ORIGINAL ARTICLE
PRACA ORYGINALNA

ENFORCEABILITY OF NON-COMPETE AGREEMENTS IN MEDICAL PRACTICE: BETWEEN LAW AND ETHICS

DOI: 10.36740/WLek201912205

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ABSTRACT

Introduction: The core of physician's non-compete agreements problematics lies in complex system of controversial interests, rights and goals of subjects involved. On the one hand non-compete restrictions and their enforceability is an obvious part of employer's legitimate business interest based on the freedom of contract, on the other – free unrestricted market, preventing of monopolization, availability of medical assistance and healthcare, right to choose a doctor are social standards and thus – a part of public interest, in addition to this – non-compete restrictions impact physician's right to work. Balance between these components is pretty sensitive and hard to achieve.

We can find enforceability of physician's non-compete provisions in different types of relations: employment contracts, partnership agreements, sale of medical practice. But complexity of mixing law, ethical, social issues along with different approaches of legal regulations rises the relevance of research.

Material and methods: This study is based on German, British, Spain, Swiss, USA regulation acts, scientific researches and opinions of progressive-minded people in this sphere. The article is based on dialectical, comparative, analytic, synthetic and comprehensive methods.

Results: Non-compete agreements may have social benefits in some situations: serve as an instrument to protect trade secrets thus stimulate innovation; reducing of worker's exit probability could increase quality of medical services due to training of employees etc. But also, there are some serious risks to employee, to employer and to society as a whole. Analyzing the sense of non-compete clause in general we can assume that it includes seven main points: the subject; the form; the time; the territory; the scope and type of restrictions; "buy out" of the clause and the compensation. These characteristics are the core of non-compete clause, and, taking into account the principle of freedom in terms of agreement conclusion, it is up to law enforcement practice to determine minimal and maximal limits of such restrictions.

US legal concept is clearly based on implementing of legally prescribed restrictions for non-compete with physicians (along with other categories). European practice being pretty similar in view on what non-compete agreement is and what principles it is based on however is obviously different in approach chosen because of absence of special legal provisions for physicians' non-compete regulation.

Conclusion: Lack of legal regulation and law enforcement practice in this sphere worldwide is obvious, so the starting point in resolving of physician's non-compete enforceability issue will be choosing of suitable concept. Analyzing of proposed concepts, we came to the conclusion that the most perspective will be an approach of specification and clarification of "reasonability" meaning in terms of evaluation physicians' non-compete agreement validity and their impact on public interest.

KEY WORDS: non-compete agreement, non-compete clause, covenant not to compete, physician employees, medical staff

Wiad Lek 2019, 72, 12 cz. II, 2421-2426

INTRODUCTION

Non-compete practice is a widespread phenomenon of nowadays' employment relations. Taking start from USA/United Kingdom [1, p. 646-47] it is covering now more and more new countries, involving new and new professions and spheres. And whereas in some technologically-based and innovative areas such non-compete clauses are justified, in others – they seem nothing, but restriction (or even violation) of employee's rights [2]. It is obvious that employer wants to eliminate (or at least minimize) the competitive effect of his former employee, because: a) employee is a "carrier of confidential information", b) employee is a "business instrument", c) employee is an "investment object", d) employee is a potential competitor.

But there can be not just employer VS employee interest. What if (and it often true) the public interest is also engaged? What if this public interest is far surpassing local employer/employee interests? Will such non-compete clause be enforceable and if yes – what criteria must be used for its enforceability?

MATERIALS AND METHODS

This study is based on German, British, Spain, Swiss, USA regulation acts, scientific researches and opinions of progressive-minded people in this sphere. The article is based on dialectical, comparative, analytic, synthetic and comprehensive methods.

RESULTS AND DISCUSSION

The classical example of abovementioned problematics is exercising of non-compete provisions in healthcare. So, what is a case of non-compete practice in healthcare?

A physician restrictive covenant, also referred to as a "non-compete agreement" or "non-compete clause" is a

clause or section in a physician's contract whereby the physician (employee) agrees not to engage in his or her chosen profession in competition with the employer. Such restriction concerns public and private medical practices. Specialty of healthcare area problematic in non-compete context is based not only on potential violation of medial personnel's' right or employer's right, but on probable affection of patients' right and interest in general, which are a part of public interest.

Non-compete agreements may have social benefits in some situations: serve as an instrument to protect trade secrets thus stimulate innovation; reducing of worker exit probability could increase quality of medical services due to training of employees etc. But also, there are risks to employee, to employer and to society as a whole.

That is why the key issues of non-compete clauses for physicians are both legal and ethical. The most experienced countries in terms of non-compete clauses implementation is USA where such practice in modern concept arises in the beginning of XX century, Germany and some others [3 p. 229]. Although there's a variety of approaches among different states, all of them are based on the same main characteristics: 1) the scope: types of agreements and types of non-compete terms in the agreement; 2) the model of law-enforcement practice in terms of non-compete clauses implementation, their enforceability. We will start the discussion from the general positions on non-compete clauses then extrapolating them on healthcare sphere.

Non-compete clauses is widely applicable and could be founded in employment agreements, partnership agreements, and agreements for the sale of a medical practice [4]

Analyzing the sense of non-compete clause in general we can assume that it includes seven main points: the subject; the form; the time; the territory; the scope and type of restrictions; "buy out" of the clause and the compensation. These characteristics are the core of non-compete clause, and, taking into account the principle of freedom in terms of agreement conclusion, it is up to law enforcement practice to determine minimal and maximal limits of such restrictions.

Subject. Subject who covered by non-compete clause must be identified – it is obvious and needs no clarifications. More interesting is that not every employee, not every medical staff member really needs to be bounded by such restrictions because of their minimal or absent impact on competition because of no connection with some sensitive commercial information of employer. But often such approach of limiting the subjects scope is not used by employers and they tend to cover with non-compete restrictions as much as possible. Such practice is highly discussed now in the US [5] and we have some positive restrictive examples in the EU countries (Germany and Belgium for instance) where the applicability of restriction is grounded on the rate of annual incomes of employee and some other restrictions [6].

Form. Non-compete clause by its restrictive nature must be clear, understandable and interpretable, so, it is obvious that such demands could be fulfilled only in the form of written mutual agreed provision, which can be a part of the existing agreement or a separate clause between the parties. But the terms of non-compete clause and agreement for their execution must be formally accepted by both parties. Such concept is general among the countries because of the fact that non-compete agreement (or clause) must meet general contractual requirements [7]

Time. Another term of non-compete clause is the period during which employee agrees not to compete with his employer as during the contract term, but such term can't be unlimited. The practice of such term is pretty common and varies between one to three years after the contract termination. European practices are the same with US in this regard [8] and it usually determine the term of restriction during the employment and for a period of time afterward. Court might further limit the duration of a non-compete restriction as he thinks appropriate to different periods, for example – a period of time needed to hire and train a new employee; the time needed for vanishing of customers' association between former employee and employer's business; period of time for confidential information to become obsolete etc.

Territory. The territorial scope could not be unlimited or not strictly defined, different countries use different approaches, it could be distance range (circle with the center – main office of the employer), it could be the administrative division (city, county, region etc.), it could be ZIP postal code area or else. Main point - it must be reasonable geographical area considering the size of the employer's market and the size of the area serviced by the employee.

Scope and type of restrictions. Types of prohibited or restricted activities must be clearly defined, be connected with employee functions. Such provisions could not be broad or not properly defined. Moreover, their definition must be connected with category of employer's "legitimate business interest" in terms of how they impact each other.

"Buy out" clause. The employee must have the right to buy-out from restriction by paying to employer some contractually predefined fee. Such clause renews the "status quo" of both parties and legitimates further possible competition and also needs to be "reasonable".

Compensation. Non-compete clause could not be just one-way obligation for the employee, such an agreement should be mutually favorable and not providing of compensation for employee for the restrictions bearing by him on the basis of non-compete agreement might be the reason of such contract (or clause) invalidity. Such practice is applicable in some US states, Germany, Belgium [9] and other countries.

So, what is the specialty of non-compete clauses regulation for physicians? The answer to this question depends on the approach chosen and may highly vary among different countries.

In US there are different approaches among the states as to how applicable non-compete agreements at all and how special is their regulation for such sensitive category of employees like physicians [10]. There are states that prohibit non-compete provision application, states that threat them

as partly-applicable and states that threat such provisions as fully-applicable (with some general restrictions) [11].

For the states in US where non-compete clauses are enforceable there are three types of law-enforcement doctrine: "Red-pencil doctrine" – courts must declare an entire non-compete contract void if one or more of its provisions are found to be defective under state law or precedent; Blue-pencil doctrine – courts delete provisions of a non-compete contract that render it overbroad or otherwise defective, retaining the enforceable subset of the contract; "Equitable reform" doctrine – courts may rewrite a non-compete contract so as to render it non-defective (this may entail insertions of new text). [5, p. 14].

The complexity of regulation approaches is even higher when we are analyzing this problematic in connection with physicians and medical professionals because some states taking into account the uniqueness of medical profession apply special rules to covenants that restricts such medical practice because of involvement of public interest, in particular the potential shortage of doctors in the area, impact on the patient's rights to obtain healthcare treatment, to choose a doctor or other medical professional etc.

Thus, even if it is declared by the state law that non-compete restrictions are generally allowed (as reasonable and legitimate) there may be a non-enforcement clause with regard to physicians. For example, Massachusetts where prohibition of physicians non-compete provisions is established since 1977 and any non-compete provision restricting "the right of a physician to practice medicine in a particular locale and/or for a defined period of time." [12, Ch. 112 § 12X] is illegal. Literally the same with Delaware [13, Title 6, Ann. § 2707], Colorado [14, § 8-2-113], Rhode Island [15, §5-37-33].

There is another approach where some states aree not prohibiting non-compete clauses for physicians in general applying to them deeper and stricter prescriptions and limits. For instance, Tennessee where there are additional restrictions for non-compete clauses with physicians in terms of duration (no longer than two years), geographical (not greater than the county of employment or 10 miles radius) facility restrictions. [16, Ann. § 63-1-148]; in Texas non competes for physicians are allowed but restrictions must not "deny the physician access to a list of the patients seen or treated within one year of termination of employment; provide access to medical records of the physician's patients upon proper authorization; provide for a buyout of the covenant by the physician at a reasonable price; and allow the physician to provide continuing care and treatment to a specific patient or patients during the course of an acute illness" [17, Ann. § 15.50]; in New Mexico there is a prohibition of agreements with restrictions to provide clinical healthcare services (except when such restrictions applied to shareholders, owners, partners, directors) but also an allowance of non-disclosure and non-solicitation provisions and very interesting rule for healthcare practitioners employed by the practice for less than three years which may be required, upon termination, to pay back certain expenses to the practice (including loans; relocation expenses; signing bonuses or other incentives related to recruitment; and education/training expenses). [18, § 24-1l-1]; in Connecticut there is limitation of non-compete clause duration (no longer than one year) and territory (not more than fifteen miles from primary site) and cause of termination (non-compete clause is unenforceable after contract termination without the cause). [19, §20-14p(b)(2)]

As we can see, nevertheless of approaches variety there is a clear trend for specification of physician's non-compete clauses regulation. US legal concept is clearly based on implementing of clear legally prescribed restrictions for non-compete with physicians.

European practice being pretty similar in view on what non-compete agreement is and what principles it is based on however is obviously different in approach chosen because of absence of special provisions for physicians' non-compete regulation [8].

In Germany non-compete provisions are regulated by different law acts [9, p. 333-335]. Such practice is regulated by Commercial Code (e.q., sec. 60, 112 HGB) [6], German Federal Labor Court (BAG), in AP-No. 7 to § 611 BGB Treuepflicht [20]; sec. 242 Civil Law Code [21]. There are no special rules for physicians or medical staff members, specialization of the approach used is based not on legal prescriptions (like in USA) but on law enforcement practice, which must observe "reasonableness" [22] of restrictions thus taking into account not only the balance of employer and employee interests, but also an impact on public interest assuming the value of medical profession.

In Spain legal regulation of covenants not to compete is different for restrictions during the employment relationship and after their termination. For the first situation such restriction is compulsory [23, art. 8.1]. There is also no special regulation for medical staff and the "difference" is made by law enforcement practice by implementing of "reasonableness" evaluation concept.

In Switzerland non-compete agreements regulation during the term of the contract is differed among employment contracts [24, Section 321a], agency [24, Section 418d), partnership [24, Section 536], partnership [24, Section 561] and Limited Liability Company [23, Section 818]. After the contract termination such restrictions are specifically regulated only in regard of employment agreements. [24, Sections 340]. Reasonableness test is in place also but no special rules for physicians.

United Kingdom. The main concept is based on evaluation of any non-compete restrictions between an employer and an employee as void on the basis of their contradictory nature to public policy. To implement such a restriction employer must show legitimate business interest that needs such protection and "reasonableness" of restriction – no further than the protection of business interest [25; 26; 27; 28]. The main goal of restriction is not limitation of competition but restriction of unfair use of employer's trade secrets or business connections [26;27] and reasonableness of restriction must be evaluated on the date of signing the contract (reasonable from beginning) [29]. As in other

European countries, in UK we can't see the legal basis for specialization of physicians' non-compete agreements. Such specialization is grounded on law enforcement practice of evaluation such categories as "legitimate business interest", "public interest", "employee's rights" etc.

As we can see from abovementioned, the divergence between US and European approaches (however they are similar in basic understanding of non-compete at all) is obvious – the US model tends to provide legally defined special restrictions for non-compete agreements with physicians while European model tends to rely the specialization of such agreements on law enforcement and judicial practice. But what is uniting both these approaches is the goal achieved – the inclusion of public interest as a main element of evaluation while qualifying the restriction. So, what is the impact of public interest in this scope, what question does it bring up in this regard?

We must say that "public interest" with regard to physicians' non-compete agreements should be deemed widely and include not only the economic aspect (as for "classical" non-compete restriction) but also the evaluation of "medical" impact of them. Nevertheless of "sensibility" of abovementioned sphere we can admit that public interest category has some aspects that "favors" and "disfavors" non-compete agreements with physicians.

On the "positive side" there are obvious categories of the freedom of contract, which is a publicly defended principle, investment in employee's development, decentralization and territorial balance of physicians.

As to **freedom of contract** – its value is obvious, but what if contract impacts (or even violates) third party's legitimate interests or rights, which is not a party of the contract and has no ability to become one? From our view in that scope the freedom of contract should be appropriately narrowed, because, for example, the right of a patient to choose treating physician is obviously affected by physician restrictive covenants. Current law enforcement practice already has such examples of contract's freedom restrictions on the basis of ensuring public interest, so one of those could be the impact of physician's non-compete clause.

Regarding **encouraging of investment in development** of young physicians, non-compete restrictions really could guarantee that employer will have the ability to recoup capital outlay spent on employee training. Without restrictive measures such as non-compete agreements potential employers will be less willing to invest in physician employees and all that will impact healthcare services availability in general.

Talking about **decentralization and territorial balance** of physicians we must admit that non-compete restrictions could have positive public impact by encouraging them to move to rural areas (or areas with low level of medical services) thus providing broader availability of healthcare.

On the "negative side" we can admit pretty obvious problematics of impact on public interest [30, p.3] – they are patient's right to freely choose a doctor, a problem of healthcare availability (especially when it comes to non-compete restrictions for highly-qualified specialists), public health, ability to preserve continuity of care in cases where it is important (parental care, chronical deceases), ethical aspect of restriction itself and so on.

General position of **discouraging of non-compete agreements** for physicians are global [31; 32] and needs no clarification. It is obvious that any restriction of physician's professional activity inevitably will bring up ethical concerns.

Same with the **right to choose a doctor** – it is a worldwide standard, and restriction of it will impact satisfaction of the patient, quality of services etc. [30, p.3-4]. The resulted impact will depend on the geographical and time scales of restriction but the fact of negative effect is undoubtful.

Shortage of physicians also could be an example of negative impact of non-compete agreements in this sphere on public interest. It is obvious that above restrictions could create a problem of physician's shortage in territories where there was no such problem before and could deepen the problem where it already exists. And a lot of countries already faced such issue, including US [33, 34], Europe [35]

Assuming the abovementioned, what regulative options do we have? If we look at the problem more generally there are three conceptual approaches as to how to treat non-compete agreements (covenants, clauses) with physicians. Let's name them: 1) "commercial public interest" concept; 2) "invalidity of any restrictions" concept; 3) "broadening of reasonability" concept. We are not pretending on deep analysis of each abovementioned approaches due to this could be a basis for the separate research, but we will try to accommodate here a brief overview of them.

Lack of legal regulation and law enforcement practice in this sphere worldwide is obvious, so the starting point in resolving of physician's non-compete issue will be choosing of suitable concept.

"Commercial public interest" concept is based on extrapolation of traditional understanding of public interest and assessment of impact on it as an economical category. Such approach is somehow mixing the interests of employer and public interest, and defining public interest as a complex of economical (efficiency of business, employment costs in case of enforcing of non-compete clause) and socio-economical (right to work, standard of living etc.) categories. But such an approach gives us no answer to the public impact that could not be economically evaluated – public health, public safety, healthcare availability etc. Thus, described approach couldn't be deemed appropriate.

"Invalidity of any restrictions" concept is pretty clear and is grounded on the point of view that any restrictions of physician's professional activity are anyway against the public interest. Universality of this approach has also a negative side – not every non-compete agreement poses equal threat (or equal unfluence) to public interest. Moreover, absence of restrictions will more or less initiate rise of concerns that encourage non-compete restrictions from the point of view of "public interest", will eliminate all their positive social impact. That is why, along with previously

mentioned, such model hardly could be effective in long-term perspective.

"Broadening of reasonability" concept is based on necessity of understanding the definition of "reasonability" as an essential criteria of legitimacy evaluation of non-compete agreements in broader sense taking into account their impact (not only economic) on public interest. Physicians' restrictive non-compete clauses could not be simply compared to similar commercial covenants because of their services nature because of involvement of categories such as public health, medical ethics and others. Thus, the law enforcement practice must evaluate physicians' non-compete restrictions with three main points as a base: existence of legitimate business interest and employer actions must be strictly and truly directed to protect them, non-compete restriction is constructed as strictly as possible to protect such interests, the public interests are treated widely then just an economic category and thoroughly vetted, balanced and evaluated. From our view the abovementioned model by avoiding disadvantages of both previous could be deemed as perspective one even regardless of its obvious complexity. It is a vice balance of individual (employer and employee) and public interests.

CONCLUSION

Beyond the differences between European and US approaches there's a clear understanding of non-compete clauses' use unstoppable widening. But while the general concept of such restrictions and their enforceability are properly determined as in doctrine and law, their enforcement for special categories such as physicians needs particular attention and specification of law regulation. Because restriction (even on the basis of legitimate business interest) of physician's professional activity gives rise to a massive scope of concerns, involving those of public interest.

We clearly distinguish that the main regulative difference between European and US approaches lies in the instruments used for regulation: US concept favors inclusion of special provisions into laws while European one prefers to keep non-compete as a unite concept regardless profession thus relying the necessity of evaluation of "reasonability" of restriction on law enforcement bodies.

Results of research conducted drive us to the conclusion that physician restrictive non-compete clauses could not be simply compared to similar commercial covenants because of services nature and involvement of categories such as public health, medical ethics and others to the scope. Regulation also should not restrict non-compete clauses for physicians at all because the side effects of that could contradict public interests. From our point of view the concept of regulation must be grounded on enhancements of understanding the "reasonability" as a special category when it comes to physician's non-compete clauses. Law enforcement practice must evaluate if there's a legitimate business interest and employer's actions truly directed to protect them, is non-compete restriction is constructed as strictly as possible to protect such interests, are public interests treated widely then just an economic category and thoroughly vetted, balanced and evaluated. Implementation of such an approach will be a vice balance of individual and public interests.

REFERENCES

1. Harlan M. Blake, Employee Agreements Not to Compete, 73 HARV. L. REV. 625, (1960) doi: 10.2307/1338051
2. Steven M. Harris Physician Noncompete Clauses. The Hospitalist. 2012 July;2012(7). Available from: https://www.the-hospitalist.org/hospitalist/article/125197/physician-noncompete-clauses [reviewed 2019.08.15]
3. Whalley, M.; Semler, F.-j. (eds). International Business Acquisitions: Major Legal Issues and Due Diligence. 3rd ed. The Hague London: Kluwer Law International, 2007, p. xi, 169, 268. 5 Ibid.
4. 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(1975)
5. Non-compete Contracts: Economic Effects and Policy Implications / Office of Economic Policy, U.S. Department of the Treasury. Available from: https://www.treasury.gov/resource-center/economic-policy/Documents/ [reviewed 2019.08.15]
6. German Commercial Code. Available from: https://www.gesetze-im-internet.de/hgb/__74.html [reviewed 2019.08.15]
7. Shadowen, S. d.; Voytek, K. economic and critical analyses of the law of covenants not to compete. Georgetown Law Journal. 1983–1984, 72(4): 1425–1450.
8. Norton Rose Fulbright. A comparison of laws in selected EU jurisdictions relating to post-contractual, non-competition agreements between employers and employees. Available from: https://www.nortonrosefulbright.com/en/knowledge/publications/9807eea3/a-comparison-of-laws-in-selected-eu-jurisdictions-relating-to-post-contractual-non-competition-agreements-between-employers-and-employees [reviewed 2019.08.15]
9. Summary of Covenants Not To Compete: A Global Perspective Compliments of Fenwick & West LLP, a member of The TechLaw Group. Available from: https://www.fenwick.com/FenwickDocuments/RS_Summary-of-Covenants.pdf [reviewed 2019.08.15]
10. Aaron Hall. Physician Noncompete Agreements: Enforceable in Medical & Healthcare Organizations Available from: https://aaronhall.com/physician-noncompete-agreements-enforceable-in-medical-healthcare/ [reviewed 2019.08.15]
11. 11. Employee Noncompetes. A State by State Survey / Beck Reed Riden LLP Available from:
12. https://www.faircompetitionlaw.com/wp-content/uploads/2019/10/Noncompetes-BRR-50-State-Survey-Chart-20191019.pdf [reviewed 2019.08.15]
13. Massachusetts General Law Ch. 112 § 12X. Available from: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section12x [reviewed 2019.08.15]
14. Delaware Code, Title 6, Ann. § 2707, Available from: https://delcode.delaware.gov/title6/c027/sc01/index.shtml [reviewed 2019.08.15]
15. Colorado Revised Statute § 8-2-113. Available from: https://law.justia.com/codes/colorado/2018/title-8/labor-i-department-of-labor-and-employment/article-2/part-1/section-8-2-113/ [reviewed 2019.08.15]
16. Rhode Island General Laws Title 5. Businesses and Professions § 5-37-33 Available from: https://codes.findlaw.com/ri/title-5-businesses-and-professions/ri-gen-laws-sect-5-37-33.html [reviewed 2019.08.15]

17. Tennessee Code Title 63 Available from: https://law.justia.com/codes/tennessee/2010/title-63/chapter-1/part-1/63-1-148 [reviewed 2019.08.15]
18. Texas Business and Commerce Code. Available from: https://codes.findlaw.com/tx/business-and-commerce-code/bus-com-sect-15-50.html [reviewed 2019.08.15]
19. New Mexico Statutes. Chapter 24: Health and Safety. Available from: https://law.justia.com/codes/new-mexico/2011/chapter24/ [reviewed 2019.08.15]
20. Connecticut General Statutes 20-14p. Available from: https://www.lawserver.com/law/state/connecticut/ct-laws/connecticut_statutes_20-14p [reviewed 2019.08.15]
21. Achim Seifert, Elke Funken-Hötzel Wrongful Dismissals In The Federal Republic Of Germany. Available from: https://www.upf.edu/documents/3885005/3888714/AchimSeifertGermany.pdf/78df9b21-8b1b-4575-89c9-182e6f74acd8 [reviewed 2019.08.15]
22. German Civil Code BGB. Available from: https://www.gesetze-im-internet.de/englisch_bgb/ [reviewed 2019.08.15]
23. German Federal Court of Justice (BGHZ 91, 1). Available from: https://germanlawarchive.iuscomp.org/?p=189 [reviewed 2019.08.15]
24. REAL DECRETO 1382/1985, Available from: http://www.juntadeandalucia.es/empleo/anexos/ccarl/2_86_1.pdf [reviewed 2019.08.15]
25. Federal Act on the Amendment of the Swiss Civil Code. Available from: https://www.admin.ch/opc/en/classified-compilation/19110009/index.html [reviewed 2019.08.15]
26. Mason v Provident Clothing & Supply Co Ltd [1913] AC 724. Available from: https://www.lawteacher.net/cases/mason-v-provident-clothing.php
27. Herbert Morris Ltd v Saxelby [1916]. Available from: https://www.lawteacher.net/cases/morris-v-saxelby.php [reviewed 2019.08.15]
28. Stenhouse Australia Ltd v Phillips [1974]. Available from: https://www.i-law.com/ilaw/doc/view.htm?id=146833 [reviewed 2019.08.15]
29. TFS Derivatives Ltd v Morgan [2005]. Available from: https://uk.practicallaw.thomsonreuters.com/D-015-4756?transitionType=Default&contextData=(sc.Default) [reviewed 2019.08.15]
30. Rex Stewart Jeffries Parker Ginsburg Ltd v Parker [1988]. Available from: https://uk.practicallaw.thomsonreuters.com/D-015-4756?transitionType=Default&contextData=(sc.Default)&bhcp=1 [reviewed 2019.08.15]
31. Jeanne M. Lambrew, "Choice" in Health Care: What Do People Really Want?, ISSUE BRIEF, (The Commonwealth Fund, New York, N.Y.), Sept. 2005, Available from: http://www.commonwealthfund.org/usr_doc/lambrew__853_choice__ib.pdf?sections=4039 [reviewed 2019.08.15]
32. Amaerican MED. ASS'N, CODE OF MEDICAL ETHICS § E-9.02 (2009), Available from: http://www.ama-assn.org/amal/pub/upload/mm/Code_of_Med_Eth/toc.html
33. Principles of European Medical Ethics. Available from: http://www.ceom-ecmo.eu/en/view/principles-of-european-medical-ethics [reviewed 2019.08.15]
34. America's aging population is leading to a doctor shortage crisis. Available from: https://www.cnbc.com/2019/09/06/americas-aging-population-is-leading-to-a-doctor-shortage-crisis.html [reviewed 2019.08.15]
35. Miriam A Knoll. Doctoring The Doctor Shortage. Available from: https://www.forbes.com/sites/miriamknoll/2019/03/07/doctoring-the-doctor-shortage/#62be107876f3 [reviewed 2019.08.15]
36. Europe faces a shortage of doctors. Available from: https://voxeurop.eu/en/2018/public-health-5122358 [reviewed 2019.08.15]

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Conflict of interest:
The Authors declare no conflict of interest.

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Received: 05.09.2019
Accepted: 27.11.2019