General

The Impact of a Non-Compete Clause on Patient Care and Orthopaedic Surgeons in the State of Louisiana: Afraid of a Little Competition?

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Background

Non-compete clauses (NCC) are commonly required for physicians practicing in an employed model. With growing pressures driving surgeons to practice in an employed model instead of physician-led practices, the purpose of this survey was to determine the impact of NCCs on orthopaedic surgeons and their patients in Louisiana.

Methods

A voluntary, single-mode online survey containing 23 questions was created using the Qualtrics XM Platform (Qualtrics, Provo, UT) and distributed to 259 orthopaedic surgeons who are members of the Louisiana Orthopaedic Association. Survey questions assessed the prevalence and details of existing NCCs and perceptions of their impact on surgeons' practice, patients, and personal life.

Results

117 members responded (response rate: 45.2%), of which 91 (77.8%) finished the survey. Nearly half (44%) of respondents had an expired or active NCC in their contract. Most (84.3%) believed NCCs give employers unfair leverage during contract negotiations. NCCs have deterred or would deter 71.4% of respondents from accepting another job offer. Respondents believed NCCs 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%). Many respondents reported NCCs also exert significant detrimental effects on their personal life, including mandatory relocation of their family (67.0%). Nearly all (97.8%) believed such clauses have become unreasonable over the last decade with the rise of large hospital conglomerates. Most surgeons (83.7%) believed that removal of NCCs from all orthopaedic surgeons' contracts would improve the overall healthcare of orthopaedic patients in Louisiana.

Conclusion

Perceptions of NCCs were overwhelmingly negative among orthopaedic surgeons in Louisiana. Such clauses give employers an unfair advantage during contract negotiations and exert a significant detrimental impact on surgeons and their patients. While NCCs may be reasonable in the business sector and other professions, it is unclear how such clauses benefit surgeons or improve patient care and may be detrimental to both.

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Study Design

Cross-sectional Survey

INTRODUCTION

Restrictive covenants, also known as non-compete clauses (NCC), have been a highly contested contractual agreement of the employed physician model, and the changing landscape of healthcare continues to bring this to the forefront.[1,2] Physician employment by large groups, hospitals, and hospital systems has grown such that up to 36.2% of specialty surgeons in 2020 were currently employed or worked in employed models compared to 25.1% in 2012 according to the American Medical Association.[3–5] Increased hospital employment of physicians may increase inappropriate referrals, unnecessary imaging, and hospital-physician integration potentially resulting in low-value patient care.[6]

Hospital employed models rise at the expense of private practices due to myriad reasons including disproportionate reimbursements via insurers, hospital-owned primary care driving referrals, and lack of governmental funding to private groups.[7–9] Analysis of the 2005 to 2014 trend of outpatient isolated arthroscopic partial meniscectomy charges by LaPrade et al. revealed hospital reimbursement increased steadily by 28.8% while surgeon payments declined by 15.5% over the same time period indicating a widening gap between hospital and surgeon reimbursement.[10,11] Additionally, in a 2021 study, Jeurissen et al. determined the growth of for-profit hospitals was largely due to subsidy access and favorable reimbursement plans from public health care payors, which aided the creation and expansion of new for-profit hospitals.[12] As the increased trend of independent orthopaedic practice acquisition by large healthcare entities in the U.S. continues, NCCs will become an even greater issue for both surgeons and their patients.[8]

NCCs in business were initially established to prevent turnover, and in many cases, to prevent an employee who received training regarding a specific technology from competing with the former employer.[13,14] In medicine, the services provided by the surgeon are learned and acquired prior to employment; the employer is not providing proprietary trade secrets, knowledge, or skills that would protect the employer from unfair competition. Instead, the purpose of the NCC is largely to deter a physician from leaving an employer by not allowing them to continue to practice in the same community, which can give an unfair leverage to employers/large hospital systems.[15,16]

With growing pressures driving surgeons into employed models instead of physician-led practices, the purpose of this survey was to determine the impact of NCCs on orthopaedic surgeons and their patients in a state where the law allows employers to place this restriction on their physicians.

MATERIALS AND METHODS

After obtaining exemption from our institution's Institutional Review Board (IRB#2021-1034), a link to an anonymous online survey was distributed via email to 259 board-eligible or board-certified orthopaedic surgeons who are current members of the Louisiana Orthopaedic Association (LOA). The total collection period for the survey data was from November 21, 2021 to February 12, 2022. Four follow-up emails were sent to non-respondents at three weeks, six weeks, nine weeks, and eleven weeks after initial communication in order to boost participation and maximize the response rate.

A voluntary, single-mode (online) survey containing 23 questions (**Appendix 1**) was created and distributed using Qualtrics XM Platform (Qualtrics, Provo, UT, USA). Objective questions asked about the prevalence of NCCs in surgeons' contracts (expired or active clause versus no such clause at any time), details of existing NCCs (e.g., duration and regional coverage), surgeons' status as a president or senior partner of a group, and requirements for NCCs for new employees. Subjective questions asked about rationales for NCCs and perceptions of their impact on surgeons (personally and professionally), patients, and practices. One of these questions included an optional text response component for respondents to elaborate on their answer. Six questions were in a multiple response format in which more than one option could be chosen by respondents. Therefore, percentages may not total 100% for those questions. Demographic data including years in practice, orthopaedic subspecialty, practice type, and practice area (i.e., rural or urban and population size) were also collected. Respondents who did not finish the survey were excluded from the analysis.

STATISTICAL ANALYSIS

Statistical analyses on deidentified survey data were performed using Microsoft Excel (Microsoft Corporation, Redmond, WA, USA) with the XLStat statistical package add-on (Addinsoft Inc., New York, NY, USA) with an α level set to 0.05. A survey sample power analysis with a finite population correction determined that 155 respondents were needed to achieve a 95% confidence interval (CI) with a 5% sampling error for the results. Univariate analyses were performed to compare survey responses for (A) surgeons with versus without a NCC in their contract, (B) surgeons in private practice versus other practice types, and (C) presidents/senior partners of groups versus junior partners/employees. Proportions of responses were compared with a chi-square test with Yate's continuity correction or Fischer's exact test when a count for a response was less than 5.

Table 1. Demographic data of survey respondents stratified by the presence or absence of an expired or active non-compete clause (NCC) in respondents' contracts.

Demographic Parameter	All Respondents (n = 91)	NCC (n = 40)	No NCC (n = 51)	p-value
Years in Practice, n (%)				
< 5 years	13 (14.3)	9 (22.5)	4 (7.8)	0.069
5—10 years	16 (17.6)	7 (17.5)	9 (17.6)	0.796
10—15 years	29 (31.9)	12 (33.0)	17 (33.3)	0.911
> 15 years	33 (36.3)	12 (33.0)	21 (41.2)	0.378
Subspecialty, n (%)				
Foot / Ankle	8 (8.8)	1 (2.5)	7 (13.7)	0.074
General Orthopaedics	16 (17.6)	7 (17.5)	9 (17.6)	0.796
Hand	9 (9.9)	5 (12.5)	4 (7.8)	0.499
Oncology	1 (1.1)	0 (0.0)	1 (2.0)	1
Other	3 (3.3)	1 (2.5)	2 (3.9)	1
Pediatrics	4 (4.4)	2 (5.0)	2 (3.9)	1
Shoulder / Elbow	7 (7.7)	3 (7.5)	4 (7.8)	1
Spine	4 (4.4)	1 (2.5)	3 (5.9)	0.628
Sports Medicine	19 (20.9)	12 (30.0)	7 (13.7)	0.102
Trauma	6 (6.6)	2 (5.0)	4 (7.8)	0.691
Total Joints	14 (15.4)	5 (12.5)	9 (17.6)	0.702
Practice Type, n (%)[1]				
Private Practice	56 (61.5)	17 (42.5)	39 (76.5)	**0.002**
Academics	17 (18.9)	6 (15.0)	11 (21.6)	0.598
Hospital-Based Practice	26 (28.6)	20 (50.0)	6 (11.8)	**< 0.001**
Veterans Affairs Center	2 (2.2)	0 (0.0)	2 (3.9)	1
State Employee	1 (1.1)	0 (0.0)	1 (2.0)	1
Not Specified	1 (1.1)	1 (2.5)	0 (0.0)	0.440
President / Senior Partner, n (%)	36 (39.6)	11 (27.5)	25 (49.0)	**0.037**
Practice Area, n (%)				
Rural, < 10k population size	2 (2.2)	1 (2.5)	1 (2.0)	1
Rural, 10k—50k population size	15 (16.5)	9 (22.5)	6 (11.8)	0.278
Urban, > 50k population size	74 (81.3)	30 (75.0)	44 (86.3)	0.272

[1]Respondents were instructed to select all applicable practice types; because 9 (9.9%) respondents reported practicing in multiple practice types, the percentages do not add up to 100%. Bolded p-values indicate statistically significant results.

RESULTS

RESPONDENT DEMOGRAPHICS

The survey was distributed to 259 orthopaedic surgeons who are active members of the LOA, of which 117 responded (response rate: 45.2%). Most respondents (n = 91, 77.8%) finished the survey (**Table 1**). With only 91 respondents, the study was underpowered to achieve a 95% CI with a 5% margin of error. Post-hoc calculations showed that the analysis was adequately powered to achieve a 95% CI with a 9% margin of error.

As determined by a multiple response set, most LOA members worked in a private group (n = 56, 61.5%) or in a hospital-based practice (n = 26, 28.6%). A substantial proportion of respondents were president or senior partners of a group (n = 36, 39.6%). Most respondents practiced in an urban area with a population density > 50,000 people (81.3%) and had been in practice for at least 10 years (68.2%). The most common subspecialties represented were sports medicine (20.9%), general orthopaedics (17.6%), and total joints (15.4%).

A slight majority (56.0%) of the 91 LOA members who completed the survey never had a NCC in their contract. As determined by a multiple response set, significantly more respondents without a NCC work in private practices (76.5% vs. 42.5%, p = 0.002) while significantly more respondents with a NCC work in hospital-based practices (50.0% vs. 11.8%, p < 0.001). Additionally, significantly more surgeons without a NCC are president or senior partner of their group (49.0% vs. 27.5%, p = 0.037).

Table 2. Details of expired or active non-compete clauses among LOA members.

Question / Answers	n (%)
Does your non-compete clause expire after a certain time of employment?)[1]	n = 35
Yes, after 1 year	4 (11.4)
Yes, after 2 years	17 (48.6)
Yes, after 3 year	1 (2.9)
Yes, after 4 year	0 (0.0)
Yes, after 5 year	1 (2.9)
It does not expire	12 (34.3)
How widespread was/is your non-compete clause?[1,2]	n = 35
It covers my city	10 (28.6)
It covers my region / zip code	24 (68.6)
It covers my state	3 (8.6)
It covers an area with any facility owned or operated by my employer / group	9 (25.7)
Did your non-compete clause change after your employer began expanding locations?	n = 40
Yes	9 (22.5)
No	24 (60.0)
N/A	7 (17.5)
Do you require non-compete clauses for your newly employed surgeons/junior partners?[3]	n = 36
Yes	9 (25.0)
No	21 (58.3)
N/A	6 (16.7)
Why do you primarily require non-compete clauses?[2,4]	n = 9
Reduce competition	1 (11.1)
Invested time/effort to employ partners	7 (77.8)
Deter partners from starting their own practice	3 (33.3)
Create a goodwill between practice and partners	2 (22.2)
Other (Paraphrased free text: "They are required at my practice but I am against them")	1 (11.1)

[1]Question not answered by 5 respondents with a non-compete clause. [2]Respondents were instructed to select all applicable responses; because some respondents selected multiple answers, the percentages do not add up to 100%. [3]Question answered by current presidents / senior partners of groups. [4]Question answered by current presidents / senior partners of groups who require non-compete clauses for all newly hired surgeons.

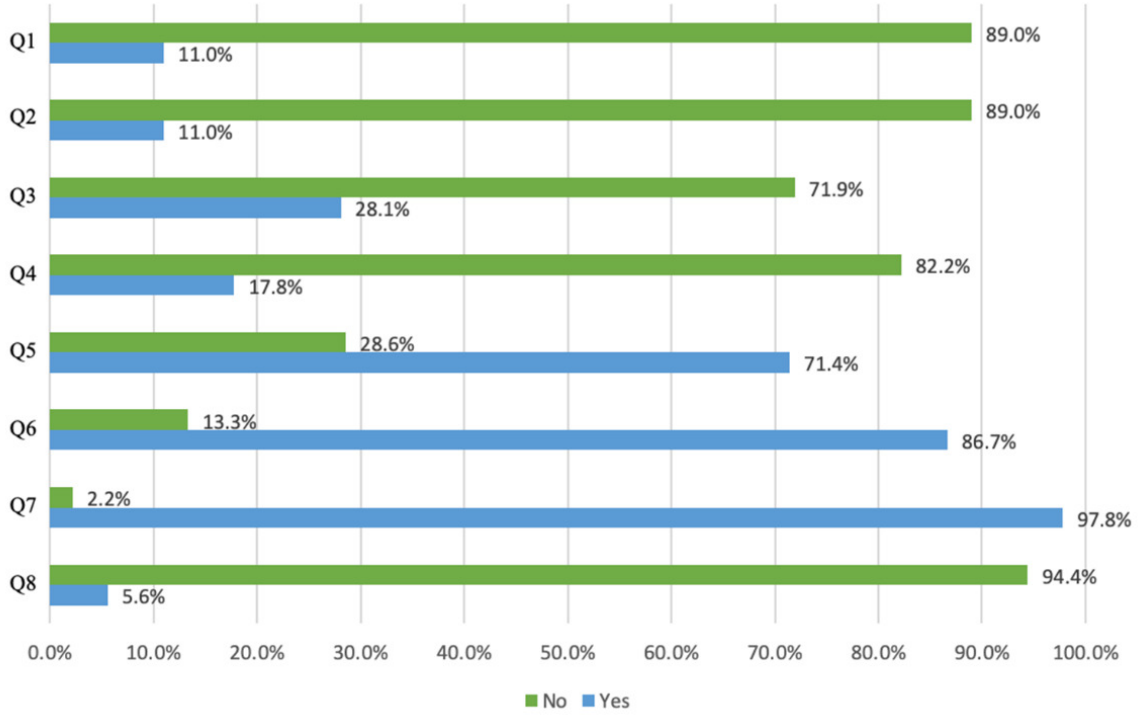
DETAILS OF NON-COMPETE CLAUSES

Many (48.6%) respondents with a NCC in their contract reported that their clause had or would expire after two years of employment (**Table 2**). As determined by a multiple response set, 68.6% (24/35) of respondents' NCCs cover their region / zip code. The terms of NCCs changed for 9 (22.5%) surgeons when their employer began expanding locations, while the clause did not change for 24 (60.0 %) surgeons. Among the 36 presidents or senior partners of a group, 21 (58.3%) do not require NCCs for newly hired surgeons. The 9 (25.0%) presidents or senior partners of groups who do mandate NCCs for all new hires most commonly cited the investment of time and effort it takes to employ partners (77.8%) as the reason for this requirement.

PERCEPTIONS OF NON-COMPETE CLAUSES

Perceptions of NCCs among LOA members were overwhelmingly negative: 86.7% of respondents supported removing NCCs from all orthopedic surgeons' contracts and 97.8% believed that such clauses have become increasingly unreasonable over the last decade with the rise of hospital conglomerates (**Figure 1**). Notably, a moderate proportion (17.8%) of LOA members would leave their current job if their contract did not have a NCC, and a majority (71.4%) reported that NCCs have previously deterred them from accepting another job offer or would do so in the future. Nearly all respondents (94.4%) believed that insertion of NCCs during annual contract renewals should not be allowed.

Perceptions and attitudes towards NCCs varied between different LOA member demographics (**Table 3**). Notably, 40% of LOA members with a NCC would leave their current job if there was no NCC, while 0% of respondents without a NCC expressed desire to seek new employment ($p < 0.001$). A significantly larger percentage of current presidents or senior partners of groups believed that NCCs are important for private groups to be able to recruit new surgeons (19.4% vs. 5.5%, $p = 0.046$) while significantly more junior partners



Q1) Do you feel a non-compete is important for a private group to have to be able to recruit new surgeons?
Q2) Do you feel a non-compete is important for a hospital group to have to be able to recruit new surgeons?
Q3) Did you feel that a contract that includes a non-compete clause was necessary to practice in your area?
Q4) Would you leave your current job if you did not have a non-compete?
Q5) Has a non-compete deterred you or would it deter you from accepting a job offer?
Q6) Do you feel non-compete clauses should be removed from all orthopaedic surgeon contracts?
Q7) Do you feel that non-competes have changes over the past decade as hospitals have become conglomerates and now extend their presence to many outlying communities such that they have become unreasonable?
Q8) With contracts being renewed on a yearly basis at several practices/institutions/hospitals, should a non-compete be allowed to be inserted during a yearly contract renewal to a practicing surgeon who is currently employed by a practice/institution/hospital?

Figure 1. Perceptions of non-compete clauses among all survey respondents.

or employees supported removing NCCs from all orthopaedic surgeons' contracts (92.7% vs. 77.1%, p = 0.034).

IMPACT OF NON-COMPETE CLAUSES ON SURGEONS AND PATIENTS

Perceptions regarding the impact of NCCs on orthopaedic surgeons and patients were overwhelmingly negative (**Figure 2**). Most respondents (84.3%) believed that NCCs give employers unfair leverage during contract renegotiations and a substantial proportion believed that such clauses force surgeons to abandon their patients (76.7%). Additionally, 83.7% of surgeons felt that removal of all NCCs would improve the overall healthcare of orthopaedic patients in Louisiana (**Table 4**).

NCCs also exert several negative effects on respondents' personal lives. A majority of surgeons believed that such clauses would prevent maintenance of their current practice in their desired city (67%), forcing surgeons to relocate their family (67%). More than half of respondents (60.4%) would be unhappy in their current job if their contract included a NCC but would be unable to relocate due to personal reasons. Many surgeons reported that they would resent their partners (47.3%) or hospital (58.2%) for including a NCC in their contract.

Several notable differences were found regarding the impact of NCCs on surgeons and patients between different LOA member demographics (**Tables 5—7**). In terms of personal impact, significantly more surgeons with a NCC reported that they have had or would have to relocate their family due to the clause (80.0% vs. 56.9%, p = 0.035). Additionally, significantly more non-private practice surgeons felt they would have to relocate their family due to a NCC (84.9% vs. 58.9%, p = 0.021). As compared to current presidents or senior partners of groups, significantly more junior partners or employees believed that NCCs give employers unfair leverage during contract renegotiations (94.4% vs. 68.6%, p = 0.002). Conversely, a significantly higher percentage of current presidents or senior partners believed that NCCs have no impact on future contract renegotiations (20.0% vs. 3.7%, p = 0.026).

DISCUSSION

NCCs have been utilized in several health care fields such as counseling, social work, and medicine; enacting such

Table 3. Perceptions of NCCs for respondents with vs. without a NCC, private practice vs. other practice type, and president/senior partners vs. junior partners/employees.

	NCC (n = 40)	No NCC (n = 51)	p-value	Private Practice (n = 56)	Other Practice Types (n = 34)	p-value	President or Senior Partner (n = 36)	Junior Partner or Employee (n = 55)	p-value
Do you feel a non-compete is important for a private group to have to be able to recruit new surgeons? n (%)									
Yes	5 (12.5)	5 (9.8)	0.944	7 (12.5)	3 (8.8)	0.737	7 (19.4)	3 (5.5)	**0.046**
No	35 (87.5)	46 (90.2)		49 (87.5)	31 (91.2)		29 (80.6)	52 (94.5)	
Do you feel a non-compete is important for a hospital group to have to be able to recruit new surgeons? n (%)									
Yes	4 (10.0)	6 (11.7)	1	9 (16.1)	1 (2.9)	0.083	6 (16.7)	4 (7.3)	0.185
No	36 (90.0)	45 (88.3)		47 (83.9)	33 (97.1)		30 (83.3)	51 (92.7)	
Did you feel that a contract that includes a non-compete clause was necessary to practice in your area? n (%)									
Yes	19 (47.5)	7 (14.3)*	**0.001**	11 (20.4)*	14 (41.2)	**0.035**	10 (29.4)*	16 (29.1)	0.836
No	21 (52.5)	42 (85.7)		43 (79.6)	20 (58.8)		24 (70.6)	39 (70.9)	
Would you leave your current job if you did not have a non-compete? n (%)									
Yes	16 (40.0)	0 (0.0)*	**< 0.001**	6 (10.7)	9 (27.3)	0.085	4 (11.1)	12 (22.2)*	0.261
No	24 (60.0)	50 (100.0)		50 (89.3)	24 (72.7)		32 (88.9)	42 (77.8)	
Has a non-compete deterred you or would it deter you from accepting a job offer? n (%)									
Yes	31 (77.5)	34 (66.7)	0.367	37 (66.1)	27 (79.4)	0.265	25 (69.4)	40 (72.7)	0.919
No	9 (22.5)	17 (33.3)		19 (33.9)	7 (20.6)		11 (30.6)	15 (27.3)	
Do you feel non-compete clauses should be removed from all orthopaedic surgeon contracts? n (%)									
Yes	36 (90.0)	42 (84.0)*	0.537	44 (80.0)*	33 (97.1)	**0.026**	27 (77.1) *≈	51 (92.7)	**0.034**
No	4 (10.0)	8 (16.0)		11 (20.0)	1 (2.9)		8 (22.9)	4 (7.3)	
Do you feel that non-competes have changes over the past decade as hospitals have become conglomerates and now extend their presence to many outlying communities such that they have become unreasonable? n (%)									
Yes	39 (97.5)	50 (98.0)	1	55 (98.2)	33 (97.1)	1	35 (97.2)	54 (98.2)	1
No	1 (2.5)	1 (2.0)		1 (1.8)	1 (2.9)		1 (2.8)	1 (1.8)	
With contracts being renewed on a yearly basis at several practices/institutions/hospitals, should a non-compete be allowed to be inserted during a yearly contract renewal to a practicing surgeon who is currently employed? n (%)									
Yes	4 (10.0)	1 (2.0)	0.165	3 (5.5)*	2 (5.9)	1	3 (8.6)*	2 (3.7)*	0.378
No	36 (90.0)	50 (98.0)		52 (94.5)	32 (94.1)		32 (91.4)	52 (96.3)	

*Throughout the table, there are instances in which a few respondents did not provide an answer to the given question. In such cases, the percentages reported were calculated out of the total number of respondents from the cohort that answered the question. Bolded p-values indicate statistically significant results.

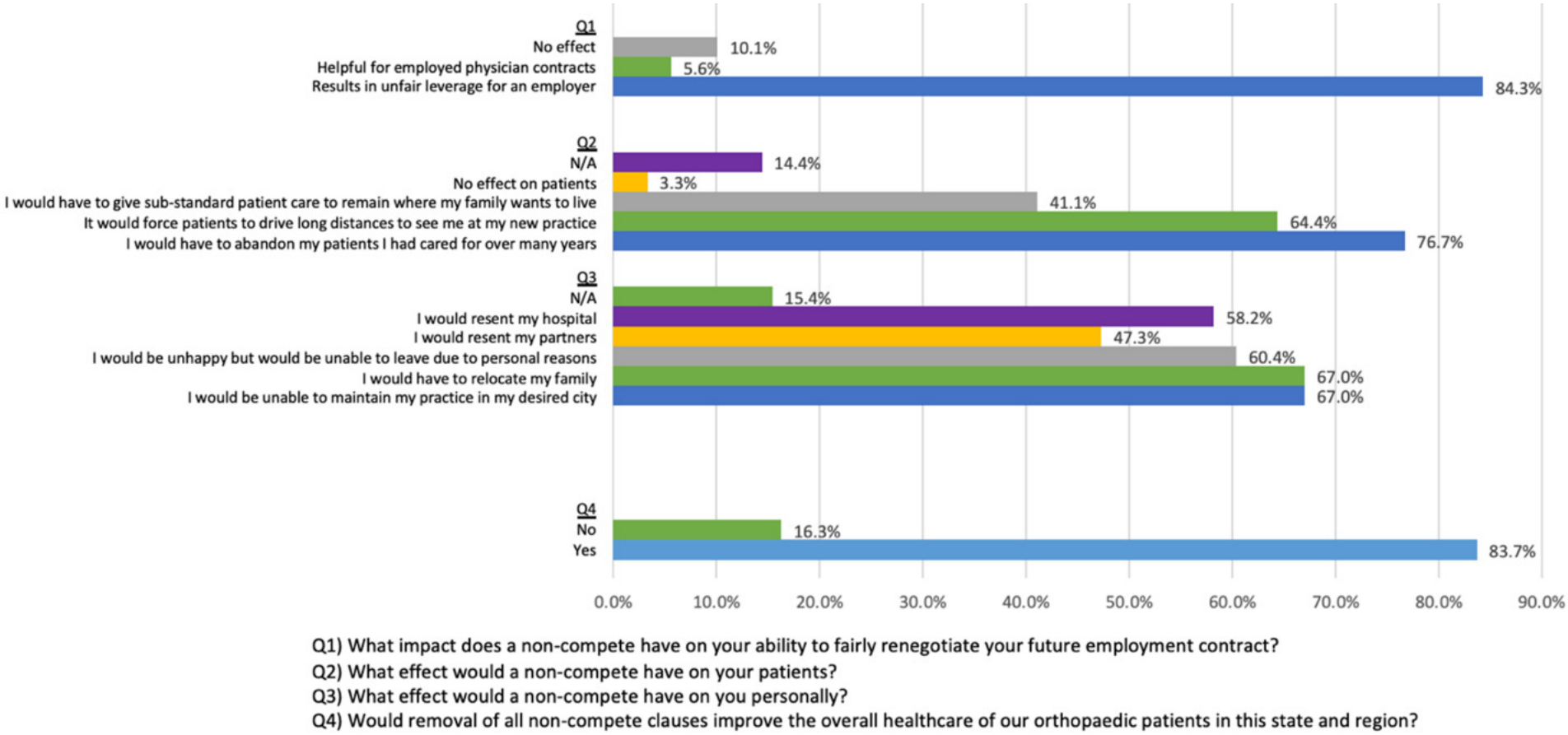


Figure 2. Perceived impact of non-compete clauses on surgeons and patients among all LOA members who completed the survey.

covenants can cause harmful disruption of the patient-physician relationship, which is the foundation of clinical care.[13] Physicians are integrally involved in the community. In the event of termination of a contract with a NCC, or if a position of employment becomes untenable, the surgeon-patient relationship is unnecessarily ended when a surgeon could otherwise continue to provide care in the same community.[15] Surgeons are often chosen by their patients after much research, and long-term care follows through the development of trust in the surgeon over time. Chapon et al. reported clarity of information and a surgeon's reputation are the most important factors influencing patients' surgeon selection, confirming that patients are motivated to choose their surgeon based on the core value of the fiduciary relationship.[17] Patients who are awaiting a surgical procedure or are in the post-operative phase are particularly vulnerable to a surgeon's departure. Compared to surgeons with no restrictive covenants, our survey demonstrated a significant majority (60%) of respondents with NCCs had concerns about providing sub-standard care due to their NCC preventing them from leaving their current job and remaining in the area where their family lives.

Currently, the state of Louisiana is ranked 46th in overall healthcare according to U.S. News & World Report.[18] This low ranking illustrates ample opportunity for improvement. However, restrictive covenants may impede recruitment of some of the brightest and best trained surgeons to practice in Louisiana. This notion was supported by our survey in which 71.4% of surgeons believed that a NCC had previously or would deter them from accepting a new job, with most respondents being subspecialized (82.4%) and having at least 10 years of practice experience (68.2%). As a result of NCCs being legal and relatively common in Louisiana, skilled surgeons with options may choose to practice in states with less contractual restrictions. For example, California, North Dakota, and Oklahoma have enacted statutes declaring non-competition agreements void, while Colorado, Massachusetts, and Delaware have passed statutes that severely limit the enforceability of NCCs.[19] Such measures grant significantly greater professional and personal autonomy and may entice talented physicians to relocate to these areas for practice. Notably, almost all non-private practice surgeons (96.9%) in this survey believed the overall healthcare of patients in Louisiana would improve by removing NCCs from the contracts of all orthopaedic surgeons. This result illustrates that NCCs exert a detrimental impact not only on surgeons in our state, but also their patients.

On April 2nd, 2021, House Bill 483 entitled "Prohibition of Noncompete Contract Clauses" was introduced by a state representative to the Louisiana State Legislature.[20] Although the proposed bill initially encompassed the same provisions for all physicians, new modifications in the engrossed bill and now re-engrossed bill will limit the scope of non-compete agreements for only certain types of physicians. Under the proposed law, NCCs will be prohibited for all primary care physicians in the state of Louisiana, while only being prohibited for physician specialists including orthopaedic surgeons who are not state employees and have worked for an employer for at least three years.[21–23] Although a reasonable buyout clause can be utilized in contracts with physician specialists, specific criteria remain. Egregiously, only non-state employed physician specialists will still be prohibited from practicing within a restrictive geographic area for a maximum of two years.[23] After passing in the Louisiana House of Representatives on May 11, 2021, the bill was sent to the State Senate where it is currently awaiting review by the Committee on Commerce, Consumer Protection, and International Affairs.[20] In its current form, the revised bill has striking disparities in the contractual limitations of NCCs based on whether a physician provides primary care or specialty services. The underlying motives for these differences are unclear. Although all physicians have taken an ethical oath to treat their patients impartially, a critical question must be asked: why should physician specialists such as orthopaedic surgeons be treated differently under law? This discrepancy is likely due to a monetary influence by employers rather than a strategy for improving the general welfare of patients. In the event a community is underserved by specialists, which is a growing concern in communities around the country, this policy can work directly against the mission to improve access to specialty healthcare.[24–26]

On July 9, 2021, Executive Order 14036, "Promoting Competition in the American Economy," was signed by the President of the United States to curtail unfair anti-competitive practices including non-compete agreements used by companies that restrict the ability of workers to change jobs.[27] However, the long-term effects of this directive may be restricted and less impactful for physicians as physician contracts are subject to the strictures of state laws.[28] As NCCs are frequently regulated by states, each state not only has the ability to ban non-compete covenants, but also to determine the scope, parameters, and situation for which NCCs can be banned. For example, certain states including Washington, Oregon, Nevada, Illinois, Virginia, Maryland, Delaware, Rhode Island, Connecticut, Massachusetts, Maine, and New Hampshire only ban NCCs for low-wage/hourly workers. It must be noted that these restrictive covenants affect not only healthcare workers of all wages, including surgeons, but also patients. Another principal concern revealed in this survey was a significant and overwhelming majority of respondents working in practice types other than private practice believed that NCCs would force them to abandon their patients if they left their job (91.2%). Furthermore, as a consequence of NCCs, a majority of respondents (52.9%) believed they have previously or would hypothetically have to provide sub-standard patient care in order to remain in their desired city compared to their private practice counterparts.

According to a 2020 physician survey assessing the impact of COVID-19 on the U.S. healthcare system, 50% of physicians believed that hospitals will exert stronger influence over the organization and delivery of healthcare as a result of the pandemic.[29] Some of the lasting effects of the COVID-19 pandemic have already become apparent.[30] In a 2021 Physician Advocacy Institute report conducted by Avalere Health, the COVID-19 pandemic was noted to

Table 4. Optional free text response for improvement to healthcare question.

Would removal of all non-compete clauses improve the overall healthcare of our orthopaedic patients in this state and region?
Yes
• Now that insurance companies can be bought by systems, they control the patients. Controlling the surgeons means they cannot leave if the care is substandard. Non-compete clauses need to go away.
• Doctors and patients would then be free to choose what is best for themselves.
• Competition in a marketplace only results in improved care for patients.
• Jobs & situations change. With healthcare systems that now cover huge areas, being outside of those areas is not realistic.
• Possibly attract more good surgeons to the area.
• Let the patients decide where their care is best. Do not allow systems to make doctors choose between where they want to practice and succumb to whatever rules the hospital system decides for them.
• The practices would better assist the clinicians to live productive lives while having better control over their practices.
• Non-compete clauses strictly keep surgeons from building a patient base and only allow the employers/hospitals the ability to control surgeon salary and patients.
• There would be better access to care.
• Surgeons who remain in unhealthy orthopaedic groups/practices cannot emotionally or psychologically be their best versions.
• There is no reason to restrict access to a physician. If your group/facility is good enough, they should be able to tolerate any loss of patients or income if an individual physician should decide to leave. If they are not good enough, they should get out of the business.
• It would allow physicians greater ability to align and collaborate to create quality programs.
• Physicians should choose where to practice regardless of healthcare entity presence.
• Non-competes in contracts are leverage of a large corporation or entity against a single unit or person. They are completely and totally unfair.
• Patients should be allowed to go with their surgeons. Period.
• Non-competes drive competitive surgeons out of the New Orleans area and sometimes out of the state. This leaves our patients in the region with substandard care.
• Removal of non-competes would require employers to compete for my service and allow me to better negotiate for patient care needs that I'm currently being denied.
• Removal of non-competes would force hospitals to provide better support to physicians in order to balance the demands of patient care.
• Your employer or group would have to improve your treatment or practice to keep you.
• Patient-doctor relationships are the basis of medicine, not patient-hospital or patient-practice relationships.

accelerate the decade-long trend of healthcare consolidation: 48,400 additional physicians left private practice to become employees of hospitals or other corporate entities, with these large systems now owning more than half of all U.S. medical practices.[31] As consolidation continues, nearly all respondents of this survey (97.8%) believed that NCCs have become unreasonable over the last decade with the rise of hospital conglomerates. This finding highlights the stark contrast between the beneficial impact of NCCs on large employers and the significant detrimental effects on surgeons professionally and personally.

With the changing landscape of healthcare, restrictive covenants have become an archaic tool for large hospital systems to leverage their power and monopolize healthcare. By controlling the surgeons' ability to seek innovative technologies with which to treat patients in the same region or expand their own ability to provide a higher-level of patient care by accepting another job, aggressive utilization of stringent NCCs is directly limiting patients' access to specialty healthcare. Additionally, as few employees have the resources required for prolonged litigation, these individuals face the unfair choice of remaining with their current employer or outright leaving their community.[27] In this survey, 67.0% of surgeons believed that a NCC would disrupt their current state of practice in their desired city and force them to relocate their families. Furthermore, more than half of respondents (60.4%) expressed that they would be unhappy in their current job if their contract included a NCC, but would be unable to relocate due to personal reasons such as having children in school or family in the area. This finding highlights how employers further limit surgeons' autonomy through NCCs as physicians' personal lives may already restrict their ability to seek new employment. Thus, NCCs may be used as leverage both during the hiring process and contract re-negotiations. Our survey illustrates how the restriction of surgeons' personal auton-

Table 5. Perceived impact of NCCs on surgeons and patients for respondents with vs. without a NCC.

	NCC (n = 40)	No NCC (n = 51)	p-value
What impact does a non-compete have on your ability to fairly renegotiate your future employment contract? n (%)	n = 39	n = 50	
Results in unfair leverage for an employer	33 (84.6)	42 (84.0)	0.830
Helpful for employed physician contracts	5 (12.8)	0 (0.0)	**0.014**
No effect	1 (2.6)	8 (16.0)	0.072
What effect would a non-compete have on your patients? n (%)	n = 39	n = 50	
I would have to abandon patients I had cared for over many years leaving their care to someone who did not know them or their surgical history as well	32 (82.1)	37 (72.6)	0.421
My patients would have to drive a long distance to see me at my new practice after I left due to my non-compete clause	28 (71.8)	30 (58.8)	0.293
I would have to give sub-standard patient care because my non-compete prevents me from leaving my job and remaining in the area my family wishes to live	23 (60.0)	14 (27.5)	**0.005**
A non-compete would have no effect on my patients	2 (5.1)	1 (2.0)	0.577
N/A	0 (0.0)	13 (25.5)	**< 0.001**
What effect would a non-compete have on you personally? n (%)	n = 40	n = 51	
I would be unable to maintain my practice in my desired city	30 (75.0)	31 (60.8)	0.227
I would have to relocate my family due to a non-compete	32 (80.0)	29 (56.9)	**0.035**
I would be unhappy with my job but would be unable to leave due to a personal situation (kids in school, family in the region, etc.)	28 (70.0)	27 (52.9)	0.151
I would resent my partners for mandating a non-compete clause in my contract	20 (50.0)	23 (45.1)	0.800
I would resent my hospital for mandated a non-compete clause in my contract	27 (67.5)	26 (60.0)	0.170
N/A	2 (5.1)	12 (23.5)	**0.019**
Would removal of non-compete clauses improve overall healthcare of orthopaedic patients in Louisiana? n (%)	n = 37	n = 49	
Yes	33 (89.2)	39 (79.6)	0.377
No	4 (10.8)	10 (20.4)	

Bolded p-values indicate statistically significant results.

omy by NCCs occurs not only in the short-term, but persists and may increase with time.

LIMITATIONS

There are several limitations to this study. Of the 259 orthopaedic surgeons to whom the survey was distributed, only 117 (45.2%) surgeons responded and only 91 (35.1%) completed the survey in its entirety. Therefore, the views expressed by respondents in this study may not reflect those of the entire LOA membership nor all orthopaedic surgeons in Louisiana. The response rate may have been improved with a longer period of data collection; however, the duration of the study and follow-up emails were limited purposefully to decrease survey fatigue. It is also possible that response bias is present given that this study relied on subjective responses to survey questions and similar individuals may have answered certain questions differently. Additionally, the possibility for selection bias exists with the low response rate. Post-hoc calculations showed that, based on the response rate, the survey was adequately powered to detect significant differences with a 95% CI and a 9% margin of error. Though the survey was better powered to detect significant differences with a 90% CI and 7% error margin, which are acceptable parameters and commonly used in social sciences, an α of 0.05 was used to maximize the validity of the significant findings. An additional limitation is that the LOA membership may not have been entirely consistent during the survey distribution time such that members who initially received the survey may have left the society and new members may have joined during data collection. These numbers have been explored, however, and the impact of this limitation on the results is negligible.

CONCLUSION

NCCs were initially established in business to reduce turnover and prevent employees from being trained on proprietary technology at an employer and then leaving to work for a competitor. In medicine, however, physicians are trained prior to employment and there are no tangible improvements in clinical knowledge or skill conferred solely by working for a single employer. This survey demonstrated that perceptions of NCCs are overwhelmingly negative among orthopaedic surgeons in Louisiana. Such clauses give employers an unfair advantage during contract negotiations and exert a significant detrimental impact on surgeons and their patients. While NCCs may be reasonable in the business sector and other professions, it is unclear how

Table 6. Perceived impact of NCCs on surgeons and patients for surgeons in private practice vs. other practice types.

	Private Practice (n = 56)	Other Practice Types* (n = 34)	p-value
What impact does a non-compete have on your ability to fairly renegotiate your future employment contract? n (%)	n = 55	n = 34	
Results in unfair leverage for an employer	43 (78.2)	32 (94.1)	0.070
Helpful for employed physician contracts	5 (9.1)	0 (0.0)	0.152
No effect	7 (12.7)	2 (5.9)	0.473
What effect would a non-compete have on your patients? n (%)	n = 55	n = 34	
I would have to abandon patients I had cared for over many years leaving their care to someone who did not know them or their surgical history as well	38 (69.1)	31 (91.2)	**0.019**
My patients would have to drive a long distance to see me at my new practice after I left due to my non-compete clause	33 (60.0)	25 (75.5)	0.283
I would have to give sub-standard patient care because my non-compete prevents me from leaving my job and remaining in the area my family wishes to live	19 (34.6)	18 (52.9)	0.136
A non-compete would have no effect on my patients	2 (3.6)	1 (2.9)	1
N/A	12 (21.8)	1 (2.9)	**0.014**
What effect would a non-compete have on you personally? n (%)	n = 56	n = 33	
I would be unable to maintain my practice in my desired city	35 (62.5)	26 (78.8)	0.173
I would have to relocate my family due to a non-compete	33 (58.9)	28 (84.9)	**0.021**
I would be unhappy with my job but would be unable to leave due to a personal situation (kids in school, family in the region, etc.)	33 (58.9)	28 (84.9)	**0.021**
I would resent my partners for mandating a non-compete clause in my contract	29 (51.8)	14 (42.4)	0.526
I would resent my hospital for mandated a non-compete clause in my contract	30 (53.6)	23 (69.7)	0.203
N/A	11 (19.6)	3 (9.1)	0.238
Would removal of non-compete clauses improve overall healthcare of orthopaedic patients in Louisiana? n (%)	n = 53	n = 32	
Yes	40 (75.5)	31 (96.9)	**0.014**
No	13 (24.5)	1 (3.1)	

*Includes physicians working in an academic practice, hospital-based practice, VA center, and state employees. Bolded p-values indicate statistically significant results.

such clauses benefit surgeons or improve patient care and may be detrimental to both.

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AUTHOR CONTRIBUTIONS

W.S.: Study design, Writing manuscript, Final manuscript approval

A.P.: Literature review, Data collection, Writing manuscript, Editing manuscript

B.R.: Data analysis, Writing manuscript, Editing manuscript

O.L.: Study design, Editing manuscript, Final manuscript approval

C.W.: Survey distribution, Editing manuscript, Final manuscript approval

F.H.: Study design, Editing manuscript, Final manuscript approval

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Table 7. Perceived impact of NCCs on surgeons and patients for presidents / senior partners versus junior partners / employees.

	President / Senior Partner (n = 36)	Junior Partner / Employee (n = 55)	p-value
What impact does a non-compete have on your ability to fairly renegotiate your future employment contract? n (%)	n = 35	n = 54	
Results in unfair leverage for an employer	24 (68.6)	51 (94.4)	**0.002**
Helpful for employed physician contracts	4 (11.4)	1 (1.9)	0.076
No effect	7 (20.0)	2 (3.7)	**0.026**
What effect would a non-compete have on your patients? n (%)	n = 35	n = 55	
I would have to abandon patients I had cared for over many years leaving their care to someone who did not know them or their surgical history as well	26 (74.3)	43 (78.2)	0.865
My patients would have to drive a long distance to see me at my new practice after I left due to my non-compete clause	24 (68.6)	34 (61.8)	0.670
I would have to give sub-standard patient care because my non-compete prevents me from leaving my job and remaining in the area my family wishes to live	14 (40.0)	23 (41.8)	0.961
A non-compete would have no effect on my patients	0 (0.0)	3 (5.5)	0.279
N/A	7 (20.0)	6 (10.9)	0.374
What effect would a non-compete have on you personally? n (%)	n = 36	n = 55	
I would be unable to maintain my practice in my desired city	24 (66.7)	37 (67.3)	0.867
I would have to relocate my family due to a non-compete	24 (66.7)	37 (67.3)	0.867
I would be unhappy with my job but would be unable to leave due to a personal situation (kids in school, family in the region, etc.)	25 (69.4)	30 (54.6)	0.229
I would resent my partners for mandating a non-compete clause in my contract	16 (44.4)	27 (49.1)	0.826
I would resent my hospital for mandated a non-compete clause in my contract	20 (55.6)	33 (60.0)	0.839
N/A	4 (11.1)	10 (18.2)	0.554
Would removal of non-compete clauses improve overall healthcare of orthopaedic patients in Louisiana? n (%)	n = 35	n = 51	
Yes	27 (77.1)	45 (88.2)	0.284
No	8 (22.9)	6 (11.8)	

Bolded p-values indicate statistically significant results.

ADDITIONAL INFORMATION

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REFERENCES

1. Mezrich JL, Siegel EL. Noncompete clauses: a contract provision that has exhausted its usefulness? *J Am Coll Radiol*. 2014;11(2):145-152. doi:10.1016/j.jacr.2013.03.014

2. Huntoon K, Stacy J, Cioffi S, et al. The Enforceability of Noncompete Clauses in the Medical Profession: A Review by the Workforce Committee and the Medicolegal Committee of the Council of State Neurosurgical Societies. *Neurosurg*. 2020;87(6):1085-1090. doi:10.1093/neuros/nyaa426

3. Singleton T, Miller P. The Physician Employment Trend: What You Need to Know. *Fam Pract Manag*. 2015;22(4):11-15. Accessed March 5, 2022. https://pubmed.ncbi.nlm.nih.gov/26176503/

4. Kane CK. Policy Research Perspectives: Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020. Published May 2021. Accessed March 5, 2022. https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf

5. Kane CK, Emmons DW. New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment. Published 2013. Accessed March 5, 2022. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf

6. Young GJ, Zepeda ED, Flaherty S, Thai N. Hospital Employment Of Physicians In Massachusetts Is Associated With Inappropriate Diagnostic Imaging. *Health Aff (Millwood)*. 2021;40(5):710-718. doi:10.1377/hlthaff.2020.01183

7. McClelland WB, McCollam SM. Impact of the Current United States Health Care Environment on Practice: A Private Practice Viewpoint. *Hand Clin*. 2020;36(2):155-163. doi:10.1016/j.hcl.2020.01.015

8. Mikhail C, Shankar D, Taree A, et al. Trends in Private Equity Acquisition of Orthopaedic Surgery Practices in the United States. *J Am Acad Orthop Surg Glob Res Rev*. 2021;5(12):e21.00162-8. doi:10.5435/jaaosglobal-d-21-00162

9. Lundy DW. A Day at the Office: Is Private Practice Orthopaedic Surgery Dead? *Clin Orthop Relat Res*. 2016;474(11):2354-2356. doi:10.1007/s11999-016-5034-6

10. LaPrade MD, Camp CL, Krych AJ, Werner BC. Analysis of Charges and Payments for Outpatient Arthroscopic Meniscectomy From 2005 to 2014: Hospital Reimbursement Increased Steadily as Surgeon Payments Declined. *Orthop J Sport Med*. 2021;9(6):232596712110104. doi:10.1177/23259671211010482

11. Pollock JR, Richman EH, Estipona BI, et al. Inflation-Adjusted Medicare Reimbursement Has Decreased for Orthopaedic Sports Medicine Procedures: Analysis From 2000 to 2020. *Orthop J Sport Med*. 2022;10(2):232596712110737. doi:10.1177/23259671211073722

12. Jeurissen PPT, Kruse FM, Busse R, Himmelstein DU, Mossialos E, Woolhandler S. For-Profit Hospitals Have Thrived Because of Generous Public Reimbursement Schemes, Not Greater Efficiency: A Multi-Country Case Study. *Int J Health Serv*. 2021;51(1):67-89. doi:10.1177/0020731420966976

13. Brown KJ, Flora SR, Brown MK. Noncompete Clauses in Applied Behavior Analysis: A Prevalence and Practice Impact Survey. *Behav Anal Pract*. 2020;13(4):924-938. doi:10.1007/s40617-020-00469-0

14. Austin MG, Grosack M. What you should know about restrictive covenants in health care. *Healthc Financ Manage*. 2013;67(1):92-96. Accessed March 5, 2022. https://pubmed.ncbi.nlm.nih.gov/23360060/

15. Alderman AK, Bacon-Tinsley A. Understanding the Basics of Restrictive Covenants in Employment Agreements. *Plast Reconstr Surg*. 2021;147(4):680e-686e. doi:10.1097/prs.0000000000007787

16. Harris SM. Understanding non-compete employment clauses. Orthopedics Today. Published February 6, 2014. Accessed March 5, 2022. https://www.healio.com/news/orthopedics/20140206/10_3928_1081_597x_20140101_04_1332471

17. Chapon MP, Ghabi A, Choufani C, et al. How do patients choose their surgeon? Example of anterior cruciate ligament reconstruction. *Orthop Traumatol Surg Res*. 2021;108(3):103037. doi:10.1016/j.otsr.2021.103037

18. Louisiana Rankings and Facts. U.S. News & World Report. Published 2022. Accessed March 5, 2022. https://www.usnews.com/news/best-states/louisiana

19. Breitenbach RW. The basics of restrictive covenants. *J Am Coll Radiol*. 2006;3(10):733-734. doi:10.1016/j.jacr.2006.05.012

20. Wright M. Proposition of House Bill 483. Louisiana State Legislature 2021 Regular Session. Published April 21, 2021. Accessed March 5, 2022. https://www.legis.la.gov/legis/BillInfo.aspx?i=240437

21. Wright M. Original House Bill 483. Published April 2021. Accessed March 5, 2022. https://www.legis.la.gov/legis/ViewDocument.aspx?d=1211576

22. Wright M. Engrossed House Bill 483. Published April 2021. Accessed March 5, 2022. https://www.legis.la.gov/legis/ViewDocument.aspx?d=1220225

23. Wright M. Reengrossed House Bill 483. Published May 2021. Accessed March 5, 2022. https://www.legis.la.gov/legis/ViewDocument.aspx?d=1223413

24. Cyr ME, Etchin AG, Guthrie BJ, Benneyan JC. Access to specialty healthcare in urban versus rural US populations: a systematic literature review. *BMC Health Serv Res*. 2019;19(1):974. doi:10.1186/s12913-019-4815-5

25. Khubchandani JA, Shen C, Ayturk D, Kiefe CI, Santry HP. Disparities in access to emergency general surgery care in the United States. *Surgery*. 2018;163(2):243-250. doi:10.1016/j.surg.2017.07.026

26. Resad Ferati S, Parisien RL, Joslin P, Knapp B, Li X, Curry EJ. Socioeconomic Status Impacts Access to Orthopaedic Specialty Care. *JBJS Rev*. 2022;10(2). doi:10.2106/jbjs.rvw.21.00139

27. Smith EB. Ending Physician Noncompete Agreements—Time for a National Solution. *JAMA Heal Forum*. 2021;2(12):e214018. doi:10.1001/jamahealthforum.2021.4018

28. Mergo NS, Ellis P. What President Biden's Executive Order on Non-Compete Agreements May Mean for Healthcare Providers. JD Supra. Published July 20, 2021. Accessed March 5, 2022. https://www.jdsupra.com/legalnews/what-president-biden-s-executive-order-6423710/#_ftn2

29. New Survey Uncovers Nearly Half of Physicians Believe COVID-19 Will Not Be Under Control Until After June 2021. The Physicians Foundation. Published August 18, 2020. Accessed March 5, 2022. https://physiciansfoundation.org/press-releases/new-survey-uncovers-nearly-half-of-physicians-believe-covid-19-will-not-be-under-control-until-after-june-2021/

30. Kenney K. Congressional Letter: Physician Employment Trends Study 2019-2020. Published June 28, 2021. Accessed March 5, 2022. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Congressional-Letter-physician-employment-trends-study-2019-20-FINAL.pdf?ver=tlMzQXr4H_7rDIvWmB3JTQ%3D%3D

31. Avalere Health. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020. Published June 8, 2021. Accessed March 5, 2022. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3D%3D

APPENDIX 1. NON-COMPETE CLAUSE SURVEY DISTRIBUTED TO LOA MEMBERS

Q1: DO YOU HAVE A NON-COMPETE CLAUSE IN YOUR CONTRACT?

a) Yes
b) No
c) I had one that is now expired

Q2: IF QUESTION 1 IS A OR C, THEN DOES YOUR NON-COMPETE EXPIRE AFTER A CERTAIN AMOUNT OF EMPLOYMENT?

a) Yes after 1 year
b) Yes after 2 years
c) Yes after 3 years
d) Yes after 4 years
e) Yes after 5+ years
f) It does not expire

Q3: IF QUESTION 1 IS A OR C, THEN HOW WIDESPREAD IS OR WAS YOUR NON-COMPETE CLAUSE? (SELECT ALL THAT APPLY)

☐ It covers my city
☐ It covers my region/zip code
☐ It covers statewide
☐ It covers an area within any facility owned or operated by my employer/group
☐ N/A

Q4: IF QUESTION 3 IS A-D, THEN DID YOUR NON-COMPETE CHANGE AFTER YOUR EMPLOYER BEGAN EXPANDING LOCATIONS? (I.E. WHEN YOU SIGNED YOUR CONTRACT, IT SAID "YOU CANNOT WORK WITHIN X MILES FROM YOUR EMPLOYER'S FACILITY," THEN THE FACILITY EXPANDED, AND NOW THE DISTANCE FROM YOUR NON-COMPETE HAS ALSO EXPANDED)

a) Yes
b) No
c) N/A

Q5: ARE YOU THE PRESIDENT OR A SENIOR PARTNER OF A GROUP?

a) Yes
b) No

Q6: IF YES TO QUESTION 5, DO YOU REQUIRE NON-COMPETE CLAUSES FOR YOUR NEW EMPLOYED SURGEONS/JUNIOR PARTNERS?

a) Yes
b) No
c) N/A

Q7: DO YOU FEEL A NON-COMPETE IS IMPORTANT FOR A **PRIVATE GROUP** TO HAVE TO BE ABLE TO RECRUIT NEW SURGEONS?

a) Yes
b) No

Q8: DO YOU FEEL A NON-COMPETE IS IMPORTANT FOR A **HOSPITAL GROUP** TO HAVE TO BE ABLE TO RECRUIT NEW SURGEONS?

a) Yes
b) No

Q9: IF YES TO QUESTION 6, WHY DO YOU PRIMARILY REQUIRE NON-COMPETE CLAUSES? (SELECT ALL THAT APPLY)

a) Reduce competition
b) Invested time/effort to employ partners
c) Deter partners from starting their own practice
d) Create a goodwill between practice and partners
e) Other ____

Q10: WHAT IMPACT DOES A NON-COMPETE HAVE ON YOUR ABILITY TO FAIRLY RENEGOTIATE YOUR FUTURE EMPLOYMENT CONTRACT:

a) No effect
b) Helpful for employed physician contracts
c) Results in unfair leverage for an employer

Q11: DID YOU FEEL THAT A CONTRACT THAT INCLUDES A NON-COMPETE CLAUSE WAS NECESSARY TO PRACTICE IN YOUR AREA? (SELECT ALL THAT APPLY)

☐ Yes, there was only one viable employer
☐ Yes, all employers required non-compete
☐ Yes, the employer had such a large market share the contract was non-negotiable
☐ No

Q12: WOULD YOU LEAVE YOUR CURRENT JOB IF YOU DID NOT HAVE A NON-COMPETE?

a) Yes
b) No

Q13: HAS A NON-COMPETE DETERRED YOU OR WOULD IT DETER YOU FROM ACCEPTING A JOB OFFER?

a) Yes
b) No

Q14: WHAT EFFECT WOULD A NON-COMPETE **HAVE ON YOUR PATIENTS**? (SELECT ALL THAT APPLY)

☐ I would have to abandon patients I had cared for over many years leaving their care to someone who did not know them or their surgical history as well
☐ My patients would have to drive a long distance to see

me at my new practice after leaving the previous practice due to my non-compete
☐ I would have to give them care I felt was sub-standard or continue to do so because my non-compete does not allow for me to leave my current job and remain in the area my family wishes to live
☐ A non-compete would have no effect on my patients
☐ N/A

Q15: WHAT EFFECT WOULD A NON-COMPETE **HAVE ON YOU PERSONALLY**? (SELECT ALL THAT APPLY)

☐ I would be unable to maintain my practice in my desired city due to a non-compete
☐ I would have to relocate my family due to a non-compete
☐ I would be unhappy with my job due to a non-compete and would not be able to leave due to my personal situation (kids in school, family in the region, etc.)
☐ I would resent my partners for mandating a non-compete clause in my contract
☐ I would resent my hospital for mandating a non-compete clause in my contract
☐ N/A

Q16: DO YOU FEEL NON-COMPETE CLAUSES SHOULD BE REMOVED FROM ALL ORTHOPAEDIC SURGEON CONTRACTS?

a) Yes
b) No

Q17: DO YOU FEEL THAT NON-COMPETES HAVE CHANGED OVER THE PAST DECADE AS HOSPITALS HAVE BECOME CONGLOMERATES AND NOW EXTEND THEIR PRESENCE TO MANY OUTLYING COMMUNITIES SUCH THAT THEY HAVE BECOME UNREASONABLE?

a) Yes
b) No

Q18: WOULD REMOVAL OF ALL NON-COMPETE CLAUSES IMPROVE THE OVERALL HEALTHCARE OF OUR ORTHOPAEDIC PATIENTS IN THIS STATE AND REGION?

a) Yes (if yes, please explain why) _____
b) No (if no, please explain why not) _____

Q19: WITH CONTRACTS BEING RENEWED ON A YEARLY BASIS AT SEVERAL PRACTICES/INSTITUTIONS/ HOSPITALS, SHOULD A NON-COMPETE BE ALLOWED TO BE INSERTED DURING A YEARLY CONTRACT RENEWAL TO A PRACTICING SURGEON WHO IS CURRENTLY EMPLOYED BY A PRACTICE/INSTITUTION/HOSPITAL?

a) Yes
b) No

Q20: HOW MANY YEARS HAVE YOU BEEN IN PRACTICE?

☐ Less than 5 years (1)
☐ Between 5-10 years (2)
☐ Between 10-15 years (3)
☐ Greater than 15 years (4)

Q21: WHAT IS YOUR SUB-SPECIALTY?

a) General
b) Hand
c) Shoulder/elbow
d) Foot/ankle
e) Total Joints
f) Orthopaedic Trauma
g) Sports Medicine
h) Spine
i) Pediatric Orthopaedics
j) Oncology
k) Other (please specify) _____

Q22: WHICH OF THE FOLLOWING BEST DESCRIBES YOUR PRACTICE SETTING? (SELECT ALL THAT APPLY)

☐ Private practice-community base
☐ Academic
☐ Hospital based
☐ Veterans administration
☐ Military
☐ State employee

Q23: WHAT SETTING BEST DESCRIBES YOUR PRACTICE AREA?

a) Urban area with a population ⩾ 50,000 people
b) Large rural area with a population between 10,000 to 49,999 people
c) Small rural area with a population <10,000 people