

LITIGATION REVIEW

UP-TO-DATE ANALYSIS FOR CLIENTS AND FRIENDS OF THE FIRM

Restrictive Covenants in Physician's Employment Agreements

Mitchell L. Marinello, *Partner*, Novack and Macey LLP
312.419.6900
mlm@novackandmacey.com

During the past several months, Novack and Macey has handled a number of cases involving non-compete agreements between medical organizations and physicians who left those organizations to join rival medical groups or to open their own practices. This article summarizes the law in this area and reviews some of the basic issues that arise in these kinds of cases.

WHAT IS A RESTRICTIVE COVENANT?

The terms restrictive covenant and non-compete agreement are often used interchangeably. Although not limited to the employment context, these terms are often used to describe agreements that prohibit an employee from competing with his former employer for a period of time after the employment relationship has ended.

In medicine, it is common for such agreements to require a doctor to refrain from soliciting his or her former patients and/or from practicing medicine within a specified geographic radius of the medical offices where the doctor was formerly employed. Typically, these kind of agreements remain in force for one to several years.¹

ARE RESTRICTIVE COVENANTS ENFORCEABLE AGAINST DOCTORS?

In Illinois, restrictive covenants in physician employment agreements historically have been held to be valid and enforceable. In fact, restrictive covenants have been easier to enforce against doctors than against many other types of professionals or employees. But before explaining the law applicable to physicians, and some of the recent developments in the case law, it would be worthwhile to discuss restrictive covenants generally.

WHAT ARE THE GENERAL PRINCIPLES APPLICABLE TO RESTRICTIVE COVENANTS?

Restrictive covenants limit an employee's ability to use his or her labor in the marketplace. Thus, by their very nature, they are anti-competitive. Because the courts generally value competition and are unwilling to enforce efforts to suppress it, the courts view restrictive covenants with skepticism and enforce them only in limited circumstances.

As a general matter, for a restrictive covenant in an employment agreement to be enforceable: (i) the employer must have what the courts term a "protectible interest;" (ii) the restrictions on the employee must be reasonable in geographic scope and duration; and (iii) there cannot be any public policy concerns or other factors that make the enforcement of the restrictive covenant inappropriate.

In order to have a protectible interest, a typical, non-medical employer normally must show that it has long-standing, "near-permanent" relationships with its customers and that its employee would not have had contact with those customers but for his or her employment.² To do so, employers normally must present evidence concerning such factors as the length of time the customer has been purchasing goods or services from the employer, the investment in time and money that the employer made to obtain its customers, and the difficulty involved in developing the customer relationships.

To be enforceable, restrictive covenants also must be reasonable in geographic scope and duration. This means that they must be tailored so that they protect the employer's legitimate interests but do not needlessly hinder the employee's ability to earn a living. It also means that the restrictions probably can last for only a limited amount of time. On these matters, there are no precise rules. The exact scope and duration that will be enforced by the courts is a matter of judgment that depends on the specific facts of the case including the type of business involved, the employee's duties and length of employment, and the equities of the situation.

In addition to these considerations, restrictive covenants will not be enforced if they conflict with public policy. This factor will be discussed in detail below, because it recently has received particular attention in cases involving the practice of medicine.

WHAT MUST DOCTORS PROVE TO BE ENTITLED TO ENFORCE A RESTRICTIVE COVENANT?

Unlike most other employers, doctors usually have not had to show that they have a protectible interest in their patient relationships in order to enforce a restrictive covenant against a former partner or employee. Instead, the Illinois courts historically have recognized that such a protectible interest can be inferred from the nature of the medical profession. One court summarized the law as follows:

The Illinois Supreme Court has repeatedly upheld covenants not to compete in medical practice cases without making a specific inquiry into whether the plaintiff has demonstrated a [protectible] business interest. . . . [T]he [S]upreme [C]ourt's consistent enforcement of such covenants in the medical professional field, where the durational and geographic scope is reasonable, demonstrates its recognition that a professional's medical practice is a [protectible] business interest.

Retina Services, Ltd. v. Garoon, 182 Ill. App. 3d 851, 856 (1st Dist. 1989). In this sense, medical practice employers have enjoyed a favored position in the law.

WHAT IS THE APPROPRIATE GEOGRAPHIC SCOPE AND DURATION?

The scope and duration of a restrictive covenant initially are matters for the parties to negotiate. The role of the court is to determine if the parties' agreement is reasonable enough to be enforced. This is a matter of judgment. Factors that influence the appropriate geographic scope include the nature of the medical practice and the area from which it draws the bulk of its patients.

In areas with lower population densities, courts have enforced restrictive covenants that prohibit medical professionals from practicing within large distances of their former place(s) of employment. *Gillespie v. Carbondale & Marion Eye Centers, Ltd.*, 251 Ill. App. 3d 625 (5th Dist. 1993) (within 50 miles of five different rural offices at which the defendant

provided medical services); *Cockerill v. Wilson*, 51 Ill. 2d 179 (1972) (within 20 miles of Rushville, Illinois); *Canfield v. Spear*, 44 Ill. 2d 49 (1969) (within 25 miles of Rockford); *Bauer v. Sawyer*, 8 Ill. 2d 351 (1956) (within 25 miles of Kankakee). There are few cases that address the enforcement of medical non-compete agreements within highly-populated areas such as the City of Chicago, but large geographic restrictions may be enforceable there as well. See *Storer v. Brock*, 351 Ill. 653 (1933) (medical non-compete agreement enforced throughout the City of Chicago, but in the context of a partnership buy-out, not an employment agreement).

The length of time that a non-compete agreement will be enforced also involves the court's judgment as to what is reasonable under the circumstances. There are cases that enforce restrictive covenants that are five years long. E.g., *Bauer v. Sawyer*, 8 Ill. 2d 351 (1956); *Cockerill v. Wilson*, 51 Ill. 2d 179 (1972). There are also somewhat more recent cases that enforce them for two or three years. E.g., *Total Health Physicians, S.C. v. Barrientos, M.D.*, 151 Ill. App. 3d 726 (5th Dist. 1986). There is no clear rule as to the length of time that is appropriate.

THE PUBLIC POLICY CHALLENGE OF THE CARTER-SHIELDS DECISION

In 2000, the Appellate Court for the Fifth District of Illinois (the "Fifth District") decided the Carter-Shields case.³ At issue was a two-year non-compete agreement between Dr. Carter-Shields, an experienced family physician, and Alton Health Institute ("Alton"), a not-for-profit health care organization. The trial court had held that the non-compete agreement was valid and enforceable.

The Fifth District reversed this decision. It held that Alton had violated the corporate practice of medicine doctrine, a legal rule which says that, unless permitted by statute, corporations other than hospitals are prohibited from practicing medicine. As a result, the court held that the employment agreement between Alton and Dr. Carter-Shields was null and void, including the non-compete agreement that it contained.

In what has become the most controversial part of its opinion, the Fifth District went on to state that even if Alton were entitled to practice medicine, the non-compete agreement was void as against public policy. To support this conclusion,

the court cited *Dowd & Dowd, Ltd. v. Gleason*, 181 Ill. 2d 460 (1998), an Illinois Supreme Court decision holding that non-compete agreements are unenforceable as to attorneys. The Dowd decision was based on Rule 5.6 of the Rules of Professional Conduct, a mandatory rule issued by the Illinois Supreme Court that prohibits attorneys from entering into non-compete agreements. Dowd also was based on the “public policy” behind Rule 5.6; namely, that clients should have the freedom to choose their attorneys. Relying on what it regarded as a similar rule for doctors, the Fifth District cited section 9.2 of the Opinions of the Council on Ethical & Judicial Affairs of the American Medical Association (“Section 9.2”) which “discourages” non-compete agreements that limit a doctor’s right to practice medicine. The Fifth District reasoned that public policy also requires that patients have the unfettered right to choose their doctors.

A short time thereafter, the Appellate Court for the Fourth District of Illinois (the “Fourth District”) was faced with a nearly identical case. It refused to follow the Carter-Shields decision, however, and rejected a public policy challenge to a two-year non-compete agreement between a health care organization and an eye doctor. The Fourth District stated that Section 9.2 was not truly comparable to Rule 5.6 and found the public policy enunciated in Carter-Shields unpersuasive. It concluded by saying:

Despite our sympathy for the rights of patients to choose their own doctors, we are constrained to follow the long line of [Illinois] precedent . . . finding non-competition agreements enforceable in the medical profession. We leave the public policy pronouncements for either our supreme court or the legislature.

Prairie Eye Center, Ltd. v. Butler, 329 Ill. App. 3d 293, 300 (4th Dist. 2002).⁴

A few month’s later, the Illinois Supreme Court ruled on the appeal from the Carter-Shields case.⁵ In its decision, the Court agreed that Alton was not entitled to practice medicine and, therefore, that its employment agreement with Dr. Carter-Shields, including the non-compete provision, was void. Although the Court then had the chance to clear up the “public policy” controversy, it did not conclusively do so. Instead, it stated that the Fifth District’s ruling that non-competition covenants in physician employment agreements are invalid for public policy reasons was unnecessary to the Fifth district’s

decision and “wholly advisory.” The Court continued:

Advisory opinions are to be avoided . . . For this reason, we express no opinion with respect to the general validity of noncompetition clauses contained within physician employment agreements. We also vacate those portions of the appellate court judgment which addressed this specific issue.

Id. at 464. Where does that leave us?⁶

CONCLUSION

Although there can and will be differences of opinion about the upshot of the Carter-Shields and Prairie decisions, we probably are back to about where we started. Illinois law has a long history of enforcing non-compete agreements in the medical field, and medical professionals who challenge them as against public policy are fighting decades of precedent. When all is said and done, the only things new with which to challenge existing law are the public policy arguments in the Carter-Shields decision, but those have been vacated and no longer speak with much legal authority. Furthermore, those same public policy arguments have been rejected by the Fourth District.

Moreover, the Carter-Shields’ public policy arguments do not appear to be particularly sound. Section 9.2 is the opinion of one medical association. Unlike Rule 5.6 of the Rules of Professional Conduct, which was issued by the Illinois Supreme Court and applies to every attorney who practices in this state, Section 9.2 does not speak with the force of law. Thus, Section 9.2 and Rule 5.6 are not equals.

In addition to being more authoritative, Rule 5.6 is clear and mandatory: it prohibits non-compete agreements for attorneys. In contrast, Section 9.2 “discourages” non-compete agreements for doctors, but it does not forbid them. This, too, is an important distinction. Section 9.2 appears to recognize that non-compete agreements may be appropriate in certain circumstances.

Finally, it is understandable that litigants would identify what they view as “public policies” that do or do not favor non-compete agreements in their field or business. But, in Illinois, the Supreme Court has the ultimate authority to decide such policy matters for the legal profession. There is no similar institution for the medical profession and, accordingly, defining the appropriate “public policy” for the medical

field is not so simple. For example, some doctors are willing to trade a promise not to compete with their prospective employer in return for valuable medical training and experience that might not otherwise be available to them. It is unclear that such trade-offs should be outlawed based on general notions about the public's right to choose a particular physician. Among other considerations, the public might never have that choice if the individual doctor in question could not get the medical training that was part of his or her employment/non-compete contract.

In any event, the public policy arguments in *Carter-Shields* are not dead, and they cannot be ignored. It is a safe bet that they will be raised in just about every case involving a non-compete agreement with a physician unless and until the Supreme Court puts them to rest. Moreover, some trial courts may be sympathetic to them. This should not dissuade doctors and medical groups from using non-compete agreements in their employment agreements, but it does introduce a new element of risk that should be considered.

¹Non-compete agreements are also used when a medical practice is sold. In general, courts are far more receptive to enforcing such covenants when made in connection with the sale of a business.

²An employer also may have a protectible interest if the employee had access to the employer's trade secrets or confidential information. See *A.B. Dick Co. v. American Pro-Tech*, 159 Ill. App. 3d 786 (1st Dist. 1987).

³*Carter-Shields v. Alton Health Inst.*, 317 Ill. App. 3d 260 (5th Dist. 2000).

⁴The Fourth District had issued a prior opinion rejecting a public policy challenge to the restrictive covenant at issue and had remanded the case for trial. *Prairie Eye Center, Ltd. v. Butler, M.D.*, 305 Ill. App. 3d 442 (4th Dist. 1999). After the trial, the case was appealed for the second time, resulting in the decision and opinion discussed above.

⁵*Carter-Shields, M.D. v. Alton Health Institute, et al.*, 201 Ill. 2d 441 (2002).

⁶For a more detailed discussion of the *Carter-Shield* and *Prairie* decisions, see *Gimbel and Zaremski, Medical Restrictive Covenants in Illinois: At the Crossroads of Carter-Shield and Prairie Eye Center*, 12 *Annals Health L.* 1 (2003).

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CONTACT INFORMATION

Novack and Macey *LLP*
303 West Madison Street
Chicago, Illinois 60606-3308
T 312 419 6900
F 312 419 6928
www.novackandmacey.com

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