. *See id.*

48. A majority of states take this approach. *See id.* Although the states are split as to whether physician non-compete agreements should be enforced, the American Medical Association (AMA) has taken a firm position: it does not endorse restrictive covenants in physicians' employment contracts. *See id.* at 6-9. In 1998, the Council on Ethical and Judicial Affairs (CEJA), the judicial branch of the AMA, stated that

> [c]ovenants 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 [that] 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.

Loeser, *supra* note 4, at 287 (quoting Council on Ethical and Judicial Affairs Op. E-9.02 (1998)). Although this position seems critical, the CEJA's 1977 position was even more critical:

> Free choice of physicians is the right of every individual. One may select and change, at will, one's physicians, or may choose a medical care plan such as that provided by a closed panel or group practice or health maintenance or service organization. The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are prerequisites of ethical practice and optimal patient care.

Id. at 286 (quoting Code of Medical Ethics, Council on Ethical and Judicial Affairs Op. E-9.06 (1977)).

Representing a minority of jurisdictions, nine states have invalidated non-compete clauses in physician contracts.[49] Courts in six of those nine states rendered the covenants unenforceable *per se* through application of state antitrust statutes.[50] 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.[51]

The majority of jurisdictions view a reasonable, and therefore enforceable, non-compete provision as protection for an employer's legitimate business interest and not unduly burdensome on the physician or society.[52] Courts traditionally have determined that a medical employer's business interests are legitimate when the employer provides its employees with the following: (1) a patient base; (2) specialized training; and (3) confidential business information.[53] First, courts consider an employer's patient base a legitimate business interest because it may be misappropriated given the nature of the doctor-patient relationship.[54] When a departing physician has fre-

49. *See* Berg, *supra* note 2, at 11, 12 (noting that Alabama, California, Colorado, Delaware, Florida, Louisiana, Montana, and North Dakota have invalidated non-competition agreements in physician contracts). In addition, Massachusetts recently enacted a statute specifically invalidating covenants not to compete in physician employment contracts. MASS. ANN. LAWS ch. 112, § 12X (LexisNexis 2004).

50. Berg, *supra* note 2, at 12. These states include Alabama, California, Florida, Louisiana, Montana, and North Dakota. *Id.*; *see also* Anniston Urologic Assocs., P.C. v. Kline, 689 So. 2d 54, 57-58 (Ala. 1997) (holding that the covenant not to compete in a physician's contract was unenforceable *per se* under an Alabama statute); Hill Med. Corp. v. Wycoff, 103 Cal. Rptr. 2d 779, 784 (Ct. App. 2001) (rendering a covenant not to compete in a radiology physician's employment contract unenforceable *per se* under a California statute); Akey v. Murphy, 229 So. 2d 276-77, 279 (Fl. Dist. Ct. App. 1969) (recognizing that a covenant not to compete in a physician's employment contract was void under a Florida statute); Gauthier v. McGee, 141 So. 2d 837, 841 (La. Ct. App. 1962) (instructing that a promissory note in a physician's employment contract that would become payable if the physician competed against his employer was void under a Louisiana statute); W. Mont. Clinic v. Jacobson, 544 P.2d 807, 808, 811 (Mont. 1976) (explaining that a covenant not to compete in a physician's employment contract was unenforceable under a Montana statute); Spectrum Emergency Care v. St. Joseph's Hosp. & Health Ctr., 479 N.W.2d 848, 849, 853 (N.D. 1992) (voiding a restrictive covenant in a physician's employment contract under a North Dakota statute).

51. *See* COLO. REV. STAT. § 8-2-113(3) (2003) ("Any covenant not to compete provision of an employment, partnership, or corporate agreement between physicians which restricts the right of a physician to practice medicine . . . shall be void."); DEL. CODE ANN. tit. 6, § 2707 (2005) ("Any covenant not to compete provision of an employment, partnership or corporate agreement between and/or among physicians which restricts the right of a physician to practice medicine in a particular locale and/or for a defined period of time . . . shall be void . . . ."); MASS. ANN. LAWS ch. 112, § 12X ("Any contract or agreement which creates or establishes the terms of a partnership, employment, or any other form of professional relationship with a physician registered to practice medicine . . . in any geographic area for any period of time after the termination of such partnership, employment or professional relationship shall be void and unenforceable . . . .").

52. Loeser, *supra* note 4, at 285, 287-88.

53. Arthur S. Di Dio, *The Legal Implications of Noncompetition Agreements in Physician Contracts*, 20 J. LEGAL MED. 457, 458 (1999).

54. Berg, *supra* note 2, at 17-18; *see also* Granger v. Craven, 199 N.W. 10, 12-14 (Minn. 1924) (holding that a restrictive covenant was necessary to protect an employer's patient base because the physician-employee had a personal relationship with the employer's patients). *But see* Mandeville v. Harman, 7 A. 37, 38, 40-41 (N.J. Ch. 1886) (recognizing that a Newark medical employer's patient base was not a legitimate business interest subject to protection).

quent contact with patients, those patients develop a relationship with the physician that may influence the patients to follow the physician to his new practice.[55] Second, because medical employers add value to their physicians through specialized training, most courts hold that covenants not to compete protect a medical employer's investment.[56] If an employer trains a physician and permits him to resign and offer services in the same market, then the employer may be forced to compete against the highly-skilled former employee.[57] Third, many courts also recognize that confidential business information shared with a physician while working for a medical employer constitutes a protectable asset.[58] In the medical context, confidential business information usually includes trade secrets, patient lists, and referral source lists.[59] Courts often hold that covenants are warranted because medical employers possess an interest in safeguarding their trade secrets and contact lists.[60] Medical employers' interests are violated when former employees use those secrets or contacts.[61]

Applying the rule of reason, courts may hold that covenants not to compete are unenforceable when they are overly burdensome on the physician.[62] Physicians typically argue that, because of personal circumstances, it would be too burdensome to move their practices outside of the covenants' specified geographical locations.[63] Proving that the covenants impose a heavy burden, however, is often difficult.[64]

55. Di Dio, *supra* note 53, at 459.

56. *See, e.g.*, Duffner v. Alberty, 718 S.W.2d 111, 112 (Ark. Ct. App. 1986) (en banc) ("[T]he courts have found an interest sufficient to warrant enforcement of the covenant only in those cases where the covenantee provided special training . . . ."); Hoddeson v. Conroe Ear, Nose & Throat Assocs., P.A., 751 S.W.2d 289, 290 (Tex. App. 1988) (holding that the training medical employers provided to their physicians qualified as an investment).

57. *See* Berg, *supra* note 2, at 20. Some courts have refused to enforce covenants when a medical employer expended no additional costs to provide a physician training or experience. *Id.*; *see, e.g.*, Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 130 (Wis. Ct. App. 1981) ("The experience and skill [the physician] gained during his employment does not justify a post-employment restriction.").

58. *See, e.g.*, Pollack v. Calimag, 458 N.W.2d 591, 598-99 (Wis. Ct. App. 1990) (ruling that a medical employer was warranted in using a restrictive covenant to protect itself from harm because employees had access to patient lists).

59. Berg, *supra* note 2, at 22.

60. *See, e.g.*, Dickinson Med. Group, P.A. v. Foote, No. 834-K, 1984 WL 8208, at *1-3 (Del. Ch. May 10, 1984) (recognizing that a non-competition agreement was unenforceable *per se* under a state statute because a departing physician misappropriated a patient list).

61. *See* Berg, *supra* note 2, at 22.

62. *See* Di Dio, *supra* note 53, at 462-63.

63. *See* Berg, *supra* note 2, at 28; *see also* Lewis v. Surgery & Gynecology, Inc., No. 90AP-300, 1991 WL 35010, at *4 (Ohio Ct. App. Mar. 12, 1991) (noting plaintiff's argument that enforcing a restrictive covenant against a physician would impose a hardship on the physician's family, particularly because his daughter was making progress while attending a school where she was treated for elective mutism).

64. *See, e.g.*, Gant v. Hygeia Facilities Found., Inc., 384 S.E.2d 842, 846 n.7 (W. Va. 1989) (enforcing a covenant not to compete in a physician's contract without giving weight to his claim that enforcement would create an undue hardship). Courts frequently do not consider personal circumstances of employees. Blake, *supra* note 3, at 686.

If the provisions of a covenant not to compete unduly harm society, then a majority of courts declare the covenant unenforceable.[65] Two societal harms are recognized as grounds to invalidate non-compete covenants: (1) a shortage of physicians;[66] and (2) the subordination of a patient's interest to that of a physician or medical group.[67] When non-competition agreements create physician shortages or thwart patients' rights, courts generally conclude that the covenants are unenforceable.[68] As one commentator noted, "ideally physicians place the welfare of their patients above their own self-interest and their obligations to other groups . . . . However, physician noncompetition clauses potentially undermine this in large part, if not entirely, to protect the financial interest[s] of the employers."[69]

D. *Kansas's Approach to Covenants Not to Compete in Physician Employment Contracts*

Like most states, Kansas applies the rule of reason to evaluate the enforceability of non-compete agreements in physician employment contracts.[70] Before *Idbeis*, Kansas appellate courts decided three cases concerning physician non-compete contracts, all of which involved the following fact pattern: (1) an established employer-physician hired an employee-physician to assist with a thriving medical practice; (2) the employee-physician signed an employment contract with a covenant not to compete; (3) the employee-physician terminated employment and began practicing in the geographical area restricted by the covenant; and (4) the employer-physician sought to enforce the non-competition agreement.[71] Although all three cases involved similar basic facts, the courts' analyses evolved with each decision.[72] *Foltz v. Struxness*[73] was the first published Kansas case to

65. *See* Berg, *supra* note 2, at 15.

66. *Id.* at 28.

67. Loeser, *supra* note 4, at 287.

68. *See, e.g.*, Iredell Digestive Disease Clinic, P.A. v. Petrozza, 373 S.E.2d 449, 454 (N.C. Ct. App. 1988) (ruling that a covenant was unenforceable because "the public health and welfare would be harmed if there were only one gastroenterologist in [the community]"); New Castle Orthopedic Assocs. v. Burns, 392 A.2d 1383, 1385-86, 1388 (Pa. 1978) (explaining that a preliminary injunction forcing a surgeon to leave a community was harmful because it limited the number of orthopedic surgeons in the area). *But see* Willman v. Beheler, 499 S.W.2d 770, 773, 777 (Mo. 1973) (instructing that a covenant not to compete in a physician's employment contract was enforceable because, although enforcement would result in a shortage of physicians in the area covered by the covenant, the addition of the physician to another area would offset the resulting shortage).

69. Loeser, *supra* note 4, at 287.

70. *See, e.g.*, Weber v. Tillman 913 P.2d 84, 89 (Kan. 1996) (noting that only a reasonable non-competition covenant is enforceable).

71. *See infra* notes 75-98 and accompanying text.

72. *See infra* notes 75-98 and accompanying text.

73. 215 P.2d 133 (Kan. 1950).

evaluate the enforceability of a covenant not to compete in a physician's employment contract.[74]

In *Foltz*,[75] the Kansas Supreme Court, citing numerous non-physician cases from Kansas and other jurisdictions, applied the rule of reason to uphold the validity of a non-competition agreement.[76] Under Kansas case law, "[t]he question of reasonableness of a contract of this character frequently depends upon fundamental elements of common fairness in view of the facts and circumstances of the parties."[77] The court first considered the fairness of the covenant's territorial restriction and determined that it was reasonably necessary to protect the employer's interest.[78]

The court next evaluated the parties' original intent when contracting and explained that the covenant was fair because it operated to protect the employer's intent to sustain his practice after hiring the physician.[79] Finally, the court analyzed the public policy concerns associated with enforcing the covenant.[80] The covenant did not present any public policy concerns, and "the paramount public policy is that freedom to contract is not to be interfered with lightly."[81] As a result, the court enforced the covenant.[82] After *Foltz*, the Kansas Supreme Court did not evaluate the enforceability of a physician non-compete agreement until nearly half a century later in *Weber v. Tillman*.[83]

In *Weber*,[84] the Kansas Supreme Court introduced a four-part reasonableness test that evaluated whether a covenant (1) protected

74. *See Weber*, 913 P.2d at 89.

75. Dr. J.E. Foltz, a general physician and surgeon practicing in Hutchinson, Kansas, sought to relieve the pressure of his thriving medical practice by recruiting and hiring the young, well-qualified Dr. Erling Struxness. *Foltz*, 215 P.2d at 135. Struxness's employment contract contained a covenant not to compete. *Id.* The covenant provided the following: "[U]pon termination of this agreement . . . [Dr. Struxness] will not engage in the practice of medicine or surgery within a radius of 100 miles from Hutchinson, Reno County, Kansas, for a period of [ten] years from the date of this Agreement." *Id.* (emphasis omitted). Struxness began working for Foltz on February 1, 1948. *Id.* Failing to concur with the terms of a proposed partnership agreement, Struxness resigned on March 2, 1949, and he established his own office in Hutchinson. *Id.* at 136. Struxness had extensive contact with Foltz's patients, and, as a result, many patients followed Struxness to his new practice. *Id.* Foltz's practice was harmed, and he sued to enforce the covenant. *See id.*

76. *See id.* at 137-40.

77. *Id.* at 137 (quoting Heckard v. Park, 188 P.2d 926, 931 (Kan. 1948)).

78. *Id.*

79. *Id.* at 138-39.

80. *Id.* at 139.

81. *Id.*

82. *Id.* at 135, 140.

83. The law governing covenants not to compete in non-physician employment contracts, however, developed significantly during this time. *See, e.g.*, E. Distrib. Co. v. Flynn, 567 P.2d 1371, 1376 (Kan. 1977) (applying the reasonableness analysis to a covenant not to compete in a liquor distributor employment contract). Although the Kansas Supreme Court did not evaluate the enforceability of a covenant not to compete in a physician's contract again until 1996, it did evaluate whether valuable consideration existed for such a covenant in *Ferraro v. Fink*, 379 P.2d 266 (Kan. 1963).

84. Dr. Wallace Weber, a well-established dermatologist in Kansas, recruited Dr. Donald Tillman to assist in his practice. Weber v. Tillman, 913 P.2d 84, 87 (Kan. 1996). Tillman's employment contract contained a covenant not to compete. *Id.* The covenant provided that

one of the employer's legitimate business interests; (2) was not unduly burdensome on the employee-physician; (3) was not harmful to the public welfare; and (4) contained reasonable time and territorial restrictions.[85] The court noted that Kansas case law has recognized customer contacts as a legitimate business interest subject to protection in non-physician employment contracts.[86] Applying the same reasoning, the court determined that, because the physician treated and misappropriated the employer's patients, those patient contacts constituted a legitimate business interest.[87] Concluding that the other three prongs of the test were also satisfied, the court held that the covenant in the physician's contract was enforceable.[88]

Unlike the facts in *Idbeis*, *Foltz* and *Weber* did not involve physicians who were exclusively surgeons. Foltz was a general physician and a surgeon,[89] and Weber was a dermatologist.[90] In *Graham v. Cirocco*,[91] however, the Kansas Court of Appeals addressed the enforceability of a non-compete clause in a surgeon's employment contract for the first time.[92]

> [w]hile you are an employee, and for a period of two (2) years after your employment ends (for any reason), you will not render any medical services on behalf of yourself or any business or entity engaged in providing professional dermatology services within a thirty (30) mile radius of any office or place of business of the practice at the time your employment ends. This promise includes your not practicing at any hospital within the area described.

Id. Tillman began working for Weber in July 1992. *Id.* The physicians worked together until Tillman resigned in March 1994. *Id.* at 88. Despite the covenant in his employment contract, Tillman continued to practice in Hays, Kansas, without paying the specified liquidated damages. *Id.* Shortly thereafter, Weber filed an action, seeking to either enjoin Tillman from practicing in Hays or to require payment of the liquidated damages. *Id.*

85. *Id.* at 90. Although no Kansas court had ever applied the test, the court in *Weber* noted that *Foltz*, eight cases from other jurisdictions, and a law review article provided support for its formulation. *See id.* The court ruled that the covenant did not place an unjustifiable burden on the employee because "[Dr. Tillman] may practice dermatology anywhere and anytime except within a limited territory and time." *Id.* at 91. On this point, the court also held that the covenant did not unduly burden Tillman because he was still permitted to practice general medicine in the restricted area. *Id.* In evaluating the time and territory issue, the court ruled that the plaintiffs established no factual basis that the restrictions were overbroad. *Id.* at 92. Finally, the court determined that enforcing the covenant would not be injurious to the public because Dr. Tillman's field, dermatology, was not, "for lack or a better term, medically necessary." *Id.* at 95.

86. *Id.* at 91 (citing *Flynn*, 567 P.2d at 1376).

87. *Id.* at 92-93. Drawing on persuasive authority from other jurisdictions, the court also identified the following additional factors that are legitimate business interests subject to protection: "special training of employees, trade secrets, confidential business information, loss of clients, good will, reputation, seeing that contracts with clients continue, and *referral sources*." *Id.* at 91 (emphasis added).

88. *Id.* at 96.

89. Foltz v. Struxness, 215 P.2d 133, 135 (Kan. 1950).

90. *Weber*, 913 P.2d at 87. Although this distinction may seem innocuous at first, see *infra* Part V.D. for an explanation regarding why the nature of patient contact with surgeons appreciably differs from the nature of patient contact with other physicians.

91. 69 P.3d 194 (Kan. Ct. App. 2003).

92. *See id.* at 196.

The Kansas Court of Appeals in *Graham*[93] evaluated the reasonableness of a covenant under the four-part test developed in *Weber*.[94] Addressing whether the employer had a legitimate business interest subject to protection by the non-compete clause, the court in *Graham* cited the Kansas Supreme Court's prior dictum in *Weber* providing that both patient contacts *and* referral sources were legitimate business interests.[95] Based on the *Weber* dictum and the surgeon's active solicitation of the employer's patients and referring doctors, the court concluded that the covenant protected a legitimate business interest.[96] Because the remaining three prongs of the *Weber* test were satisfied after the court revised the contract,[97] the restrictive covenant was deemed reasonable.[98]

IV. Court's Decision

In *Idbeis v. Wichita Surgical Specialists, P.A.*, the Kansas Supreme Court analyzed the enforceability of covenants not to compete in four surgeons' employment contracts.[99] The court's primary consideration was whether the covenants served to protect a legitimate business interest of the employer-medical group.[100] The surgeons who agreed to the covenants contended that the non-compete clauses were unenforceable because the restraints were harmful to society and did not protect a legitimate business interest.[101] The group countered that the covenants were reasonable and consistent with public policy.[102]

93. Dr. Bruce Graham, an overburdened colorectal surgeon in Kansas City, Kansas, hired Dr. William Cirocco to join his practice. *Id.* On July 1, 1994, the two parties entered into an employment contract that included a restrictive covenant. *Id.* The covenant provided that

> [f]or a period of two (2) years after leaving the employment of [Graham] and within the geographic area measured by a radius of one hundred fifty (150) miles from each of the offices of [Graham], [Cirocco] agrees that he will not solicit business from the patients or referral sources of [Graham] with whom he came in contact as an employee of [Graham] . . . [Cirocco] further agrees that for a period of two (2) years after leaving the employment of [Graham], [Cirocco] will not open an office within twenty-five (25) miles of the hospitals listed in the recitals of this Agreement or provide services at said hospitals.

Id. (alterations in original). Cirocco terminated his employment with Graham on June 30, 2000. *Id.* at 197. At trial, Graham introduced evidence that Cirocco began soliciting patients and referral sources prior to leaving Graham's practice. *Id.* Three days after leaving, Cirocco opened his own colorectal surgery office next door to Graham's office. *Id.*

94. *Id.* at 198.

95. *Id.* at 199.

96. *See id.* at 197, 199.

97. The court did not consider the undue burden question because Dr. Cirocco did not raise the issue on appeal. *Id.* at 199. The court noted that the time and territorial restrictions were too broad, thus harming the public welfare because they resulted in a shortage of colorectal surgeons in the Kansas City area. *Id.* at 199-200. Addressing these problems, the court eliminated the geographical restrictions to permit Dr. Cirocco to practice in Kansas City. *Id.*

98. *Id.* Specifically, the court ruled that "[t]he 25-mile limitation on office placement and the prohibition of practice in the entire metropolitan area exceed reasonable scope." *Id.* at 200.

99. *See* Idbeis v. Wichita Surgical Specialists, P.A., 112 P.3d 81, 83-84 (Kan. 2005).

100. *See id.* at 89, 91.

101. *See* Brief of Appellants at 30, 44, *Idbeis*, 112 P.3d 81 (No. 03-91442-A). The plaintiffs framed their argument using the *Weber* test. *See id.* at 38.

102. *See Idbeis*, 112 P.3d at 89, 91.

After determining that the covenants served to protect one of the group's legitimate business interests, the court ruled that the non-competition agreements were valid and enforceable against the surgeons.[103]

Considering whether the covenants protected a legitimate business interest, the Kansas Supreme Court recognized that in *Weber* "customer contacts, . . . the special training of employees, trade secrets, confidential business information, . . . good will, . . . and referral sources" were legitimate business interests.[104] The court in *Idbeis* focused on employee training and referral sources.[105]

WSS noted that it provided its surgeons training and introduced them to new medical specialties.[106] It maintained that to further this "educational mission," it needed to sustain a certain size, or "critical mass"; therefore, its size was a legitimate business interest.[107] The plaintiffs, in counterargument, emphasized that no Kansas court had ever considered the size of a business a legitimate business interest.[108] Agreeing with the plaintiffs, the court explained that "[n]one of [the] interests [recognized in *Weber*] are related to the employer's size or the special contributions the employer might be able to make to its community because of its size."[109]

WSS next asserted that the referral relationships developed by the plaintiffs while employed with WSS were legitimate business interests.[110] The plaintiffs claimed that, even if the relationships were legitimate business interests at one time, the interests were fleeting and, therefore, ceased to be legitimate by the time the plaintiffs resigned.[111] WSS relied on several non-physician employment contract cases, including *Eastern Distributing Co. v. Flynn*,[112] which instructed

103. *Id.* at 94.

104. *Id.* at 89 (quoting Weber v. Tillman, 913 P.2d 84, 91 (Kan. 1996)).

105. *See id.* at 89-91. The plaintiffs noted that no evidence established that trade secrets or confidential business information was imparted to the surgeons as a result of working at WSS. Brief of Appellants at 48, *Idbeis*, 112 P.3d 81 (No. 03-91442-A). The court did not analyze WSS's goodwill as a legitimate business interest *per se*, but rather analyzed WSS's goodwill insofar as it related to its legitimate business interest in referral sources. *See Idbeis*, 112 P.3d at 90. The plaintiffs noted that patient contacts in a surgical setting could never be considered a legitimate business interest because the Kansas Supreme Court in *Weber* required the relationship to be "pre-exist[ing]" and "long-standing and near permanent." Brief of Appellants at 50, 51, *Idbeis*, 112 P.3d 81 (No. 03-91442-A) (citing *Weber*, 913 P.2d at 91).

106. *See* Brief of Appellee/Cross-Appellant at 44, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

107. *See id.* at 43-44.

108. Brief of Appellants at 47, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

109. *Idbeis*, 112 P.3d at 89. WSS argued that it could make "special contributions" in the form of training to further its "educational mission." Brief of Appellee/Cross-Appellant at 43-44, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

110. Brief of Appellee/Cross-Appellant at 38-39, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

111. Brief of Appellants at 49, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

112. 567 P.2d 1371 (Kan. 1977); *see also* Brief of Appellee/Cross-Appellant at 38-39, *Idbeis*, 112 P.3d 81 (No. 03-91442-A). WSS also cited *Weber* and *Foltz* to provide support for this contention. Brief of Appellee/Cross-Appellant at 38-39, *Idbeis*, 112 P.3d 81 (No. 03-91442-A). The court in *Foltz*, however, did not address the issue of whether referral sources could be a protectable interest. *See* Foltz v. Struxness, 215 P.2d 133, 136 (Kan. 1950). Further, the court in *Weber*

that all contacts made by an employee on behalf of the employer are interests of the latter, not the former.[113] In counterargument, the plaintiffs noted that the Kansas Supreme Court in *Flynn* determined that a contact interest merits protection only when the employee served as the sole or primary contact with the customer.[114] The plaintiffs asserted that they were not the sole or primary contacts with the referring cardiologists because all the surgeons at WSS had access to these referral sources.[115]

Disagreeing with the plaintiffs' position, the court held that WSS had a legitimate business interest in referral relationships and noted that "even though the plaintiffs' reputations may have become over time the paramount factor influencing referrals, they each benefited from their association and from the investment of WSS and its contribution of goodwill."[116] Further explaining its holding, the court indicated that "the paramount public policy is that freedom to contract is not to be interfered with lightly."[117] The court reasoned that Idbeis, the only plaintiff who developed a referral base in Wichita before working for WSS, chose to accept the terms of his employment contract on two separate occasions.[118] Idbeis's failure to object to the terms of his contract when he signed it weighed in favor of the covenant's enforceability.[119] Because Idbeis failed to demonstrate that WSS only sought to hinder competition, the court reasoned that the plaintiffs did not establish grounds to supercede the parties' freedom of contract.[120] Ultimately, the court determined that, in Kansas, "the

did not explain its reason for deeming referral sources legitimate business interests, only that such sources were recognized as protectable in other jurisdictions. *See* Weber v. Tillman, 913 P.2d 84, 91 (Kan. 1996).

113. *Flynn*, 567 P.2d at 1376-78.

114. *See* Brief of Appellants at 50, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

115. *Id.* at 51. The plaintiffs noted that all surgeons at WSS had contact with and actually competed for referral sources. *Id.*

116. *Idbeis*, 112 P.3d at 90.

117. *Id.* at 91 (quoting *Weber*, 913 P.2d at 96).

118. *Id*.

119. *See id.*

120. *Id.* The surgeons and WSS also provided case law from other jurisdictions addressing the question of whether referral sources are legitimate business interests. *See id.* at 89. WSS cited *Medical Specialists, Inc. v. Sleweon*, 652 N.E.2d 517 (Ind. Ct. App. 1995), in which the court held that a medical group's referral sources are a legitimate business interest that covenants not to compete should protect. *Idbeis*, 112 P.3d at 89. The court in *Sleweon* noted that "[c]learly, the continued success of [the employer's] practice, which is dependent upon patient referrals, is a legitimate interest worthy of protection." *Sleweon*, 652 N.E.2d at 523.

The plaintiffs cited to *Weintraub v. Schwartz*, 516 N.Y.S.2d 946 (App. Div. 1987), a New York case holding that a legitimate business interest did not exist because of a presumption that referrals are based on a surgeon's reputation and ability, not on a surgeon's affiliation. Brief of Appellants at 54, *Idbeis*, 112 P.3d 81 (No. 03-91442-A). The plaintiffs in *Idbeis* argued that the referrals in question were based on their skills and reputations. *Id.* at 52-53. Next, the plaintiffs cited as persuasive authority, *Cardiovascular Surgical Specialists, Corp. v. Mammana*, 61 P.3d 210 (Okla. 2002), and *Hoddeson v. Conroe Ear, Nose & Throat Associates, P.A.*, 751 S.W.2d 289 (Tex. App. 1988). Brief of Appellants at 54-55, *Idbeis*, 112 P.3d 81 (No. 03-91442-A). In *Mammana*, the Oklahoma Supreme Court held that "[o]ne surgeon has no legitimate business interest in another surgeon's referral base regardless of a past employer-employee relationship."

law is clear that referral sources are a legitimate interest [that] can be protected by a restrictive covenant even in the context of a medical practice."[121]

V. Commentary

In *Idbeis v. Wichita Surgical Specialists, P.A.*, the Kansas Supreme Court's ruling that all referral sources are legitimate business interests subject to protection by covenants not to compete was overly broad. The court failed to recognize that the dynamics of a medical group's referral structure determine the legitimacy of that group's referral relationship as a business interest. If the referral structure of the group capitalizes on the skill and reputation of its surgeon, then the referral relationship cannot be a legitimate business interest. Alternatively, if the referral structure capitalizes on the reputation and goodwill of the group, then the group has a protectable interest in the referral relationship. Moreover, the Kansas Supreme Court's ruling in *Idbeis* may lead to future restraints on trade that will harm the already overburdened healthcare industry in Kansas.

A. *All Referral Relationships Are Not Legitimate Business Interests*

To fully understand why WSS did not have a legitimate business interest in its surgeons' referral relationships, the elements of this interest must be defined. After recognition of what constitutes this interest, it is clear that only some referral relationships are legitimate. In non-compete cases involving referral sources, medical employers claim that their referral sources are legitimate business interests that warrant the protection of covenants not to compete.[122] When attempting to prove this point, the employers reason that the referral relationships result from their effort in building goodwill[123] and that those relationships exist because referring physicians recognize that

Mammana, 61 P.3d at 214. The Texas Court of Appeals in *Hoddeson* ruled that "referring physicians are governed by the skills and qualifications of the receiving physician, rather than his associations" and that medical employers do not "impart trade secrets, specialized training or confidential information to [their employees]." *Hoddeson*, 751 S.W.2d at 290. The plaintiffs in *Idbeis* argued that they never received special training, confidential business information, or trade secrets. Brief of Appellants at 17-18, *Idbeis*, 112 P.3d 81 (No. 03-91442-A). The court, also making reference to persuasive authority, noted *Community Hospital Group v. More*, 869 A.2d 884 (N.J. 2005), a case in which the New Jersey Supreme Court held that a hospital had a legitimate business interest in "protecting patient and patient referral bases." *Idbeis*, 112 P.3d at 89-90 (quoting *More*, 869 A.2d at 897).

121. *Idbeis*, 112 P.3d at 90. The court only cited *Weber* and *Graham* to support this conclusion. *Id.*

122. *See, e.g.*, Jaraki v. Cardiology Assocs. of Ne. Ark., 55 S.W.3d 799, 803 (Ark. Ct. App. 2001) (recognizing that referral sources are legitimate business interests).

123. Goodwill is defined as

> an intangible asset that is made up of the favor or prestige which a business has acquired beyond the mere value of what it sells due to the personality or *experience* of those conducting it, *their reputation for skill* or dependability, . . . or any other circumstance incidental to the business that tends to draw and retain customers.

Merriam Webster's Dictionary of Law 215-16 (1996) (emphasis added).

goodwill.[124] They maintain that physicians and surgeons who join medical groups benefit from the groups' reputations by receiving referrals.[125] Thus, groups rely on the apparent unfairness of permitting physicians to gainfully compete while benefiting from each medical employer's reputation. Employers assert that, because an employee will be a competitor, the employee's gain will result in the employer's loss.[126]

Two basic premises underlie this reasoning: (1) medical employers have a legitimate business interest in their established goodwill;[127] and (2) referring physicians refer patients to surgery groups because the physicians recognize the groups' goodwill, thereby creating referral relationships.[128] Medical employers argue that, because courts consider goodwill a legitimate business interest, and because the groups' goodwill and reputations form the foundation of referral relationships, the relationships themselves must be legitimate business interests.[129] This syllogism, however, is usually invalid because frequently the second premise is false.

The first premise—surgical groups possess protectable business interests in their goodwill—is true because it satisfies the three universal requirements of legitimate business interests: (1) the interest has value;[130] (2) the value of the interest belongs to the person asserting its legitimacy;[131] and (3) the employee may misappropriate the value of the interest.[132] Goodwill satisfies these elements.[133] It provides

124. *See, e.g.*, Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 130 (Wis. Ct. App. 1981) (noting that a clinic's referral contacts resulted from its diligence in building goodwill).

125. *See, e.g.*, Geocaris v. Surgical Consultants, Ltd., 302 N.W.2d 76, 78 (Wis. Ct. App. 1981) (indicating that a physician received referrals because the medical group aided his reputation).

126. *See* Berg, *supra* note 2, at 18-19 (explaining that when patients follow departing physicians, the employer's patient base depletes).

127. *See, e.g.*, Weber v. Tillman, 913 P.2d 84, 91 (Kan. 1996).

128. *See* Brief of Appellee/Cross-Appellant at 27, Idbeis v. Wichita Surgical Specialists, P.A., 112 P.3d 81 (Kan. 2005) (No. 03-91422-A).

129. *See, e.g.*, Jaraki v. Cardiology Assocs. of Ne. Ark., 55 S.W.3d 799, 803 (Ark. Ct. App. 2001) ("An extensive referral base established over a fifteen to sixteen year period is reflective of [the group's] goodwill and reputation . . . ."); *Fields*, 309 N.W.2d at 129-30 (noting that a clinic's referral contacts resulted from its struggle to develop its goodwill); Brief of Appellee/Cross-Appellant at 27, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

130. *See, e.g.*, E. Distrib. Co. v. Flynn, 567 P.2d 1371, 1373-74 (Kan. 1977) (noting that customer relationships have value).

131. *See, e.g.*, *Weber*, 913 P.2d at 92 (recognizing a physician's argument that the valuable asset belongs to the person asserting the interest).

132. *See, e.g.*, Graham v. Cirocco, 69 P.3d 194, 199 (Kan. Ct. App. 2003) (noting that Cirocco "took advantage" of Graham's well-established community contacts).

133. *Weber*, 913 P.2d at 91 (noting that goodwill is a legitimate business interest). An analysis of the legitimate interests cited in *Idbeis* illustrates how all protectable interests satisfy the three-part test. The Kansas Supreme Court in *Idbeis* cited author Paula Berg, recognizing that patients or "patient contacts," are legitimate business interests. *Idbeis*, 112 P.3d at 89. As the employer's source of revenue, patient relationships are often considered a medical employer's most valuable asset. *See, e.g.*, *Weber*, 913 P.2d at 92 ("Other courts have recognized that an employer's relationship with customers is its most valuable asset."). Because patient bases are valuable assets, they possess the first element common to legitimate business interests.

Patient bases also possess the second element: The value of the patient base belongs to the medical employer. *See, e.g.*, Foltz v. Struxness, 215 P.2d 133, 136 (Kan. 1950) (noting that Foltz

value to medical employers because it may attract patients or referrals.[134] This value belongs to medical groups because they expend resources to build goodwill.[135] Employee-physicians may misappropriate the value of employers' goodwill.[136] When physicians resign, they may benefit from their former association with employers and attract customers and referrals that the employers would have received if the physicians remained.[137] In this situation, the employees deprive the employers of the full value of the employers' goodwill. Therefore, employers have a protectable interest in goodwill.

The surgical group's syllogism, however, proves to be false because the second premise—referring physicians refer patients to surgical groups because they recognize the groups' goodwill—is frequently false. Referring physicians refer patients to surgical groups because physicians recognize the *operating surgeon's skill and reputation*.[138] Therefore, using the same structure of the surgical group's syllogism,[139] if groups wish to demonstrate that they have protectable in-

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informed Struxness that he would take legal action to protect *his* interest in his patients). The medical employer has a right to that value because the employer has offered services in exchange for patient relationships.

Patient relationships also satisfy the third element because the value of those relationships may be misappropriated by the employee-physician. *See* Di Dio, *supra* note 53, at 460 (noting that departing physicians harm their employers by drawing on the employer's patient base). When the employee-physician leaves the employer, the patient may follow; therefore, the employer will lose the opportunity to offer the patient services and generate revenue. *See, e.g.*, *Weber*, 913 P.2d at 92 (noting that Tillman took patients with him after his termination, and as a result, Weber experienced unfilled appointment slots); Hansen v. Edwards, 426 P.2d 792, 793-94 (Nev. 1967) ("In the short time that Hansen opened his office after terminating the employment contract he acquired approximately 180 of Edwards' customers."). Accordingly, patient relationships are legitimate business interests because the relationships satisfy all three criteria. Similarly, excluding referral sources, each of the remaining interests cited by the court in *Idbeis*—confidential business information, employee training, trade secrets, and goodwill—also satisfy the three-part test.

134. *See, e.g.*, Granger v. Craven, 199 N.W. 10, 12 (Minn. 1924) (noting that a plaintiff-physician developed a commendable reputation with his patients because of his professional effort in creating goodwill).

135. *See, e.g.*, *id.* ("What one creates by his own labor is his. . . . [The] [p]laintiff had a very substantial practice and the good will of many patients; . . . the result of nearly 30 years of professional effort.").

136. *See, e.g.*, Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 130 (Wis. Ct. App. 1981) ("It would be unfair to permit [the physician] to use the Center's . . . goodwill . . . to take away the Center's business . . . .").

137. *See* Tinio, *supra* note 41, at 1022 (noting that when a physician resigns, he may draw on the employer's patient base).

138. *See, e.g.*, Weintraub v. Schwartz, 516 N.Y.S.2d 946, 948 (App. Div. 1987) ("[T]hese referrals are presumably based upon a physician's professional judgment and evaluation of the [physician's] ability rather than on the basis of the [physician's] prior affiliation with the [employer]."); Cardiovascular Surgical Specialists, Corp. v. Mammana, 61 P.3d 210, 214 n.3 (Okla. 2002) ("Doctors refer patients to surgeons for cardiovascular surgery, not to corporations."); Hoddeson v. Conroe Ear, Nose & Throat Assocs., P.A., 751 S.W.2d 289, 290 (Tex. App. 1988) ("[R]eferring physicians are governed by the skills and qualifications of the receiving physician, rather than his associations.").

139. The employer's argument provides that if a medical group's legitimate business interest forms the basis for a referral relationship, then the relationship itself must be a protectable interest. *See, e.g.*, Jaraki v. Cardiology Assocs. of Ne. Ark., 55 S.W.3d 799, 803 (Ark. Ct. App. 2001) ("[A] network of referring physicians is akin to customer lists and trade secrets, and these relationships are protected by [the employer] . . . to maintain goodwill and reputation.").

terests in referral relationships, then they must prove that they possess legitimate business interests in their surgeons' skills and reputations.

Unlike their own goodwill, however, surgical groups cannot have a legitimate business interest in their surgeons' skills and reputations because the groups' interest in surgeons' skills and reputations do not satisfy the three-part test. With respect to the first element, surgeons' skills and reputations certainly provide value to their employers.[140] Skills and reputations also satisfy the second characteristic common to all legitimate business interests: The value of surgeons' skills belongs to surgical groups when the groups compensate their surgeons for services.[141]

The third element, however, cannot be satisfied because surgeons cannot misappropriate their skill after resignation. It is illogical to suggest that surgeons could misappropriate their own skills or reputations.[142] These attributes belong to the surgeons, not to surgical groups.[143] Therefore, medical employers cannot have a legitimate business interest in their surgeons' skills and reputations because the employers cannot have protectable interests in referral relationships that originate from the recognition of that skill.

B. *Distinguishing Between the Two Types of Referral Structures*

Because surgical groups may not maintain legitimate business interests in referral relationships based on surgeons' skills and reputations, but may possess protectable interests in referral relationships based on the groups' goodwill, a practical problem presents itself: How should courts distinguish between relationships based on surgeons' skills and reputations and those based on the groups' goodwill? The answer depends on the groups' referral schemes or structures.

Medical employers use two types of referral structures:[144] (1) structures that require groups to receive and allocate referrals to their surgeons,[145] and (2) structures that permit surgeons to directly receive referrals from referring physicians.[146] Under the first structure, re-

140. *See, e.g.*, Gelpi v. Wilbert, 119 So. 455, 456 (La. Ct. App. 1928) (indicating that a surgeon's skill and reputation are factors for determining the value of his services).

141. *See, e.g.*, Weber v. Tillman, 913 P.2d 84, 87 (Kan. 1996) (noting that Dr. Tillman was paid an annual salary plus bonuses in exchange for his medical services).

142. "Misappropriate" may also be defined as to "take for one's own use" or "embezzle." OXFORD DESK DICTIONARY AND THESAURUS: AMERICAN EDITION 505 (Frank Abate ed., 1997).

143. *E.g.*, Mandeville v. Harman, 7 A. 37, 40 (N.J. Ch. 1886) ("[P]rofessional skill, experience, and reputation are things which cannot be bought or sold. They constitute part of the individuality of the particular person, and die with him.").

144. The plaintiffs also named the methods of referral allocation "referral networks" or "systems." Brief of Appellants at 56, Idbeis v. Wichita Surgical Specialists, P.A., 112 P.3d 81 (Kan. 2005) (No. 03-91442-A).

145. *See, e.g*., Med. Specialists, Inc. v. Sleweon, 652 N.E.2d 517, 524 (Ind. Ct. App. 1995) (noting that a clinic received referrals).

146. *See, e.g.*, Hoddeson v. Conroe Ear, Nose & Throat Assocs., P.A., 751 S.W.2d 289, 290 (Tex. App. 1988) (indicating that referrals were received directly by the surgeon).

ferring physicians base their referral choices on the *goodwill* of groups;[147] whereas, under the second structure, referring physicians base their referral choices on the *skills* and *reputations* of surgeons.[148]

Referral structures that capitalize on surgical groups' goodwill share common characteristics. Because referring physicians and surgeons have minimal contact with each other, they rarely develop personal relationships.[149] Generally, these referral structures have intra-group referral systems; whereby, the groups receive referral requests and allocate them to surgeons based on their internal group policies.[150] Here, physicians refer patients to groups and not to surgeons directly. When physicians refer patients, their referrals must be based on the groups' goodwill.[151] Litigation often arises when surgeons resign from groups, take patient referral lists, and actively solicit listed referral sources.[152] In this situation, groups possess an interest in their referral source lists, which were developed as a result of their own goodwill.

Groups with referral structures that capitalize on surgeons' skills and reputations, however, do not have an interest in referral sources. Under these structures, surgeons frequently have strong, longstanding relationships with referring physicians.[153] Here, groups encourage surgeons to contact referral sources and actively solicit referrals.[154] Because bonuses or salaries in a group may be based on the number of surgeries performed, this type of referral structure fosters competition among surgeons to obtain referrals.[155] The surgeons must demonstrate their skills and reputations to referring physicians to persuade the physicians that they are deserving of referrals.[156]

147. *See, e.g.*, Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 130 (Wis. Ct. App. 1981) (indicating that patients were referred based on the clinic's goodwill).

148. *See, e.g.*, Weintraub v. Schwartz, 516 N.Y.S.2d 946, 948 (App. Div. 1987).

149. *See, e.g.*, *Fields*, 309 N.W.2d at 129 (explaining that a physician did not regularly contact referral sources).

150. *See, e.g.*, Keeley v. Cardiovascular Surgical Assocs., P.C., 510 S.E.2d 880, 884 (Ga. Ct. App. 1999) (noting that a medical group allocated referrals to its surgeons).

151. *See, e.g.*, *Fields*, 309 N.W.2d at 129 (noting that relationships were established with referral agencies through a clinic's efforts to become well-respected).

152. *See, e.g.*, Graham v. Cirocco, 69 P.3d 194, 197 (Kan. Ct. App. 2003); *Fields*, 309 N.W.2d at 130.

153. *See, e.g.*, Lewis v. Surgery & Gynecology, Inc., No. 90AP-300, 1991 WL 35010, at *4 (Ohio Ct. App. Mar. 12, 1991) ("In the four and one-half years [the surgeon] was employed by [the group], he has established relationships with the referring physicians from whom he receives the referral of his patients.").

154. *See, e.g.*, Brief of Appellants at 17, 51, Idbeis v. Wichita Surgical Specialists, P.A., 112 P.3d 81 (Kan. 2005) (No. 03-91442-A) ("*[E]very* cardiovascular surgeon at WSS has unfettered and continuous contact with any and all cardiologists in the Wichita area[ ] and actually compete with each other for referrals from these physicians.").

155. *See, e.g.*, *id.* at 17 ("The underlying purpose of the compensation system is to allocate directly to the surgeon the revenues generated by the surgeon and those expenses attributable to the surgeon's practice.").

156. *See, e.g.*, Cmty. Hosp. Group, Inc. v. More, 838 A.2d 472, 477 (N.J. Super. Ct. App. Div. 2003) ("[The physician] was featured as an expert speaker at seminars and programs sponsored by the [employer] and geared toward the referral sources.").

This second structure allows groups to generate more business through intra-group competition.[157] When groups are permitted to protect their purported interests in their surgeons' referral relationships by using covenants not to compete, the groups receive the best of both worlds: They reap the benefits of competition within their groups that result from their type of referral structures,[158] while hindering outside competition.[159] Litigation frequently arises when surgeons resign from groups and continue to receive referrals from earlier-established referral sources.[160] In this context, groups should never be permitted to enforce a covenant not to compete because their interests in referral relationships are not based on their own goodwill and, therefore, cannot be legitimate.

C. *Errors in the Kansas Supreme Court's Analysis*

1. The Court Failed to Consider WSS's Skill-Based, Competitive Structure

The court incorrectly held that the referral relationships among referring physicians and WSS's surgeons were legitimate business interests. WSS, which employed a competitive, skill-capitalizing referral structure, could not possess an interest in its surgeons' referral relationships. None of the plaintiffs in *Idbeis* were assigned referral sources during their employment at WSS.[161] Rather, the plaintiffs received referrals directly from referring cardiologists or other physicians.[162] Although the plaintiffs were provided a base salary during their first two years of employment with WSS, the surgeons' ability to "cultivate referrals" determined their compensation after that two-year period.[163] The plaintiffs were compensated based on their gross collected revenues, after deducting expenses incurred from performing surgeries.[164] Like most surgeons, the plaintiffs were fully trained prior to beginning employment at WSS and were not provided any additional training.[165]

Dr. George J. Farha, one of WSS's founders, noted that referral relationships were not established by WSS, but rather they were based

157. *See, e.g.*, *id.* (indicating that the surgeon was the group's "top producer" and "rainmaker").
158. *See, e.g.*, *id.* (noting that the number of surgeries a physician performed increased).
159. *See* Berg, *supra* note 2, at 4.
160. *See, e.g.*, Pratt v. Grunenwald, No. 14160, 1994 WL 313050, at *2 (Ohio Ct. App. June 29, 1994) (explaining that a surgeon would continue to receive referrals after leaving a medical group).
161. Brief of Appellants at 21, Idbeis v. Wichita Surgical Specialists, P.A., 112 P.3d 81 (Kan. 2005) (No. 03-91442-A).
162. *See id.* at 18.
163. *Id.* at 18-19.
164. *Id.* at 17. Expenses included the cost of the surgeons' physician assistants, continuing education, and the general overhead associated with running a surgical business. *Id.*
165. *Id.* at 18.

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on the surgeon's "affability, availability and ability—the surgeon's three A's."[166] Further, six referring cardiologists testified at trial that their referrals were never based on WSS's reputation, instead each were based on the skills and reputations of the surgeons.[167] Finally, WSS's referral scheme fostered a competitive atmosphere, driving WSS surgeons to compete against each other just as they competed with other surgeons outside of the surgical group.[168] This competition benefited WSS by generating business. The non-competition agreements also benefited WSS by discouraging its former surgeons from continuing to compete outside of the group.[169] Because WSS employed a competitive, skill-based referral structure and because the plaintiffs' referral relationships were based on their skills and reputations, the Kansas Supreme Court in *Idbeis* incorrectly held that those referral relationships were protectable business interests.

2. The Court Misapplied Prior Kansas Case Law

Misapplication of prior Kansas case law led to the Kansas Supreme Court's illogical decision in *Idbeis*. The case was one of first impression for the court because the facts were distinguishable from other Kansas cases that addressed physician non-compete clauses. *Weber v. Tillman* was the first Kansas case to recognize a referral relationship as a legitimate business interest.[170] In dictum, the court noted "other jurisdictions have recognized, in addition to customer contacts, that an employer has a legitimate business interest [in] protect[ing] . . . referral sources."[171] For support, the court in *Weber* cited only one case holding that referral sources are legitimate business interests.[172] Although *Weber* involved a physician non-competition agreement, whether referral sources were legitimate business interests was not an issue.[173] Rather, the court's decision focused on the employee-physician's solicitation and treatment of the patients he encountered while working for the employer.[174]

166. *Id.* at 19 (quoting Dr. Farha's statement made at trial).

167. *Id.* at 20.

168. *Id.* at 21.

169. *Id.* at 20.

170. *See* Weber v. Tillman, 913 P.2d 84, 91 (Kan. 1996).

171. *Id.*

172. *See id.* at 92 (citing Fields Found., Ltd. v. Christensen, 309 N.W.2d 125 (Wis. Ct. App. 1981)). In *Fields*, an abortion clinic sued its former physician-employee who took the clinic's list of referral sources and actively solicited those sources after he left. *Fields*, 309 N.W.2d at 129-30. The court in *Fields* recognized those sources as a protectable interest. *See id.*

173. With respect to legitimate business interests, the primary issue in *Weber* was whether Dr. Tillman's patient contacts were subject to protection, not whether Dr. Weber's referral sources were subject to protection. *Weber*, 913 P.2d at 91-92.

174. *Id.* at 91-93.

Idbeis differs factually from *Weber* because continued patient care was not considered in *Idbeis*.[175] Unlike the dermatologist-patient relationship in *Weber*, the surgeon-patient relationship in *Idbeis* required minimal continued patient contact or after care.[176] Generally, the surgeons in *Idbeis* only had short pre-operative and operative contact with their patients.[177] Further, most patients did not require subsequent surgical services because the referring cardiologists provided post-operative care.[178]

The court's reliance on *Graham v. Cirocco* was also misplaced because that case factually differed from *Idbeis*. The Kansas Court of Appeals in *Cirocco* ruled in favor of the employer because the employee-surgeon solicited patients and referral sources after he resigned.[179] In *Idbeis*, however, no similar solicitation of referral sources occurred.[180]

The unique facts of *Idbeis* presented the Kansas Supreme Court with the opportunity to analyze the unfair nature of the covenants. Instead, after only a cursory analysis, the court accepted the dictum in *Weber* that adopted the generalized notion that *all* referral sources are protectable interests.[181] This casual acceptance was, in part, the basis for the court's incorrect ruling that referral sources are legitimate business interests.

The court, citing *Foltz* and *Weber*, ultimately ruled that referral relationships are legitimate business interests subject to protection because "the paramount public policy is that freedom to contract is not to be interfered with lightly."[182] Indeed, freedom of contract presents a persuasive argument for the enforcement of physician non-compete covenants.[183] The Kansas Supreme Court in *Weber*, however, did not rely on freedom of contract reasoning in its legitimate business interest analysis when it created the four-pronged reasonableness test.[184] Under the *Weber* test, a court should only consider freedom of contract as a factor of the public policy prong, not the legitimate business interest prong.[185] A covenant not to compete must satisfy the legiti-

175. *See* Idbeis v. Wichita Surgical Specialists, P.A., 112 P.3d 82 (Kan. 2005).
176. *E.g.*, Wausau Med. Ctr. v. Asplund, 514 N.W.2d 34, 41 (Wis. Ct. App. 1994) ("Unlike, for example, a general practitioner, a patient's relationship with a surgeon is, hopefully, restricted to one encounter.").
177. *See* Brief of Appellants at 18, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).
178. *Id.*
179. Graham v. Cirocco, 69 P.3d 194, 197, 199 (Kan. Ct. App. 2003).
180. *See Idbeis*, 112 P.3d at 83-94.
181. *Id*. at 89.
182. *Id.* at 91 (quoting Weber v. Tillman, 913 P.2d 84, 96 (Kan. 1996)).
183. *See Weber*, 913 P.2d at 89 ("The rationale for enforcing a noncompetition covenant is based on the freedom of contract.").
184. *See id.* at 91-93 (failing to acknowledge the freedom of contract argument in the legitimate interest prong).
185. *See id.*

mate business interest prong of the *Weber* test; therefore, any covenant that does not protect a legitimate business interest, regardless of public policy concerns, cannot be enforced.[186] The Kansas Supreme Court in *Idbeis* erred in reaching its ultimate conclusion regarding freedom of contract when it ruled that WSS had a protectable interest in its physicians' referral relationships.[187]

D. *The Future of Referral Source Litigation*

Unlike non-surgeon contract disputes in which courts enforce covenants not to compete, enforcing such contracts against surgeons who solicit their own referral sources is unpalatable.[188] Despite this problem, covenants not to compete have become more prevalent in physician employment contracts.[189] With the use of non-competition agreements on the rise, surgical non-compete litigation will increase. But these agreements seem especially inappropriate in surgeon employment contracts because the surgical setting lacks the "evils" that covenants not to compete were created to remedy.

First, in the surgical employment context, employers rarely provide specialized training to their surgeons.[190] Rather, surgeons begin employment with groups fully ready to perform surgery.[191] Therefore, surgeons cannot misappropriate training that they did not receive. Second, many surgical groups do not possess trade secrets to share with their surgeons.[192] Third, with such limited patient contact in the surgical setting,[193] no real threat exists that surgeons will take their patients with them when departing. Because surgeons generate busi-

186. *See id.* (explaining that a covenant must protect a legitimate business interest).

187. *See Idbeis*, 112 P.3d at 91.

188. *Compare* E. Distrib. Co. v. Flynn, 567 P.2d 1371, 1373 (Kan. 1977) (noting that a liquor distribution salesman continued to service the customers that the covenantee provided after the salesman's employment ended), *with* Cmty. Hosp. Group, Inc. v. More, 838 A.2d 472, 477 (N.J. Super. Ct. App. Div. 2003) (noting that the physician secured his own referral sources).

189. *See* Anita J. Slomski, *Don't Let a Restrictive Covenant Send You to Siberia*, MED. ECON., Mar. 9, 1998, at 84.

190. *See, e.g.*, Hoddeson v. Conroe Ear, Nose & Throat Assocs., P.A., 751 S.W.2d 289, 290 (Tex. App. 1988) ("[The medical employer] did not impart . . . specialized training . . . to [its employees].").

191. *See, e.g.*, Lewis v. Surgery & Gynecology, Inc., No. 90AP-300, 1991 WL 35010, at *4-5 (Ohio Ct. App. Mar. 12, 1991) (noting that a restrictive covenant was not enforceable because the surgeon was well trained when he began employment with the corporation); Darrow v. Kolczun, No. 90CA004759, 1991 WL 35120, at *2 (Ohio Ct. App. Mar. 6, 1991) ("[The surgeon] gained the great bulk of his skill in the profession from his education, . . . rather than through his affiliation with the corporation.").

192. *See, e.g.*, *Hoddeson*, 751 S.W.2d at 290 ("[The medical employer] did not impart trade secrets . . . to [its employees].").

193. *See, e.g.*, Graham v. Cirocco, 69 P.3d 194, 199 (Kan. Ct. App. 2003) ("[A] patient's relationship with a . . . surgeon of almost any stripe . . . is likely to be more short-term."); Wausau Med. Ctr. v. Asplund, 514 N.W.2d 34, 41 (Wis. Ct. App. 1994); Fields Found., Ltd. v. Christensen, 309 N.W.2d 125, 130 (Wis. Ct. App. 1981) (noting that the surgeon only had "short[,] . . . one-time contacts with [his] patients").

ness primarily from receiving new patients, referral sources will be the most hotly litigated issue in surgical non-compete cases.[194]

Unless the Kansas legislature follows the well-reasoned lead of other states that prevent the enforcement of covenants not to compete in surgeon employment contracts, the decision in *Idbeis* will adversely affect Kansas surgeons.[195] Additionally, the decision could further encourage surgical groups to use non-compete clauses in conjunction with competitive, skill-based referral structures, ultimately hindering the healthcare market by limiting patient access.[196] Medical employers already possess substantial bargaining power when negotiating employment contracts with surgeons who are new to a surgical market.[197]

The court's decision in *Idbeis* may increase employers' leverage by reinforcing the notion that covenants not to compete will *always* be enforceable. Groups not currently employing a competitive, skill-based structure may be forced to implement such a scheme to stay competitive in retaining referral sources. Groups using covenants not to compete will restrain outside competition because surgeons will be prevented from competing against their employers,[198] causing the healthcare market to suffer.[199] Fewer surgical options for referring physicians and patients will likely lead to an increase in the cost of medical care.[200] Because the cost of medical care in Kansas continues to rise,[201] courts should not enforce any unreasonable restraint on trade. Unfortunately, the Kansas Supreme Court in *Idbeis* enforced such a restraint.[202]

194. *See, e.g.*, Idbeis v. Wichita Surgical Specialists, P.A., 112 P.3d 81, 86 (Kan. 2005) ("[A] cardiovascular surgeon's business is almost totally dependent upon referrals . . . .").

195. *See supra* note 51 and accompanying text.

196. *See, e.g.*, Murfreesboro Med. Clinic, P.A. v. Udom, 166 S.W.3d 674, 679 (Tenn. 2005) ("Having a greater number of physicians practicing in a community . . . provid[es] greater access to health care.").

197. *See* Loeser, *supra* note 4, at 289 ("In such markets, physicians may feel that they have no choice but to agree to the contractual terms proposed by employers."). Because it is often extremely difficult to begin working in a certain surgical market without joining an established medical group, medical employers arguably have an unequal degree of bargaining power while negotiating employment contracts. Brief of Appellants at 32, *Idbeis*, 112 P.3d 81 (No. 03-91442-A).

198. *See, e.g.*, Valley Med. Specialists v. Farber, 982 P.2d 1277, 1281 (Ariz. 1999). However, covenants not to compete that protect a referral source based on a medical group's goodwill should be enforced.

199. *See, e.g.*, *Udom*, 166 S.W.3d at 679 ("Increased competition for patients tends to improve quality of care and keeps costs affordable.").

200. *See* Berg, *supra* note 2, at 10-11 n.47 ("Increased competition among health care providers would decrease overall costs, increase the information physicians convey to patients, and reduce unnecessary procedures.") (citing James F. Blumstein & Frank A. Sloan, *Redefining the Government's Role in Healthcare: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981)).

201. Press Release, Kan. Office of the Governor, Sebelius Administration Takes More Steps for Affordable Health Care (Dec. 15, 2004), *available at* http://www.ksgovernor.org/news/docs/news_rel121504a.html.

202. *See Idbeis*, 112 P.3d at 94.

Of course, an alternative to this dismal, litigious future is for medical employers to stop requiring surgical non-competition agreements.[203] Some commentators suggest that physicians who are not required to sign non-compete agreements are happier and more effective employees.[204] As Eugene Ogrod, chief medical officer of a Sacramento-based Sutter Medical Group, noted, "[t]he worst thing in the world you can do to your business is to have unhappy physicians who don't leave because they are constrained . . . . The irony is, by eliminating restrictive covenants, you will create a warm-and-fuzzy environment that holds doctors faster, easier, and with a greater degree of satisfaction."[205]

VI. Conclusion

The Kansas Supreme Court incorrectly held that all referral sources are legitimate business interests subject to protection by covenants not to compete. The court's holding was overly broad because it did not recognize that the dynamics of a surgical group's referral structure determines the legitimacy of referral relationships as a business interest. If a group's referral scheme capitalizes on the skills and reputations of its surgeons, then referral relationships cannot be a legitimate business interest. Conversely, if a referral structure capitalizes on the goodwill of the group, then the group has a protectable interest in its referral relationships.

The court in *Idbeis* rendered an illogical decision because the group's referral structure marketed its surgeons' skills, not its own goodwill. The group did not have a legitimate business interest subject to protection in the surgeons' referral relationships. Because of the increased need for surgeons in Kansas, cases factually similar to *Idbeis* will likely arise. In the future, non-competition agreements and the injustice that arises from their enforcement will become more prevalent. Future litigation will ensue unless the Kansas legislature takes steps to render covenants not to compete in surgeon employment contracts unenforceable. Litigation may also be avoided if groups discontinue using such agreements. Although these precautions may be unsavory medicine for groups, they will cure the surgical market from the non-compete disease and alleviate its resulting symptoms of injustice and inefficiency.

203. In an effort to make their physicians feel less constrained, medical groups frequently experience positive results after they cease using covenants not to compete. *See* Slomski, *supra* note 189, at 94.
204. *See id.*
205. *Id.*