Noncompete Agreements and Their Impact on the Medical Landscape

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PRACTICE **POINTS**

- There is no active federal ban on physician noncompete agreements as of late 2025.
- Physician noncompetes have expanded alongside the corporatization of medicine but raise serious concerns about physician mobility, burnout, workforce shortages, and patient access to care, particularly in underserved areas.
- Physicians should critically evaluate noncompetes prior to signing an agreement, advocating for narrower limits or refusal altogether to protect professional autonomy, continuity of care, and patient welfare.

Physician noncompete agreements have become increasingly common with the rise of employed-physician models and the corporatization of medicine, yet they remain controversial due to their effects on physician mobility and patient access to care. Although the Federal Trade Commission proposed a nationwide ban on most noncompete agreements in April 2024, that rule was blocked by the federal court and was formally abandoned by the agency in 2025. As a result, there currently is no federal prohibition on physician noncompetes, and enforceability depends on state law and the specific terms of employment contracts. This article reviews the historical origins of noncompetes, examines employer and physician perspectives, and highlights the downstream consequences for patient continuity, access, and health care costs.

In April 2024, the Federal Trade Commission (FTC) issued a nationwide rule to ban most employee noncompete agreements, including many used in health care[1]; however, that rule never took effect. In August 2024, a federal district court ruled that the FTC had exceeded its statutory authority and blocked the ban,[2] and subsequent litigation and agency actions followed. On September 5, 2025, the FTC formally moved to accede to vacatur—in other words, it will not enforce the rule and backed away from defending it on appeal.[3] As of December 2025, there is no active federal ban on physician noncompetes. The obligations of the physician employee are dictated by state law and the precise language of the contract that is signed.

In this article, we discuss the historical origins of noncompetes, employer and physician perspectives, and the downstream consequences for patient continuity, access, and health care costs.

Background

The concept of noncompete agreements is not new—this legal principle dates back several centuries, but it was not until several hundred years later, between the 1950s and 1980s, that noncompete agreements became routine in physician contracts. This trend emerged, at least in part, from the growing commoditization of medicine, the expansion of hospital infrastructure, and the rise of physicians employed by entities rather than owning a private practice. Medical practices, hospitals, and increasingly large private groups began using noncompete agreements to prevent physicians from leaving and establishing competing practices nearby. Since then, noncompetes have remained a contentious issue within both the legal system and the broader physician-employer relationship.

Employer vs Employee Perspective

From the employer's perspective, health care systems and medical groups argue that noncompete agreements are necessary to protect legitimate business interests, citing physician training, established patient relationships, and proprietary information gained from employment with that entity as supporting reasons. Additionally, employers maintain that recouping the cost of recruitment and onboarding investments as well as sustaining continuity of care within the organization should take precedence. On occasion, health care systems will invest time and financial resources in recruiting physicians, provide administrative and clinical support, and integrate new employees into established referral pathways and patient populations. In this view, noncompetes serve as a tool to ensure stability within the health care system, discouraging abrupt departures that could fracture patient care or lead to unfair competition using institutional resources. While these arguments hold merit in certain cases, many physicians do not receive employer-funded education or training beyond

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what is required in residency and fellowship. As a result, the financial justifications for noncompetes often are overstated; on the contrary, the cost of a "buy-out" or the financial barrier imposed by a noncompete clause can amount to a considerable portion of a physician's annual salary—sometimes multiple times that amount—creating an imbalance that favors the employer and limits professional mobility.

When a physician is prohibited from practicing in a specific area after leaving an employer, a complex web of adverse consequences can arise, impacting both the physician and the patients they serve. Physician mobility and career choice become restricted, effectively constraining the physicians' livelihood and ability to provide for themselves and their dependents; in single-earner physician families, this can have devastating financial consequences. These limitations contribute to growing burnout and dissatisfaction within the medical profession, which already is facing unprecedented levels of stress and physician workforce shortages.[4]

Effect on Patients

When a physician is forced to relocate to a new geographic region because of a noncompete clause, their patients can experience substantial disruptions in care. Access to medical services may be affected, leading to longer wait-times and fewer available appointments, especially in areas that already have a shortage of providers. Patients may lose long-standing relationships with doctors who know their medical histories, which can interrupt treatment plans and increase the risk of complications. Those with chronic illnesses, complex conditions, or time-sensitive treatments are particularly vulnerable to adverse outcomes. Many patients must travel farther—sometimes out of their insurance network—to find replacement care, increasing both financial and logistical burdens. These abrupt transitions also can raise health care costs due to emergency department use, inefficient handoffs, and higher incidence of morbidity/mortality.[5] Noncompete restrictions often prevent physicians from informing patients where they are relocating, creating confusion and fragmentation of care. As a result, trust in the health care system may decline when patients perceive that business agreements are being prioritized above their wellbeing. The impact may be even more severe in rural or underserved communities where alternative providers are scarce.

Final Thoughts

In recent years, noncompete agreements in health care have come under intensified scrutiny for their potential to stifle physician mobility, reduce competition, and inflate health care costs by limiting where and how physicians can practice. The trajectory of noncompetes in physician employment reflects broader shifts in how medicine is structured and delivered in the United States. In the latter half of the 20th century, what began as a centuries-old legal concept became a standard feature of physician employment contracts. That evolution largely was driven by the corporatization of medicine and large hospital group/private equity employment of physicians. As these agreements proliferated, public policy questions emerged: What does restricting a physician's mobility do to patient access? To competition in provider markets? To the cost and availability of care? To the current epidemic of physician burnout?

These questions moved from the legal sidelines to center stage in the 2020s, when the FTC sought to tackle noncompetes across the entire economy—physicians included—on the theory they suppressed labor mobility, entrepreneurship, and competition. In February 2020, the American Medical Association submitted comments to the FTC on the utility of noncompete agreements in employee contracts stating that they restrict competition, can disrupt continuity of care, and may limit access to care.[6] Although the FTC's regulatory attempt in April 2024 provoked strong policy signals, it was challenged and ultimately blocked. Rather than a clear federal prohibition, the outcome is a more incremental state-based shift in rules governing physician noncompetes. For physicians today, this means more awareness and more leverage, but also more complexity. Whether a noncompete will be enforceable depends heavily on the state, the wording of the contract, the structure of the employer, and the specialty. From a negotiation standpoint, physicians need more guidance and awareness on the exact ramifications of their employee contract. For newly minted physicians, many of whom enter the workforce with considerable training debt, the priority often is securing employment to work toward financial stability, building a family, or both; however, all physicians should press for shorter durations, tighter geographic limits, narrower scopes of service, clear buy-out options, and explicit patient-continuity protections. Better yet, physicians can exercise the right of refusal to any noncompete clause at all. Becoming involved with a local medical organization or foundation can provide immense support, both in reviewing contracts as well as learning how to become advocates for physicians in this environment. As more physicians stand together to protect both practice autonomy and the right to quality care, we all become closer to rediscovering the beauty and fulfillment in the purest form of medicine.

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