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Stuart Gimbel
*Kamensky & Rubenstein*

Miles J. Zaremski
*Kamensky & Rubenstein*

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Medical Restrictive Covenants in Illinois:
at the Crossroads of *Carter-Shields*
and *Prairie Eye Center*

*Stuart Gimbel and Miles J. Zaremski*¹

Medical restrictive covenants² have enjoyed a unique legal heritage under Illinois law.³ However, two recent appellate court cases in Illinois have debated whether restrictive covenants of medical practitioners are unenforceable as violating Illinois' public policy. In *Carter-Shields v. Alton Health Institute,*⁴ the Fifth District Appellate Court ruled that, as a matter of law and public policy, restrictive covenants are not enforceable against medical practitioners. However, in *Prairie Eye Center, Ltd. v. Butler,*⁵ the Fourth District Appellate Court expressly rejected the holding in *Carter-Shields* and held that medical restrictive covenants are not contrary to public policy and may be enforced. Despite this conflict in the appellate districts, the Supreme Court of Illinois expressly avoided resolving the public policy issue when it affirmed, in part, the ruling in *Carter-Shields* on other grounds.⁶ Instead, the Supreme Court expressed "no opinion with respect to the general validity of non-competition

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1. Stuart Gimbel and Miles J. Zaremski are partners in the law firm of Kamensky & Rubinstein in Lincolnwood, Illinois. Stuart Gimbel has a J.D. from the University of Virginia School of Law (1986), and practices in the area of commercial litigation, with an emphasis on restrictive covenant litigation. Mr. Gimbel can be contacted at sgimbel@kr-law.com. Miles J. Zaremski has a J.D. from George Gund Hall, Case Western Reserve Law School (1973), and practices in the area of commercial litigation and health law. Mr. Zaremski can be reached at mzaremski@kr-law.com. The research, support, and overall assistance of Priscilla Dragoi, a law clerk with Kamensky & Rubinstein, is gratefully acknowledged.

2. For the purposes of this article, the term “restrictive covenant” will be used interchangeably with the related terms “covenant not-to-compete” and “non-competition agreement.”

3. *Prairie Eye Ctr., Ltd. v. Butler,* 768 N.E.2d 414, 422 (Ill. App. Ct. 2002) (“The case law governing covenants not to compete in medical employment contracts has developed separately from that applicable to other employment contracts and no special proof of entitlement to patients is required to find a protectable interest on the part of the medical practice.”).


5. *Prairie Eye Ctr.,* 768 N.E.2d at 421.

clauses contained within physician employment agreements." According to the question of whether restrictive covenants of medical practitioners are enforceable in Illinois remains unsettled.

This article will review the legal precedent leading up to the Carter-Shields and Prairie Eye Ctr. decisions, consider the reasoning of those conflicting decisions, and attempt to reconcile those decisions in a manner consistent with Illinois precedent and case law from other jurisdictions. In addition, this article will analyze the public policy concerns fueling the debate over the enforcement of medical practitioners' restrictive covenants. Considering the public policy arguments that have been advanced against enforcement of medical restrictive covenants, there are not sufficient grounds for the Supreme Court of Illinois to reverse its long history of enforcing the reasonable restrictive covenants of medical practitioners.

I. GENERAL RULES FOR ENFORCING RESTRICTIVE COVENANTS IN ILLINOIS.

Illinois courts have protected fair competition in business while "exhibiting an abhorrence of restraints of trade." Because restrictive covenants contained in employment agreements act as partial restraints of trade, such covenants are carefully scrutinized by Illinois courts. However, where neces-

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7. Id.
8. Id. Although the Supreme Court of Illinois vacated the portion of the Carter-Shields decision which found that medical restrictive covenants are contrary to public policy, the public policy issues raised in Carter-Shields have not been conclusively resolved. Id.
9. See Zimmerman v. Vill. of Skokie, 697 N.E.2d 699, 708 (Ill. App. Ct. 1998) (under the doctrine of stare decisis, the general policy of the courts is to stand by legal precedents and not disturb settled points of law). Although not an inflexible rule, given the long line of decisions enforcing reasonable restrictive covenants in the medical field, the doctrine of stare decisis dictates the guidelines for the debate over the enforcement of medical restrictive covenants.
11. Covenants seeking to prevent a person from engaging in a trade or business within a proscribed area primarily arise either in employment relationships or ancillary to the sale of a business. See O'Sullivan v. Conrad, 358 N.E.2d 926, 929 (Ill. App. Ct. 1976). Since the interests to be protected differ significantly in those two situations, the courts apply different rules for adjudicating disputes relating to covenants in each of those scenarios. Id. For purposes of this article, we will primarily address medical restrictive covenants ancillary to an employment relationship.
sary for the protection of a legitimate business interest and reasonable in duration and geographic scope, such covenants may be enforced in Illinois. One of the requirements for the enforcement of a restrictive covenant is the existence of an employer's protectable business interest. The most common interest of an employer in enforcing a restrictive covenant is the employer's interest in retaining its customers in circumstances where the employee's contacts and relationships with those customers create a substantial risk that the employee will be able to divert part or all of the employer's business. As one Illinois court succinctly put it, an "employer has a valid interest in protecting its long-standing client relationships against the subter-
Illinois courts apply a two-prong test for determining whether an employer has a protectable interest in its business relationships sufficient to enforce a restrictive covenant: (1) the employer must establish that it has a near permanent relationship with its customers, and (2) that, but for the association with the employer, the employee would not have had contact with its customers. In determining whether an employer’s relationships with its customers are near permanent, Illinois courts generally consider a variety of objective factors: the length of the employer’s relationship with its customers; the amount of customer turnover; and the time, difficulty, and most importantly, cost of acquiring its customers. However, in some cases, where the type of business involved clearly demonstrates either the existence of a near permanent relationship or the lack thereof, Illinois courts have decided whether to enforce restrictive covenants based solely upon the nature of the employer’s business. Pursuant to the “nature of the business” approach, Illinois courts have held that a near permanent relationship is likely to exist in businesses involving professional or pseudo-professional services without resorting to a cumbersome and fact intensive analysis of the objective factors identified by the courts. In addition to establishing a near per-

19. Agrimerica, 557 N.E.2d at 363 (the objective factors to be considered in determining whether a near-permanent relationship existed as follows: (1) the number of years required to develop the clientele; (2) the amount of money invested to acquire clients; (3) the degree of difficulty in acquiring clients; (4) the extent of personal contact by the employee; (5) the extent of the employer’s knowledge of its clients; (6) the duration of the customers’ association with the employer; and (7) the continuity of the employer-customer relationship). See also Office Mates 5, 599 N.E.2d at 1082-83 (applying the seven-factor test).
21. See Dam, Snell & Taveirne, Ltd. v. Verchota, 754 N.E.2d 464, 469 (Ill. App. Ct. 2001) (employers engaged in a professional or pseudo-professional practice are more likely to maintain near-permanent relationships with their client base); Williams & Montgomery, 552 N.E.2d at 1106 (quoting Image Supplies, Inc. v. Hilmert, 390 N.E.2d 68, 70 (Ill. App. Ct. 1979)) (recognizing that employers in certain professions could justifiably anticipate a near-permanent relationship with their clientele). Compare
manent relationship with its customers, an employer seeking to enforce a restrictive covenant must also establish that, but for his or her association with the employer, the employee would not have come into contact with those customers. Thus, in circumstances where an employee is servicing substantially the same customers as the employee serviced prior to joining the employer, the Illinois courts have found that no protectable business interest exists to warrant enforcement of a restrictive covenant.22

II. MEDICAL RESTRICTIVE COVENANTS IN ILLINOIS.

Despite the specific rules which Illinois courts have developed governing the enforcement of restrictive covenants, the Supreme Court of Illinois has consistently enforced the restrictive covenants of medical practitioners without regard to the analysis applied in other restrictive covenant cases. The Supreme Court of Illinois first addressed medical restrictive covenants in Linn v. Sigsbee.23

In Linn, Dr. Linn sold his medical practice to Dr. Sigsbee, and Dr. Linn agreed not to establish or attempt to establish a medical practice in the same township or within six miles of the practice. Dr. Linn violated the agreement, and the Supreme Court of Illinois held that an agreement not to practice medicine, if reasonably limited and supported by consideration, is valid.24 The restraint in Dr. Linn's case, though unlimited in time, was held to be reasonable and valid.25 In Ryan v. Hamilton, the Su-

22. See Jefco Labs., Inc. v. Carroo, 483 N.E.2d 999, 1002 (Ill. App. Ct. 1985) (finding that an employer does not have a protectable interest in customers that the employee brought to the employer). An argument looms regarding the interest of an employer with respect to clients developed by the employee during the course of his employment. See Com-Co Ins. Agency, Inc. v. Serv. Ins. Agency, Inc., 748 N.E.2d 298, 301 (Ill. App. Ct. 2001). However, most courts are hesitant to enforce a restrictive covenant when the employee was primarily responsible for establishing the customer relationship. See LSBZ, Inc. v. Brokis, 603 N.E.2d 1240, 1250 (Ill. App. Ct. 1992); Blake, supra note 13, at 667 (“Where the employer’s role in securing or retaining customers is limited in relation to the employee’s, it appears to be increasingly likely that no protectable interest sufficient to support a restraining covenant will be recognized.”).

23. Linn, 1873 Ill. LEXIS 14 (Ill. 1873).
24. Id. at *7.
25. Id. See RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. d (1979) (regarding the issue of reasonableness of covenant restrictions, it has generally been held that
preme Court of Illinois held that a similar covenant in the sale of a medical practice was enforceable.26

Thereafter, in 1933, the Supreme Court held that a covenant not to independently practice medicine in Chicago contained in a partnership agreement was reasonable and valid.27 The restrictive covenant of a partner was again found to be reasonable and enforceable by the Supreme Court in Bauer v. Sawyer.28 In 1969, the Supreme Court of Illinois for the first time addressed the enforcement of a physician’s restrictive covenant in the employment context. In Canfield v. Spear,29 the court found that Dr. Spear was a “newcomer” to the Rockford area in which the plaintiff medical partnership practiced, and that it was “doubtless through the opportunities provided by this association that he became known in the city.” The court went on to observe that Dr. Spear’s agreement not to compete in Rockford or within a 25-mile radius thereof for a period of three years following termination of his association with the partnership was one of the considerations upon which the partnership accepted him and provided him with a substantial income. Finding that

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26. Ryan [need rest of case name], 68 N.E. 781, 786 (Ill. 1903).
27. Storer v. Brock, 184 N.E. 868, 870 (Ill. 1933).
28. Bauer v. Sawyer, 134 N.E.2d 332 (Ill. 1956) (the Illinois Supreme Court held that there was no authority prohibiting members of a partnership from protecting themselves against the competition of an outgoing partner because “such agreements are classic illustrations of reasonable restraints of trade.”). Although Illinois courts have enforced partners’ restrictive covenants over the years, the application of restrictive covenants outside the employment and sale of business situations may be problematic. Since there is no reason to presume that a partner will be provided with confidential information or brought into contact with near-permanent relationships of the partnership (the employee scenario), or that a partner will receive compensation for the good will of the partnership in the event he withdraws (the sale of business scenario), one could legitimately question whether a partnership necessarily has a legitimate interest in enforcing a restrictive covenant. The most common rationale, as expressed in Bauer, is that partners can mutually agree to protect themselves against the competition of an outgoing partner. Id. See also RESTATEMENT (SECOND) OF CONTRACTS § 188 cmt. b (1979) (restrictive agreements of partners will be upheld, where reasonable in scope, “in view of the interest of each party as promisee.”). However, Illinois courts have recognized that the right to contract can be subservient to the public policy interests favoring free competition. See Hamer Holding Group, Inc. v. Elmore, 613 N.E.2d 1190, 1200 (Ill. App. Ct. 1993) (“[S]ociety prizes competition more highly than it does the ability of an individual to enter into private agreements, and . . . when the two come into direct conflict, the interest of the individual must give way to that of the many.”). Accordingly, the rationale for enforcement of restrictive covenants between partners needs further consideration.

enforcement of Dr. Spear’s covenant would not be injurious to the public, the Supreme Court concluded that the agreement was not contrary to public policy.

After *Canfield*, the Supreme Court of Illinois again upheld the enforcement of a medical practitioner’s restrictive covenant in *Cockerill v. Wilson*. *Cockerill* involved a suit to enforce a restrictive covenant not to practice veterinary medicine within a radius of 30 miles of Dr. Cockerill’s established practice for a period of five years from the termination of Dr. Wilson’s association. As in *Canfield*, the Supreme Court of Illinois recognized that in bringing Dr. Wilson, a stranger to the area, into his medical practice, Dr. Cockerill was naturally interested in protecting his clientele, which he had established over a period of years, from being taken over by Dr. Wilson. The court held that “[t]he protection of this asset is recognized as a legitimate interest of an employer.”

Significantly, in both *Canfield* and *Cockerill*, the Illinois Supreme Court upheld the restrictive covenants without any detailed consideration of the existence of a protectable interest of the employer. The Supreme Court commented in *Cockerill* that covenants “involving performances of professional services have been held valid and enforceable when the limitations as to time and territory are not unreasonable.” Failure to establish either the prerequisite protectable interest of the employer, or to otherwise mention the near-permanency test utilized in other restrictive covenant cases has led other Illinois courts to hold that a medical practitioner is presumed to have a sufficient protectable interest in his or her medical practice. Indeed, following

30. *Id.* at 435. (The court reasoned that, since it could not be said that the public interest would be adversely affected if Dr. Spear decided to move from the community, no injury to the public interest results from such an agreement in advance). *See also* Cogley Clinic v. Martini, 112 N.W.2d 678, 682 (Iowa 1962) (holding that a physician “has always had the right to retire or move from the community. No one could legally complain if he did.”).

31. *Id.*


33. *Id.* at 651.

34. *Id.* at 650.

35. *See, e.g.*, Retina Servs., Ltd. v. Garoon, 538 N.E.2d 651, 653 (Ill. App. Ct. 1989); Gillespie v. Carbondale & Marion Eye Ctr., Ltd., 622 N.E.2d 1267, 1269 (Ill. App. Ct. 1993); Sarah Bush Lincoln Health Ctr. v. Perket, 605 N.E.2d 613, 617 (Ill. App. Ct. 1993) (holding that the restrictive covenant contained in the employment agreement of its former director of physical medicine and rehabilitation “was more nearly like that of the professionals in *Cockerill* and *Canfield* and the showing of a proper protectable interest was inherent in the relationships alleged in the complaint.”).
the long line of Supreme Court decisions enforcing medical restrictive covenants, one appellate court observed that:

The Illinois Supreme Court has repeatedly upheld covenants not-to-compete in medical practice cases without making specific inquiry into whether the plaintiff has demonstrated a protectable business interest. Notwithstanding the appellate court decisions which have carefully scrutinized whether the plaintiff has shown a protectable interest in cases outside the medical practice area, the Illinois Supreme Court's consistent enforcement of such covenants in the medical professional field, where the duration and geographic scope is reasonable, demonstrates its recognition that a professional's medical practice is a protectable business interest.36

Although not irrebuttable,37 the presumption that a physician has a protectable business interest in his or her professional practice provides a strong foundation for the enforcement of medical practitioners' restrictive covenants.

36. Garoon, 538 N.E.2d at 653. This rule goes a step beyond the "nature of the business" analysis applied by some courts to determine whether an employer has a near-permanent relationship with its customers. See supra notes 20 and 21. In cases invoking the "nature of the business" test, the employer is still required to establish that, but for the employee's association with the employer, he or she would not have come into contact with those customers. See Springfield Rare Coins Galleries, Inc. v. Mileham, 620 N.E.2d 479, 489 (Ill. Ct. App. 1993) ("Where the employer is engaged in the provision of professional services and employs the employee to assist in the provision of those services, and the evidence indicates the employee would not have had contact with the clients but for the association with the employer, the near-permanency test is satisfied."); Lawrence & Allen v. Cambridge Human Res. Group, Inc., 685 N.E.2d 434, 443-44 (Ill. App. Ct. 1997). Failure to include the second prong of the near-permanency test could have a significant and unintended impact where, for example, an employer attempts to enforce a restrictive covenant against a physician who had an established patient base prior to joining the employer. The employer should not have a legitimate business interest in preventing a physician from treating patients post-employment whom the physician had treated prior to joining the employer. See Blake, supra note 13, at 663-64. ("When an employee... actually brings customers with him when he takes employment, courts are reluctant to prevent his soliciting them when he departs, regardless of the existence of a covenant not to compete.").

37. See Danville Polyclinic, Ltd. v. Dethmers, 631 N.E.2d 842, 845-46 (Ill. App. Ct. 1993) (no protectable interest exists where covenant was not to protect employer's relationship with patients, but to keep defendant associated with employer to help finance construction of a new building); S. Ill. Med. Bus. Assoc. v. Camillo, 546 N.E.2d 1059, 1065 (Ill. App. Ct. 1989) (medical laboratory group did not have protectable interest in enforcing covenant of employee who developed relationships through his own efforts); Taimoorazy v. Bloomington Anesthesiology Serv., Ltd., 122 F. Supp. 2d 967, 980 (C.D. Ill. 2000) (anesthesiology group did not have protectable interest in stopping plaintiff from practicing at hospital where the group did not and could not practice).
However, the Supreme Court of Illinois has not opined on the enforcement of medical restrictive covenants since its decision in Cockerill thirty years ago.\footnote{But see Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 108 (Ill. 1997) (though the Supreme Court of Illinois was asked to declare a physician’s restrictive covenant unenforceable, the decision turned on whether enforcement of the covenant was barred under the “corporate practice of medicine” doctrine. The Supreme Court concluded that the health center, which was duly licensed under Illinois’ Hospital Licensing Act, had the authority to practice medicine, and was therefore excepted from the corporate practice of medicine doctrine. \textit{Id.} at 114 (because the circuit court had not addressed the substantive issues of the case, the Supreme Court did not rule upon the validity of the restrictive covenant). \textit{Id. See also} Carter-Shields, infra notes 47 and 48 (where the Supreme Court refused to address the validity of medical restrictive covenants and instead held that the unlicensed, not-for-profit employer in that case was not privy to the exception to the corporate practice of medicine doctrine carved out in \textit{Berlin}).} Prior to the Cockerill decision, health care services were primarily provided on a fee for service basis. However, a year after the Cockerill decision, the passage of the Health Maintenance Organization Act of 1973 (the “HMO Act”)\footnote{42 U.S.C. §§ 300(a)-(d) (2002).} heralded a new form of health care delivery system, the HMO.\footnote{See Rush Prudential HMO, Inc. v. Moran, 2002 U.S. LEXIS 4644 (2002).} The Supreme Court of Illinois has recognized that this new health care model dramatically alters the manner in which health care services are provided in the post-Cockerill era.\footnote{See Jones v. Chicago HMO Ltd. of Ill., 730 N.E.2d 1119, 1128 (Ill. 2000) (“HMOs undertake an expansive role in arranging for and providing health care services to their members.”). \textit{See also} Berlin, 688 N.E.2d at 114 (“[W]e believe that extensive changes in the health care industry since the time of the \textit{Kerner} decision, including the emergence of corporate health maintenance organizations. . . have greatly altered the concern over the commercialization of health care.”); Pegram v. Herdrich, 530 U.S. 211, 219 (2000) (the United States Supreme Court has recognized that HMOs change the financial incentives of health care providers, encouraging physicians to provide less care in order to control costs and improve the financial performance of the HMO).}

Unfortunately, there has been a paucity of discussion regarding how the dramatic changes in the health care delivery system have affected the validity of medical practitioners’ restrictive covenants. The decisions of the Supreme Court of Illinois in Canfield and Cockerill were predicated upon the development of a traditional physician-patient relationship. However, given the advent of managed care and, in particular, HMOs, where a patient’s relationship with a physician is ordinarily governed by the contractual agreement between the patient’s employer and the managed care entity, and the contractual relationship between the managed care entity and its member providers, there
is a legitimate basis for questioning the historical justification for enforcing medical restrictive covenants in this new era of health care delivery.

Despite the genesis of the formation of the physician-patient relationship, the ultimate responsibility for patient care resides in the physician. Thus, even in this new era of health care delivery, it appears that a medical practitioner develops a sufficiently close relationship with patients to warrant protection of those relationships through a reasonable restrictive covenant. However, close scrutiny is needed to assure that the historical foundation for the enforcement of such covenants is appropriately utilized to protect a legitimate business interest, as opposed to merely restricting competition, in the modern post-Cockerill health care delivery system.

III. CARTER-SHIELDS DECLARES MEDICAL RESTRICTIVE COVENANTS VOID.

The strong historical foundation for the enforcement of medical restrictive covenants in Illinois has been called into question as a result of the Supreme Court of Illinois’ promulgation of a rule of professional conduct, which prohibits a lawyer from offering or making a partnership or employment agreement which restricts the rights of a lawyer to practice after termination of the relationship. Illinois Rule of Professional Conduct 5.6 took effect on August 1, 1990. In Dowd & Dowd, Ltd. v. Gleason, the Supreme Court of Illinois determined that Rule 5.6, which is designed to afford clients greater freedom in choosing counsel and to protect lawyers from onerous conditions that would unduly limit their mobility, retroactively prohibited enforcement of a lawyer’s non-competition agreement.

Shortly after Rule 5.6 took effect, at least one Illinois court questioned whether the prohibition against lawyers entering into restrictive agreements should logically be extended to physicians. However, not until the appellate court’s decision in Carter-Shields v. Alton Health Inst. in December 2000, did any

42. Pegram, 530 U.S. at 229-30.
43. Ill. Sup. Ct. R.P.C. 5.6(a).
44. Gleason, 693 N.E.2d 358, 369 (Ill. 1998).
45. Id. at 370.
46. See Bishop v. Lakeland Animal Hosp., 644 N.E.2d 33, 36 (Ill. App. Ct. 1994) (“If attorneys are precluded from entering into [restrictive covenants], the same prohibition should arguably be extended to other holders of professional licenses.”).
Illinois court ever purport to broadly invalidate physician restrictive covenants on public policy grounds. 47

_Carter-Shields_ involved a physician who had practiced medicine for 12 years before entering into an agreement with Alton Health Institute ("AHI"), a not-for-profit health care organization. The agreement included a two-year non-competition provision. 48 Less then two years after her employment with AHI began, Dr. Carter-Shields filed a declaratory judgment action seeking to have her agreement with AHI, including the non-competition provision, declared invalid. 49 The trial court found that Dr. Carter-Shields’ employment agreement was valid and enforceable, and enjoined her from practicing medicine within a 20-mile radius of AHI. 50

On appeal, the Fifth District Appellate Court in _Carter-Shields_ first considered whether AHI was precluded from enforcing the restrictive covenant by the corporate practice of medicine doctrine. 51 Illinois courts have long held that, unless otherwise permitted by the legislature, corporations are prohibited from providing professional medical services. 52 However, in the _Berlin_ case, the Illinois Supreme Court carved out an exception to the corporate practice of medicine doctrine for licensed hospitals. 53 The appellate court in _Carter-Shields_ initially held that AHI, because of its status as a not-for-profit health care corporation, did not come within the narrow exception to the corporate practice of medicine doctrine created for licensed hospitals by _Berlin_. 54 Because AHI was not authorized to prac-
tice medicine, the appellate court concluded that the contract between AHI and Dr. Carter-Shields, including the non-compete provision, was void.\textsuperscript{55}

Thereafter, "[a]ssuming arguendo that Berlin applies to the facts of the instant case," the appellate court in \textit{Carter-Shields} went on to consider whether AHI had a legitimate business interest in enforcing the non-competition provision in any event. Finding that Dr. Carter-Shields had "basically started a new business for AHI," the appellate court concluded that there was "no showing that AHI had a near-permanent relationship with any of plaintiff's patients."\textsuperscript{56} In so holding, the appellate court specifically found that "[t]his is not a case where a physician with an established practice takes on a newcomer and the newcomer usurps the clientele."\textsuperscript{57}

Finally, the appellate court in \textit{Carter-Shields} noted that a 1986 Opinion of the American Medical Association's Council on Ethical & Judicial Affairs ("Opinions") "discourage[d] any agreement between physicians 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 or a partnership or a corporate agreement."\textsuperscript{58} The appellate court further observed that in \textit{Dowd & Dowd}, the Supreme Court relied upon Rule 5.6 of the Code of Professional Conduct to determine that non-competition provisions among lawyers were void and unenforceable.\textsuperscript{59} Finding that Section 9.2 of the AMA's Opinions and Rule 5.6 were similar in scope, and that the same public policy arguments that prohibited lawyers from making non-competition agreements were applicable to physicians, the appellate court in \textit{Carter-Shields} held that Dr. Carter-Shields' restrictive covenant was unenforceable on public policy grounds.\textsuperscript{60}

The Illinois Supreme Court affirmed the appellate court's ruling that AHI was prohibited from practicing medicine under the corporate practice of medicine doctrine.\textsuperscript{61} Having determined

\textsuperscript{55} Id.
\textsuperscript{56} Id. at 576.
\textsuperscript{57} Id.
\textsuperscript{58} Id. (citing section 9.2 of the Opinions of the Council on Ethical & Judicial Affairs of the Am. Med. Ass'n (1986)).
\textsuperscript{59} Id.
\textsuperscript{60} Id. at 577.
\textsuperscript{61} Carter-Shields, No. 90767, 2002 WL 31087256, at *11 (Ill. 2002).
that the contract between Dr. Carter-Shields and AHI was void, the court expressed "no opinion with respect to the general validity of non-competition clauses contained within physician employment agreements."62

IV. PRAIRIE EYE CENTER REJECTS CARTER-SHIELDS.

The public policy holding of the appellate court in Carter-Shields called into question the long line of decisions in Illinois enforcing reasonable medical restrictive covenants.63 Not only did the Carter-Shields decision represent a complete reversal of the more than one hundred years of Supreme Court authority enforcing medical restrictive covenants in Illinois, but it also was contrary to the weight of authority from other jurisdictions holding that reasonable restrictive covenants of medical practitioners are not per se unenforceable.64 Indeed, as the Superior Court of Pennsylvania recently observed, "no jurisdiction has recognized

62. Id. However, the Supreme Court found that the portion of the Fifth District Appellate Court's opinion holding that physician restrictive covenants are unenforceable as a matter of public policy was wholly advisory. Accordingly, the Supreme Court vacated that portion of the decision. Consequently, the entire appellate court discussion of its public policy concerns regarding the enforcement of medical restrictive covenants has been nullified by the Supreme Court, and that discussion no longer has precedential value in the debate over medical restrictive covenants. See People v. Eidel, 745 N.E.2d 736, 744 (Ill. App. Ct. 2001) (citing New York Life Ins. Co. v. Sogol, 724 N.E.2d 105, 105 (Ill. App. Ct. 1999)) (holding that vacated judgment is void and "vacatur returns parties to status quo ante, as though . . . judgment had never been entered.").

63. See discussion supra Section II.

64. E.g., Ohio Urology, Inc. v. Poll, 594 N.E.2d 1027, 1031 (Ohio Ct. App. 1991) ("Today, the weight of authority holds that reasonable covenants not to compete after termination of employment entered into between physicians are enforceable."). See also Duneland Emergency Physician's Med. Group, P.C. v. Brunk, 723 N.E.2d 963, 966 (Ind. Ct. App. 2000) (citing Norlund v. Faust, 675 N.E.2d 1142, 1153 (Ind. Ct. App. 1997)) ("[N]on-compete covenants which restrict medical services in a particular area are not void per se as against public policy"); Cogley Clinic v. Martini, 112 N.W.2d 678, 682 (Iowa 1962) (finding that the public has no vested right to the services of the covenantee); Hall v. Willard & Woolsey, P.C., 471 S.W.2d 316, 318 (Ky. 1971) (policy of State is to enforce covenants, including those involving professional services, unless serious inequities would result); Middlesex Neurological Assocs., Inc. v. Cohen, 324 N.E.2d 911, 915 (Mass. 1975) (though not deciding whether restrictive covenants in medical employment contracts are invalid per se; the court declared that the "tendency of the authority seems to the contrary."); Armstrong v. Cape Girardeau Physician Assocs., 49 S.W.3d 821, 825 (Mo. Ct. App. 2001) ("Missouri has no per se rule against enforcing covenants not to compete between medical practitioners.") (citing William v. Beheler, 499 S.W.2d 770, 775 (Mo. 1973); Hansen v. Edwards, 426 P.2d 792, 793 ( Nev. 1967) ("The medical profession is not exempt from a restrictive covenant . . ."); Karlin v. Weinberg, 390 A.2d 1161, 1168 (N.J. 1978) ("[W]e do not find restrictive covenants between physicians to be Per se unreasonable and unenforceable."); Concord Orthopaedics Prof'l Ass'n v. Forbes, 702 A.2d 1273, 1275 (N.H. 2002) [13] Medical Restrictive Covenants in Illinois: At the Crossroads of
a public interest in assuring the unrestricted ability of a particular patient in continuity of care with a single physician.\textsuperscript{65} Although several states' legislatures have either declared medical restrictive covenants unenforceable\textsuperscript{66} or have provided that all restraints of trade are void,\textsuperscript{67} the \textit{Carter-Shields} decision was unique in that a court was declaring the entire field of medical restrictive covenants void as against public policy.\textsuperscript{68}

While the \textit{Carter-Shields} case was pending before the Supreme Court of Illinois, the Fourth District Appellate Court rendered its decision in \textit{Prairie Eye Ctr.} expressly rejecting the public policy holding in \textit{Carter-Shields}.\textsuperscript{69} In \textit{Prairie Eye Ctr.}, the court considered a two-year, ten-mile restrictive covenant of Dr. Butler, an ophthalmologist.\textsuperscript{70} After the trial court entered a final injunction against Dr. Butler,\textsuperscript{71} as well as awarding substantial damages for his breaches of the covenant and of the preliminary injunction, Dr. Butler, relying on \textit{Carter-Shields}, ar-

\textsuperscript{65} W. Penn Specialty MSO, Inc. v. Nolan, 737 A.2d 295, 301 (Pa. Super. Ct. 1999). However, some courts have refused to rule out the possibility that medical restrictive covenants are \textit{per se} unenforceable, leaving the issue open. See Valley Med. Specialists v. Farber, 982 P.2d 1277, 1283 (Ariz. 1999) (finding the covenant at issue unreasonable and thus unenforceable, the court did not find need to address the contention that restrictive covenants are void \textit{per se} as against public policy); Med. Educ. Assistance Corp. v. Tenn., 19 S.W.3d 803, 816 (Tenn. Ct. App. 1999) ("We express no opinion whether the public's interest would mandate enforcement or non-enforcement of a covenant not to compete involving a physician's leaving his private practice group to compete against that private practice group."); Valley Med. Specialists, 982 P.2d at 1282-83. (The court held that, in light of the great public policy interest involved in covenants not to compete between physicians, "the interests of the public may outweigh the protectable interests of the [employer].").

\textsuperscript{66} E.g., \textsc{Del. Code Ann. tit. 6, § 2707 (1999).}

Any covenant not to compete provision of an employment, partnership or corporate agreement between and/or among physicians which restricts the right of a physician to practice medicine in a particular locale and/or for a defined period of time, upon the termination of the principal agreement of which such provision is a part, shall be void . . . . However, the Delaware provision does allow the enforcement of covenant not to compete provisions that require the payment of damages). \textit{Id.} See also Paula Berg, \textit{Judicial Enforcement of Covenants Not to Compete Between Physicians: Protecting Doctors' Interests at Patients' Expense}, 45 \textsc{Rutgers L. Rev.} 1, 10-14 (1992) (discussing various state statutes relating to medical restrictive covenants, or general restraint of trade legislation).

\textsuperscript{67} E.g., \textsc{Cal. Bus. & Prof. Code} § 16600 (1997).

\textsuperscript{68} See supra notes 61-62.


\textsuperscript{70} Id.

gued that his restrictive covenant was unenforceable on public policy grounds. The Prairie Eye Ctr. court rejected that argument and declined to follow Carter-Shields, noting that in Dowd, the court relied on Rule 5.6 of the Rules of Professional Conduct, which prohibits lawyers from participating in any employment agreement restricting the rights of lawyers to practice after termination of an employment agreement. Finding the non-competition agreement void and unenforceable, the court stated the rule was designed to further the public policy objective of affording clients freedom in choosing counsel as well as to protect lawyers from conditions unduly restricting their mobility. In Carter-Shields, the court relied on Section 9.2 of the Opinions of the Council on Ethical & Judicial Affairs of the American Medical Ass’n. (1986), which states non-competition agreements between physicians are discouraged as not in the public interest.

While Rule 5.6 and Section 9.2 may share some of the same public policy concerns, they have different applicability when considered here.

First, the wording of Rule 5.6 is mandatory while that in Section 9.2 is advisory only. Of more importance, Rule 5.6 is codified in the rules of the Illinois Supreme Court and has the force of law; also, it is indicative of public policy in the area of attorney conduct. Section 9.2, on the other hand, is not codified in the State of Illinois; thus, it does not establish public policy. While there may be no real difference in the concerns of clients in keeping or choosing lawyers of their own choice and patients in keeping or choosing doctors of their own choice, a distinct difference lies in the legal underpinnings of Dowd and Carter-Shields. Despite our sympathy for the rights of patients to choose their own doctors, we are constrained to follow the long line of precedent finding non-competition agreements enforcea-

72. Prairie Eye Ctr., 768 N.E.2d at 416.
73. IL. RULES OF PROF’L CONDUCT, ART. VIII, R. 5.6 (2002).
74. Prairie Eye Ctr., 713 N.E.2d at 612 (citing Dowd, 693 N.E.2d at 369).
ble in the medical profession.\textsuperscript{78} We leave the public policy pronouncements for either our supreme court or the legislature.\textsuperscript{79}

On the surface, the appellate court decisions in \textit{Carter-Shields} and \textit{Prairie Eye Ctr.} seem diametrically opposed to each other. However, those decisions are not entirely incompatible in light of the prior precedent in Illinois regarding medical restrictive covenants. Although such covenants have enjoyed a special heritage that has led to a presumption of the existence of a protectable interest,\textsuperscript{80} that presumption has not been treated as irrebuttable. In fact, when the basis for the presumption of a protectable interest has been shown not to apply, the Illinois courts have refused to enforce medical restrictive covenants.\textsuperscript{81}

The \textit{Carter-Shields} case involved the employment of an experienced medical professional who apparently did not need or use his employer's reputation or good will to develop her medical practice. In such a case, the theoretical underpinnings for enforcement of a restrictive covenant are not present. In that situation, it would violate the public policy of Illinois to allow the employer to interfere in an employee's ability to practice his or her profession when no legitimate interest of the employer would warrant such a result. To that extent, the appellate court's decision in \textit{Carter-Shields} is perfectly in accord with prior precedent.

V. \textbf{Evaluating the Public Policy Arguments in \textit{Carter-Shields}.}

It is in the alternate ruling of \textit{Carter-Shields} suggesting that medical restrictive covenants are \textit{per se} contrary to public policy that the Fifth District strayed from prior precedent in Illinois,\textsuperscript{82} as well as from other jurisdictions.\textsuperscript{83} Despite the fact that the Supreme Court of Illinois vacated that portion of the \textit{Carter-Shields} decision, the underlying policy issues raised in the opinion must eventually be addressed.\textsuperscript{84} Consideration of the bases

\begin{thebibliography}{99}
\item 80. \textit{See supra} text accompanying note 37.
\item 81. \textit{See supra} text accompanying note 38.
\item 82. \textit{See supra} Section II.
\item 83. \textit{See supra} note 58.
\item 84. The Supreme Court of Illinois is currently considering a petition for leave to appeal in the \textit{Prairie Eye Center} case. Prairie Eye Ctr., Ltd. v. Butler, 768 N.E.2d 414,
\end{thebibliography}
for the *Carter-Shields* decision leads to the conclusion that the broad public policy pronouncement in the now vacated portion of that decision was not supported.

Initially, the *Carter-Shields* decision pointed out that the American Medical Association (AMA) disfavors the use of any restrictive covenant in either an employment or partnership agreement among physicians.\(^85\) However, “[f]or the past 60 years, the AMA has consistently taken the position that non-competition agreements between physicians impact negatively on patient care.”\(^86\) Since 1933, Illinois courts could have looked to the AMA and found that restrictive covenants are, to varying degrees, discouraged.\(^87\) Nevertheless, as discussed above, the Illinois courts have routinely enforced reasonable restrictive covenants of medical practitioners. Because the AMA’s ethical opinion is only a guide to professional behavior,\(^88\) several courts have refused to declare medical restrictive covenants unenforceable on the basis of the AMA’s non-binding guidance.\(^89\) Most importantly, as recognized in *Prairie Eye Ctr.*, the AMA does not establish the public policy of Illinois.\(^90\) Accordingly, Section 9.02 of the AMA’s Opinions does not support the sweeping prohibition of medical restrictive covenants suggested by the appellate court in *Carter-Shields*.\(^91\)


87. *See id.* at 6-9.


90. *Prairie Eye Ctr.*, 768 N.E.2d at 420. *See also* Karlin *v. Weinberg*, 390 A.2d 1161, 1168 (N.J. 1978) (hesitating to afford significant weight to those pronouncements of private professional organizations which have not been adopted by any governmental body or court).

The appellate court in Carter-Shields also based its conclusion that medical restrictive covenants are contrary to public policy upon the ruling of the Supreme Court of Illinois in Dowd & Dowd. The Dowd court looked to Rule 5.6 of the Rules of Professional Conduct to conclude that restrictive covenants are not enforceable between lawyers. Although the Supreme Court of Illinois, in its capacity as the governing body for attorneys, has made a bright line rule prohibiting restrictive covenants for lawyers, neither the legislature nor the Supreme Court has announced a similar public policy foundation for extending that prohibition to physicians. Accordingly, the rule prohibiting lawyers from entering into restrictive covenants does not, in and of itself, justify a sweeping prohibition of restrictive covenants for physicians.

Finally, the appellate court in Carter-Shields found that an agreement restricting the right of a physician to practice medicine not only limits the physician’s autonomy, but also interferes in the patient’s freedom to choose a doctor. Observing that free choice of physicians is the right of every individual, the appellate court in Carter-Shields concluded that the restrictive covenant of Dr. Carter-Shields was unenforceable on public policy grounds. However, that argument had been previously rejected by the Illinois Supreme Court, which recognized that since a patient’s right to freely choose a physician did not prohibit the physician from voluntarily retiring or leaving the com-

94. Ill. RULES OF PROF’L. CONDUCT, ART. VIII, R. 5.6 (2002).
95. See Prairie Eye Ctr., 768 N.E.2d at 421 (leaving public policy pronouncements for either the state supreme court or the legislature); see also Ohio Urology, Inc. v. Poll, 594 N.E.2d 1027, 1030-31 (Ohio App. Ct. 1991) (finding that, unlike disciplinary rules expressly prohibiting restrictive covenants among lawyers, the ethical standards pertaining to physicians do not mandate unenforceability); Karlin v. Scheinmen, 390 N.E.2d 1165, 1168 (N.Y. App. Ct. 1979) (observing that regulations governing physicians do not contain restrictions similar to disciplinary rule forbidding attorneys from entering into restrictive covenants).
96. Carter-Shields, 739 N.E.2d at 577.
97. Id. (Citing Michael R. Sullivan, Covenants Not to Compete and Liquidated Damage Clauses: Diagnosis and Treatment for Physicians, 46 S.C.L. REV. 505, 514 (1995)) (referring to section 9.02 of the Opinions of the Council on Ethical & Judicial Affairs of the Am. Med. Ass’n (1982)). Interestingly, the treatise cited in Carter-Shields immediately followed the quoted section by stating, “[h]owever, AMA opinions are merely advisory and do not bind members of the association. In fact, the general counsel of the AMA suggests that most states will enforce such restraints if reasonable.” Id. (Note omitted).]
2003] Medical Restrictive Covenants in Illinois

community, a physician’s voluntary covenant to practice outside a specified area did not violate public policy. That position is consistent with the unanimous weight of authority from other jurisdictions.

Indeed, the enforcement of medical restrictive covenants could be supported on several public policy grounds. First, such covenants could actually enhance stability in patient relationships with physicians. The premise of a valid medical restrictive covenant is that the employer has a near-permanent relationship with its patients. Thus, in the appropriate circumstances envisioned for the enforcement of medical restrictive covenants, it was not the choice of the patient to establish a relationship with an employed physician, but that of the employer who brought the physician into an existing medical practice and into contact with existing physician-patients’ relationships.

Accordingly, when applied properly, a medical restrictive covenant should actually preserve the long-standing relationship

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98. See supra note 31.
100. It is not our intention to decide the public policy debate. We are merely suggesting that the public policy issue requires significantly more analysis than was provided by the appellate court in Carter-Shields before such an important and complex decision is made. As the Supreme Court has recognized in Pegram v. Herdrich, 530 U.S. 211, 221 (2000), in the health care field, “such complicated factfinding and such a debatable judgment are not wisely required of courts unless for some reason resort cannot be had to the legislative process, with its preferable forum for comprehensive investigations and judgments of social value . . . .” By suggesting policy considerations beyond the “freedom of patient choice” versus “freedom of contract” debate, we agree with the Supreme Court that the “very difficulty of these policy considerations, and Congress’ superior institutional competence to pursue this debate, suggest that legislative not judicial solutions are preferable.” Id. at 222. Indeed, in 1999, a proposed amendment to the Medical Practice Act of 1987 prohibiting physicians from entering into restrictive covenants was introduced in the Illinois Senate. S. 925, 91st Gen. Assemb., Reg. Sess. (Ill. 1999). No action was taken on that bill.
101. See, e.g., Canfield, 254 N.E.2d 433, 434 (Ill. 1969). That reasoning has been extended to cover the referral sources of a medical practice. See Retina Servs., Ltd. v. Garoon, 538 N.E.2d 651, 654 (Ill. App. Ct. 1989). In any event, the question of a patient’s right to choose a physician is not an issue in a referral situation.
102. Because the existence of a near-permanent relationship between an existing medical practice and its patients can be rebutted, the courts can and should avoid enforcing restrictive covenants when they do not protect a legitimate interest of the employers. See supra note 38. Indeed, because the facts apparently disclosed that the employer did not have a protectable interest in existing relationships with its patients in Carter-Shields, the appellate court decision was warranted on that ground alone, without invalidating all medical restrictive covenants. Carter-Shields v. Alton Health Inst., 739 N.E.2d 569, 578 (Ill. App. Ct. 2000).
of the patient with a medical practice. Absent such a covenant, an employed physician might establish a separate practice and begin competing for the business of the patients, who would be forced to decide between the employer, with whom the patient had a long-standing relationship, and the departing physician. The restrictive covenant would encourage the physician to remain with the employer, thus preserving the patients' relationships both with the physician and the practice.

The destabilizing effect of declaring all medical restrictive covenants unenforceable is particularly acute, because the prohibition against medical restrictive covenants suggested by the appellate court in Carter-Shields seems to apply equally to restrictive covenants between medical partners. Without such covenants, medical partners would be emboldened to dissolve their partnerships and begin competing with their former partners. Such a result would cause precisely the dislocations in the continuity of care asserted as a basis against the enforcement of medical restrictive covenants.

Not only would broadly prohibiting medical restrictive covenants likely result in significant turmoil as employees and partners began competing against their former practices, but such a prohibition would also interfere in the manner in which employers deploy their manpower. Thus, restrictive covenants may ac-

103. Cockerill v. Wilson, 281 N.E.2d 648, 648 (Ill. 1972) (holding that because of the defendant's contact with a clientele the plaintiff had established, the plaintiff was naturally interested in protecting his clients from being taken over by defendant).

104. See Blake, supra note 13, at 657. (Observing that a covenant not to compete "may deter the employee from leaving his employment and thus from finding himself in a position to compete for customers.").

105. The reasons cited by the appellate court in Carter-Shields for invalidating that employment covenant on public policy grounds are equally applicable to covenants made by partners in a medical practice. Carter-Shields, 739 N.E.2d at 577. The AMA's position discouraging restrictive covenants for physicians specifically refers to partnership (or corporate) agreements, as well as those of employees. See AMA Council on Ethical & Judicial Affairs, Op.E-9.02 (1998), available at http://www.ama-assn.org. In addition, the patient's right of free choice of physician relied upon by the Carter-Shields court would apply regardless of the form of the relationship between the physician and its employer/partners. Finally, the Rules of Professional Conduct for attorneys expressly prohibits partnership agreements, as well as employment agreements, restricting the rights of a lawyer to practice after termination of the relationship. IL. RULES OF PROF'L CONDUCT, ART. VIII, R. 5.6 (2002), available at http://www.state.il.us/court/Supremecourt/Rules/Art_VIII/ArtVIII.htm. Accordingly, if the reasoning of the appellate court Carter-Shields is adopted, then partnership restrictive covenants of medical practitioners should also be unenforceable as contrary to public policy.

106. See Berg, supra note 66, at 31. (Contending that continuity in the doctor-patient relationship fosters the delivery of quality health care).
ultimately increase efficiency by encouraging an employer to entrust information to an employee. The same is true with respect to patient relationships. If medical restrictive covenants were prohibited, then employers would be encouraged to manipulate the manner in which employed physicians are utilized in an attempt to preserve the employer's relationship with patients. Alternatively, employers would be encouraged to simply hire fewer employees. In either event, the likely result is that the public would end up with less than optimal access to employed physicians.

Finally, the prohibition against medical restrictive covenants suggested by the appellate court's decision in Carter-Shields would open the floodgates to other professionals seeking relief from their covenants on public policy grounds. Extension of the prohibition against restrictive covenants among lawyers to physicians would logically require the further extension of that prohibition to other professionals, such as accountants. However, Illinois courts have routinely enforced reasonable restrictive covenants of accounting professionals. Accordingly, the public policy debate cannot be limited to only physicians, but must, necessarily, consider the effects of prohibiting restrictive covenants in all professional fields, including accounting.

**Conclusion**

The Supreme Court of Illinois' failure to resolve the public policy debate in the Carter-Shields case leaves medical practitioners and their lawyers guessing at the direction that the Illinois courts will go with respect to the enforcement of medical restrictive covenants. However, the basis for determining the future of such covenants can be determined by looking to the past precedent relating to medical restrictive covenants. By fol-

107. **Restatement (Second) of Contracts** § 188 cmt. c (2002).
108. See **Blake**, supra note 13, at 652. (Reciting the argument that, "[u]nless some enforceable commitment or effective deterrent is possible, employers will not be justified in making the optimum outlay on employee-training programs.").
109. See Serena L. Kafker, **Golden Handcuffs: Enforceability of Non-Competition Clauses in Professional Partnership Agreements of Accountants, Physicians and Attorneys**, 31 AM. BUS. L.J. 31, 32-33 (1993) (suggesting that, since clients or patients of an accountant or physician have as strong an interest in freedom of choice as a lawyer's client, the complete prohibition against enforcement of the restrictive covenants of lawyers is inappropriate, and instead, all professional covenants should be held enforceable through reasonable financial forfeiture provisions).
ollowing that precedent, the Supreme Court of Illinois can reconcile the conflicting appellate court decisions by enforcing medical restrictive covenants only when the nature of the employment relationship supports the existence of a protectable business interest. However, the Supreme Court of Illinois must recognize that the public policy debate has not provided a sufficiently strong reason for it to overturn its consistent enforcement of reasonable medical restrictive covenants. Instead, the Supreme Court of Illinois should reject the argument raised by the appellate court in *Carter-Shields* that medical restrictive covenants are void as contrary to public policy and continue to recognize the special heritage of medical restrictive covenants under Illinois law. Given the complexity of the public policy issues involved in evaluating whether or not to enforce restrictive covenants in the medical field, any such decision should be left to the legislature.

However, until such time as the Supreme Court of Illinois conclusively resolves the public policy debate, which it refused to do in the *Carter-Shields* case, medical professionals are cautioned from placing excessive reliance upon restrictive covenants of their employees or partners. Particular attention should be paid to determine whether the presumption of a near-permanent relationship, which the Illinois courts have applied to medical practitioners, is well-founded in their case. Indeed, until the public policy issues are resolved, it is reasonable to assume that lower courts in Illinois will look carefully to determine whether a medical restrictive covenant should be invalidated on other grounds. For that reason, we call upon the Supreme Court of Illinois to reaffirm the validity of medical restrictive covenants and confirm the proper use of such covenants within the business of the practice of medicine in the State of Illinois.