

ARE PHYSICIAN NON-COMPETE AGREEMENTS UNDER ATTACK IN IOWA?

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On November 26, 2008, the Iowa Court of Appeals issued a decision refusing to enforce a non-compete covenant in a physician employment agreement that could have far-reaching impact on Iowa medical practices, hospitals, and other entities that employ physicians. In *Board of Regents v. Warren*, ____ N.W.2d ____, 2008 WL 5003750 (Iowa Ct. App. 2008)(final publication decision pending), the Court refused to enforce a two-year, 50-mile non-compete covenant involving a physician previously employed by the University of Iowa Hospitals and Clinics (“UIHC”). The critical question for employers of physicians is whether this case is a unique result based on the specific facts of the case, or whether it signals a change in the way Iowa courts will evaluate physician non-compete covenants.

Prior to *Warren*, Iowa Courts had long recognized that restrictive covenants prohibiting physicians from competing with former employers were valid and enforceable. See *Cogley Clinic v. Martini*, 112 N.W.2d 678, 681 (Iowa 1962); *Oates v. Leonard*, 183 N.W. 462 (Iowa 1921); *Rowe v. Toon*, 169 N.W. 38 (Iowa 1918). In *Cogley Clinic*, the Supreme Court of Iowa upheld a three-year restrictive covenant prohibiting an orthopedic surgeon from practicing within a 25-mile radius of Council Bluffs. The Court found, in 1962, that good roads, available transportation, and an expanding perimeter for business and professional influence made 25 miles not too far for a patient to travel to see a medical professional. Even though *Martini*, the

defendant doctor, would have been the only orthopedic surgeon in Council Bluffs, the Court found the availability of several orthopedic surgeons in Omaha (within the 25 mile non-compete radius) meant that patients, inconvenience having to travel for care did not rise to the level of violating public policy. In enforcing the restrictive covenant, the Court found the public policy of enforcing contracts outweighed any inconvenience to the patient public.

Based on *Cogley Clinic*, the prevailing view in Iowa has been that physician non-compete covenants were enforceable to the same extent as other professions. For the many years since *Cogley Clinic*, employers of physicians have had the comfort that a public policy argument based on patient access to care would not defeat the enforcement of physician restrictive covenants, especially as patient's ability and willingness to travel for medical care increased.

Any employer of physicians that is reliant upon non-competition covenant should no longer feel that same level of comfort. In *Warren*, the Court of Appeals held that a restrictive covenant prohibiting an oncologist from practicing in Cedar Rapids, which had been designated by the Federal Government as underserved by oncologists, was prejudicial to the public interest. Thus, there is a chance that the *Warren* decision represents a new hostility by Iowa Courts to physician non-compete agreements based on public policy grounds.

There are aspects of the *Warren* decision that could limit its applicability to the unique facts in the case. Dr. Warren spent 80% of his time employed by UIHC performing research and only 20% of his time providing patient care. Dr. Warren's allegedly competing employment involved 100% patient care. The facts also appear to establish that Dr. Warren's patient care in

Cedar Rapids rarely competed with UIHC, and that Dr. Warren actually referred some patients to UIHC. The Court found these facts failed to establish that prohibiting Dr. Warren's patient care in Cedar Rapids was necessary for the protection of UIHC's business. The Court also noted that UIHC failed to present any evidence that it had promoted Dr. Warren's services within the community, or expended any money to obtain patients for Dr. Warren. There was also no evidence that UIHC provided Dr. Warren with any unique training. Interestingly, the court found that the temporal and geographic elements of the non-compete, 2 years and 50 miles, did not appear unduly restrictive. The court ultimately concluded that UIHC's failure to prove enforcement of Warren's non-compete was necessary to protect its business, and the prejudice to the public interest, outweighed the apparently reasonable geographic and temporal restrictions.

The *Warren* decision may be limited to the unique situation of a physician moving from a research-based employment to a clinical employment. In that case, the decision is unlikely to have any practical impact on the employment of physicians in Iowa. However, the *Warren* decision could just as easily be read as recognizing a new willingness of Iowa's courts to declare physician restrictive covenants unenforceable on public policy grounds, especially when the physician seeks to practice in any federally designated underserved areas. Iowa could be on its way to joining the growing list of states that either outright prohibit, or apply strict scrutiny, to physician non-compete agreements. See e.g. Colo. Rev. Stat. Ann. § 8-2-113(3)(2003); Del. C. Ann. Title 6, § 2707(1993); Mass. Gen. Laws Ann. Ch. 112, § 12X (1991); *Valley Medical Specialists v. Farber*, 982 P.2d 1277 (Ariz. 1999)(stricter scrutiny); *Iredell Digestive Disease Clinic v. Petrozza*, 373 S.E.2d 449, 455 (N.C. App. 1988)(stricter scrutiny); *Ohio Urology Inc. v. Poll*, 594 N.E.2d 1027 (Ohio App. 1991)(stricter scrutiny); *Ellis v. McDaniel*, 596 P.2d 222

(Nev. 1979)(stricter scrutiny); *Statesville Medical Group v. Dickey*, 418 S.E.2d 256 (N.C. App. 1992)(stricter scrutiny); *Odess v. Taylor*, 211 So.2d 805 (1968)(prohibited on antitrust grounds); *Bosley Medical Group v. Abramson*, 207 Cal. Rep. 477 (Cal App. 1984)(prohibited on antitrust grounds); *Bergh v. Stephens*, 175 So.2d 787 (Fl. Dist. Ct. App. 1965)(prohibited on antitrust grounds); *Gauthier v. Magee*, 141 So.2d 837 (La. App. 1962)(prohibited on antitrust grounds); *West Montana Clinic v. Jacobson*, 544 P.2d 807 (Mont. 1976)(prohibited on antitrust grounds); *Spectrum Emergency Care, Inc. v. St. Joseph Hospital and Health Center*, 479 N.W.2d 848 (N.D. 1992)(prohibited on antitrust grounds).

A more hostile view of non-competes might align more closely with the current AMA code of ethics. In 1980, after the *Cogley Clinic* decision, the AMA took the position that physician non-compete agreements impact negatively on healthcare and are not in the public interest. See AMA Code of Medical Ethics, § E-9.02. While stopping short of completely prohibiting covenants not to compete, the AMA strongly discourages them. *Id.* The AMA Code states that non-compete agreements “restrict competition, disrupt continuity of care, and potentially deprive the public of medical services.” *Id.* The AMA has found that a person’s right to choose a physician and free competition among physicians are “prerequisites of ethical practice.” *Id.* at Section E-9.09. However, the last sentence of an AMA ethical canon provides an “out” for courts still looking to enforce restrictive covenants against physicians. The last sentence states: “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 patients’ choice of physician.” AMA Code § E-9.02. Courts have relied on that last sentence to uphold physician restrictive covenants even when the contract at issue contained a clause that

stated no provision in violation of the AMA Code of Medical ethics could be enforced. See *Calhoun v. WHA Medical Clinic*, 632 S.E.2d 563, 574 (N.C. App. 2006).

Whatever the future impact of *Warren*, which cannot be determined with certainty until a more standard physician non-compete fact pattern is decided by Iowa's appellate courts, the decision presents an excellent opportunity for all employers of physicians to re-evaluate non-compete covenants. A tightly crafted and specific covenant is more likely to be enforceable, regardless of whether Iowa courts embark upon a new reluctance to enforce physician non-compete agreements.