# RESTRICTIVE COVENANTS IN THE MEDICAL PROFESSION

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## I. INTRODUCTION

The issues surrounding physician restrictive covenant agreements highlight a clash of competing interests, rights, and individual freedoms. On one hand, there are the legitimate business interests of employers and physician practice groups to consider, as well as the freedom and sanctity of contract. Physician practice groups expend substantial time and money developing their practices and seek to protect their patient base. Hospitals must concern themselves with extending hospital privileges to physicians who have entered into restrictive covenant agreements prohibiting them from practicing their specialty, or medicine in general, within the hospital's locale.

On the other hand, society has an interest in promoting a free market place, and preventing monopolies, and ensuring the fullest availability of professional medical assistance. Additional considerations favoring unenforceability are a physician's right to work and the interest of patients in choosing their own doctors, including the ability to follow their doctor to a different practice group.

Physician restrictive covenants appear in various types of agreements, including employment agreements, partnership agreements, and agreements for the sale of a medical practice. While restrictive covenants in these differing contexts raise discreet issues, this paper is limited to restrictive covenants that are incidental to employment agreements. It should be noted, however, that these employment agreements may also include non-solicitation of patient provisions and a liquidated damages clause or some combination of the three. This paper focuses only on the non-compete clause in which employers will seek either injunctive relief to enjoin the activities prohibited by the restrictive covenant or, if the contract provides for them, liquidated damages.

The use of restrictive covenants is not a new phenomenon. Some of the earliest cases at English common law date back to 1414, holding that an employee's covenant not to compete was per se void, as were all restraints on trade. This early line of cases involved apprentices or journeymen who faced unethical masters attempting to prolong the traditional period of training.

Covenants in restraint of trade are still disfavored today, yet courts are willing to enforce them if they are reasonable. To qualify as reasonable, the covenant must be no greater than necessary to protect the employer's interest, not impose an undo hardship on the employee, and not harm the public. This test applies with equal force to restrictive covenants in the medical profession.

## II. THE AMERICAN MEDICAL ASSOCIATION VIEW OF PHYSICIAN RESTRICTIVE COVENANTS

While not dispositive, one public policy consideration is the position of the AMA. The current position of the AMA discourages the use of physician restrictive covenants in all contexts. Moreover, where a restrictive covenant is excessive in scope or duration or fails to make reasonable accommodation of patient's choice of physician, the AMA's current standards go beyond discouraging such covenants and condemn them outright as unethical.

Since it's founding in 1847, the AMA has written and published its Code of Medical Ethics governing the conduct of physicians. The 1847 Version of the AMA Code of Medical Ethics did not address the ethical propriety of restrictive covenants. A significant change to the AMA Code of Medical Ethics relating to restrictive covenants occurred in 1922 when the Judicial Counsel completely prohibited physicians from soliciting patients. This policy remained in effect until 1980. Although the AMA Code during this period did not expressly address covenants restricting a physician's right to practice medicine, the direct prohibition of advertising and solicitation of patients would have obviated the need for non-solicitation provisions that are seen in many of today's physician employment agreements. The other relevant provisions from the 1847 Code of Medical Ethics remained in effect.

In 1957, the AMA restructured its collection of ethic statements and opinions. Drawing upon the existing Code of Medical Ethics and Opinions of the Judicial Counsel, the AMA distilled the existing code into ten abstract Principals of Medical Ethics. As a result of this change, the AMA Code of Ethics now consists of the Principals of Medical Ethics and a codified compilation of the current opinions of the Counsel on Ethical and Judicial Affairs (hereinafter "CEJA"). The 1957 Principals of Medical Ethics provided that a physician may choose whom he will serve as well as providing that a physician should not solicit patients. In 1980 the Principals of Medical Ethics were again amended to repeal the absolute prohibition on solicitation of patients. Two additional principals adopted that year are relevant to physician restrictive covenants. First, the 1980 Principals of Medical Ethics provided that a physician shall respect the rights of patients and shall safeguard a patient's confidences within the constraints of the law. Second, the 1980 Principals of Medical Ethics provided that a physician shall recognize responsibility to participate in activities contributing to an improved community. Relying on these two principals, the CEJA opined that restrictive covenants should be discouraged.

The current CEJA opinion was established in 1988 which now discourages the use of any physician restrictive covenant:

> Covenants not to compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Counsel on Ethical and Judicial Affairs discourages any agreement which restricts the

> right of a physician to practice medicine for a specified period of time or in a specified area upon termination of employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of a patient's choice of physician.

In 2006, the CEJA recommended substantive changes to its opinion recommending language that would encourage physicians to be more accommodating of patient choice when entering into restrictive covenants. However, the proposed amendments were met with resistance from the AMA House of Delegates which referred the report back to the CEJA which withdrew the report in 2007.

Whether the AMA is an organization who will take an even stronger ethical stance against physician restrictive covenants remains to be seen. The historical picture reflects a trend toward a stronger position disfavoring physician restrictive covenants as unethical.

## III. PHYSICIAN RESTRICTIVE COVENANTS IN ILLINOIS

The earliest Illinois Supreme Court case dealing with restrictive covenants is *Hursen v. Gavin*, 162 Ill.377, 44 N.E. 735 (1896). The Illinois Supreme Court affirmed the trial court's grant of an injunction restraining the defendant from engaging in the livery and undertaking business for five years within the boundaries of the City of Chicago. Seven years later, the Court had its first opportunity to address restrictive covenants in the medical profession. In *Ryan v. Hamilton*, 205 Ill.191, 68 N.E. 781 (1903) the Court reversed the Appellate Court, upholding the trial court's grant of an injunction restraining the defendant from practicing general medicine "in or within" eight miles of the Village of Viola in Mercer County, finding that the restrictive covenant was enforceable since the limitation as to territory was reasonable. Subsequently, in *Bauer v. Sawyer*, 8 Ill.2d 351, 134 N.E.2d 329 (1956) the Illinois Supreme Court upheld an enforcement of another restrictive covenant regarding a former partner who was enjoined from practicing medicine and noted that: "The principals governing cases of these kind were stated in *Ryan v. Hamilton.*" The *Bauer* court added the following: "In determining whether a restraint is reasonable, it is necessary to consider whether enforcement will be injurious of the public or cause an undo hardship to the promissor, and whether the restraint imposed is greater than is necessary to protect the promisee."

The Illinois Supreme Court's most recent decision on the enforceability of physician restrictive covenants is *Mohanty v. St. John Heart Clinic*, 225 Ill.2d 52, 866 N.E.2d 85 (2006). In *Mohanty*, a group of physicians filed a declaratory judgment action against their employer, alleging that the restrictive covenants in their employment contracts were void as against public policy and unenforceable. The defendants cited to the AMA Counsel on Ethical and Judicial Affairs' opinion concerning physician covenants not to compete, arguing that it was similar to the Illinois Rules of Professional Conduct, Rule 5.6, which the Illinois Supreme Court previously relied upon in finding

that restrictive covenants in attorney agreements were void. Specifically, the plaintiffs cited to AMA Opinion 9.02 which they claim provided the necessary expression of public policy allowing the Court to invalidate restrictive covenants in physician employment agreements. The Court disagreed noting that while AMA Opinion 9.02 was informative, it was not the equivalent of an Illinois Statute or Rule of Professional Conduct and for that reason it did not provide a clear expression of the public policy of the state. AMA Opinion 9.02 could not dictate the manner in which restrictive covenants should be construed in Illinois.

The Court also noted that Opinion 9.02 did not prohibit, but merely discouraged restrictive covenants in medical employment contracts and was commensurate with the manner in which restrictive covenants in physician employment agreements had been historically treated in Illinois. As noted, historically, covenants restricting the performance of medical professional services had been valid and enforceable in Illinois as long as the durational and geographic scope were not unreasonable, taking into account the effect on the public and any undo hardship on the parties to the agreement. The Court noted that AMA Opinion 9.02 was no different from the common law requirements of the State of Illinois.

In *Mohanty*, the Illinois Supreme Court determined that the restrictive covenant restraining cardiologists from practicing "medicine" for a three year period within a two mile radius of the clinic's offices and for five years within a five mile radius of the clinic's offices were enforceable. The Court stated that restrictive covenants protect business interests of established physicians and in this way encouraged them to take on younger, inexperienced doctors. Accordingly, restrictive covenants can have a positive impact on patient care. The Court noted it had a long tradition of upholding covenants not to compete in employment contracts involving the performance of professional services when the limitations as to time and territory were not unreasonable.

Of importance, was the Court's upholding of the restriction on the practice of cardiology within this time and territory limitation but also the broader restriction on "the practice of medicine" within this time and territory limitation. The Court noted that under the circumstances of the case, the restriction on the "practice of medicine" was not unreasonable." Cardiology, like other specialties, is inextricably intertwined with the practice of medicine. For this reason, restrictive covenants precluding the practice of medicine against physicians who practice a specialty have been upheld as reasonable citing to cases involving dermatologists and as well as ophthalmologists. Of importance to the Court's decision was testimony that it took the clinic ten years to establish a successful cardiology practice and one of the participating doctors himself a minimum of three to five years to develop a referral base. Based upon this testimony, the Court found the two and five mile restrictions as well as the three and five year restrictions neither unreasonable nor would it cause an undo hardship on the plaintiff physicians.

The Illinois Supreme Court determined that the restrictive covenant restraining these cardiologists from practicing medicine was enforceable relying upon the time and territory tests, without ever mentioning or relying upon what had previously been referred

to as the "legitimate-business interest" test. Subsequent Appellate Court decisions have held that restrictive covenants should be evaluated only on the time and territory restrictions contained therein and a court should only find a restrictive covenant unenforceable where the court finds that the time and territory restrictions are unreasonable.

## IV. CONCLUSION

Ultimately, the legislature is responsible for declaring the public policy of the state and may adopt a statutory response. However, in the absence of legislative action, Illinois Courts will not hesitate to enforce physician restrictive covenants that are reasonable under the time and territory test. Such action by the courts, at least in the context of physician restrictive covenants, should not be perceived as an affront on the legislature's prerogative in setting the public policy of the state, but rather a faithful application of a long standing rule regarding the judiciary to evaluate the public effects of enforcing private contracts.

Certainly, physician restrictive covenants that limit both the practice of a medical specialty as well as the general practice of medicine for periods of three to five years and for geographic boundaries within two to five miles of the clinic's offices will be upheld, especially when including a provision recognizing a patient's choice of a physician. It is yet to be determined whether the Illinois Supreme Court will take a different position if the AMA's House of Delegates adopts a CEJA recommendation to bar restrictive covenants. Until then, hospitals will have to be vigilant that its staff physicians, or hospital privileged physicians, are not working in violation of prior restrictive covenants and medical practice groups will continue to be aggressive in enforcing their contractual rights to prohibit competitive medical practices.