

Employee Relations

LAW JOURNAL

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Restrictive Covenants in a Physician's Employment Agreement: The New Jersey Example

Thomas B. Lewis and Amy Beth Dambeck

A recent decision by New Jersey's top court has important implications for employers, sending a signal and instruction to lower courts that, to the extent they are reasonable, restrictive covenants in employment agreements are to be upheld.

For decades, employers have utilized restrictive covenants to protect the profitability, trade secrets, and customer base of their businesses. Restrictive covenants are legal tools which, when incorporated into employment agreements, are designed to prohibit departing employees from competing with or soliciting the customers or business of their former employers after the employment relationship concludes. Their use has been employed in most every major American industry and private sector service, including the medical profession, which has used restrictive covenants to provide medical practices—and hospitals—with the ability to protect their patient and referral bases when new physicians are hired or brought into a practice group.

Recently in New Jersey, however, the protection enjoyed by physicians through the use of restrictive covenants seemed to be in jeopardy. Fearing that the use of restrictive covenants in physician agreements was on the verge of being prohibited, deemed unenforceable or, at the very least, limited—many physician-employers feared that an even greater strain would be placed upon practitioners who were already struggling to remain profitable in light of the array of regulatory and financial challenges currently facing physicians.

For the past quarter century, New Jersey courts have enforced restrictive covenants in physician agreements. In 1978, the New Jersey Supreme Court in *Karlin v. Weinberg*¹ held that restrictive covenants in physician employment agreements are enforceable if they protect a legitimate interest of the employer, impose no undue hardship on the employee and are not injurious to the public. At the time that the *Karlin* Court issued its decision, the American Medical Association (AMA) had

Thomas B. Lewis, chair of Stark & Stark's Employment Group, regularly represents companies and executives in restrictive covenant cases and in defending claims of sexual harassment, discrimination, and wrongful discharge. Amy Beth Dambeck, a member of Stark & Stark's Employment Group, concentrates her practice in litigating restrictive covenant agreements. Resident in the firm's office in Lawrenceville, NJ, the authors may be reached at tlewis@stark-stark.com and adambeck@stark-stark.com, respectively.

not expressed any ethical concerns regarding the use of reasonable restrictive covenants. In the years since 1978, however, the AMA's position has changed, and now maintains that non-competition agreements amongst physicians are not in the public interest and could implicate considerable ethical concerns for treating physicians.

In the recent case of *Community Hospital Group, Inc. v. More*, the New Jersey Supreme Court considered whether it was time to address and, potentially overturn, *Karlin v. Weinberg*. At issue before the Court was whether a restrictive covenant that barred a physician from practicing neurosurgery for a period of two years within 30 miles of his former employer was enforceable. Also at issue was whether restrictions that prevent physicians from practicing at specific hospitals or require relinquishment of hospital privileges are enforceable. The Court's decision in *More* is not only expected to have far-reaching effects on the medical profession in New Jersey, but may very well impact other states as they address the scope in which restrictive covenants can be enforced.

SURVEY OF OTHER STATES

A review of the authority governing restrictive covenants in physicians' agreements reveals that the majority of states, including New Jersey, still view noncompetition clauses in employment agreements as partial restraints on trade and will enforce clauses deemed to be reasonable under the circumstances. Such states include Arizona, Illinois, Oregon, Tennessee, Virginia, and West Virginia.

As a practice matter, it is often difficult to understand and trace current legal trends regarding restrictive covenants in physicians' agreements. For example, some courts focus on the manner in which the employment relationship was terminated. Some states have statutes on point, but most do not. Other courts "blue pencil" the restrictive covenant in order to uphold a reasonable restriction on the departing physician. Some courts rule that the geographic scope is too broad, but that the time period for the restriction is reasonable. Other courts focus on the point in time during the physician's employment when he or she was confronted with the restrictions. Overall, enforcement of any covenant is a fact-sensitive exercise.

Not all states, however, will enforce such covenants. In some instances, state legislatures have rendered physician restrictive covenants unenforceable. The Massachusetts legislature has deemed such covenants void and unenforceable. Colorado² and Delaware³ have also enacted statutes that expressly forbid noncompetition clauses in physician agreements. Alabama has enacted legislation that addressed restraining the exercise of a lawful profession and subsequent cases have interpreted this statute to apply to the medical profession.⁴ Unfortunately (or fortunately) for physicians in this state, the New Jersey legislature has not yet addressed

the issue. As a result of this silence, New Jersey courts have been forced to navigate between the rights of both medical practices and departing physicians and the rights of patients to freely choose their physician once his or her employment relationship has ended.

NEW JERSEY RESTRICTIVE COVENANTS

Keeping with the state's business-friendly policies, New Jersey courts have expressed some reluctance to enforce noncompetition clauses in employment agreements. In 1965, this policy was stated by the New Jersey Chancery Division in *Magic Fingers, Inc. v. Robins*:

Courts have attributed much strength to the social policy that every man should be free to earn his own living and have also recognized that an employee who is asked to sign a covenant may not have a full freedom to bargain about its terms that exist in other business situations. In other words, contracts of this type—if they are to be enforced—must pass a stricter test than other types of contracts; it is not enough to say the parties signed a document in good faith and are, therefore, bound to respect all of its terms.⁵

Further clarification of the enforceability of restrictive covenants came in 1970, when the New Jersey Supreme Court in *Solari Industries, Inc. v. Malady* set forth a three-prong test of reasonableness for a restrictive covenant. The Court determined that in order to be enforceable, a restrictive covenant must:

1. Protect a legitimate interest of the employer;
2. Impose no undue hardship upon the employee; and
3. Not impair the public interest.⁶

Subsequent decisions which interpreted *Solari* balanced the potentially devastating effects on a former employee against the only limited (and mainly financial) effects upon the employer.⁷

The Supreme Court of New Jersey in *Ingersoll-Rand Co. v. Ciavatta*, applying the *Solari* test, also weighed the manner in which the employment relationship was terminated.⁸ The *Ingersoll-Rand Co.* Court held that a restraint upon a former employee who had been fired was “unreasonable and hence unenforceable,” and determined that the manner of an employee's departure from his former employment, while not dispositive, is a fact that a court should consider.⁹ For some time, it appeared that New Jersey courts were looking for exceptions to the enforcement of employment restrictive covenants.

RESTRICTIVE COVENANTS IN PHYSICIAN AGREEMENTS

Thus far, New Jersey courts have been willing to enforce restrictions in physician agreements—provided that certain tests are met. The seminal New Jersey case with respect to physician restrictive covenants is *Karlin v. Weinberg*. In 1978, the *Karlin* Court held that restrictive covenants ancillary to employment contracts between physicians are enforceable to the extent that they protect the legitimate interests of the employer, impose no undue hardship on the employee, and are not injurious to the public. The *Karlin* Court, did, however, enunciate the need for a case-by-case review to determine enforceability of restrictive covenants in physician employment agreements. With its opinion, *Karlin* attempted to balance needs of physicians as businessmen/women versus physicians as medical healers.

Karlin distinguished itself from a prior Chancery Division decision in the case of *Dwyer v. Jung*, which held that restrictive covenants among attorneys are unreasonable *per se* because they are injurious to the public as a matter of law.¹⁰ The *Karlin* Court distinguished the holdings on the basis that the *Dwyer* decision was restricted to covenants between attorneys and the attorney-client relationship. The *Karlin* Court has been considered to have found that the key to *Dwyer's* holding was the fact that the Supreme Court had the exclusive responsibility to regulate attorneys while the Board of Medical Examiners regulates physicians, and that the American Bar Association (ABA) expressly forbade attorneys from entering into restrictive covenants of any kind. At the time of the *Karlin* decision, regulations governing physicians did not contain any similar restrictions. Rather, the AMA had still favored the use of restrictive covenants and, in a footnote to its decision, the *Karlin* Court cited Section 4.6.3, Restrictive Covenants, of the Principles of Medical Ethics published by the AMA, which read:

There is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood, and consistent with local law. Whether it is advisable as being in the best interest of the public depends on all of the surrounding facts. Ethically, such agreements are not forbidden.¹¹

Another notable distinction was that in *Dwyer*, the attorney was prohibited from “doing business” with any particular person—while *Karlin* only prohibited patients access to the physician in a certain geographical area. The *Karlin* Court remanded the case to the trial judge to determine the reasonableness of the restriction under the circumstances and enunciated its intention to provide for a case-by-case analysis as to whether enforcement of the covenant would be detrimental to the public interest.

In recognizing that the physician-employer has a legitimate interest in protecting on-going relationships with patients, the *Karlin* Court determined that the ultimate analysis for future courts to employ should look to the balance the employer's need for the covenant's protections and the effect of the covenant on the departing physician and the potential impact of the restrictions on the public."¹²

In analyzing each particular case and set of circumstances, the *Karlin* Court provided a non-exhaustive list of relevant factors for judges to consider when determining the enforceability of restrictive covenants among physicians:

1. The time the employer needs to rebuild the practice after a physician leaves;
2. The period needed for the employer (or any new physician taken on) to demonstrate his or her effectiveness to the patients;
3. The geographical area needed to protect the employer's practice/the reasonableness of the geographic scope;
4. The similarity of the activities the departing physician is barred from engaging in and those the employer engages in—covenants will be unenforceable if they restrict the employee from engaging in activities not in competition with those of his former employer;
5. The hardships on the departing physician;
6. The reason for the termination of the employment;
7. The likelihood that another physician in the area can provide the same services; and
8. The effect on the public interest of enforcing the covenant—the degree to which enforcement would foreclose resort to the services of the departing physician by those patients who might otherwise desire to seek him or her out at his or her new location.

Writing for three dissenting jurists, Justice Sullivan argued that restrictive covenants involving physicians should be held *per se* invalid as against public policy because of the nature of the physician-patient relationship, believing the same principals at work in the physician-patient relationships as in the attorney-client relationships. Justice Sullivan also disagreed with the majority's interpretation of *Dwyer* as having rested on the existence of the ABA disciplinary rule—arguing that the *Dwyer*

Court merely cited the ABA rule to demonstrate the strength of the public policy weighing in favor of prohibiting the covenants.

In the time since *Karlin*, the AMA, whose *Principles of Medical Ethics* the *Karlin* Court cited, has revised its opinion with respect to physician restrictive covenants. Despite the existence of the Opinion cited by the *Karlin* Court, the AMA has consistently taken the position that non-competition agreements impact negatively on patient care. In June, 1933, the AMA's House of Delegates approved a Judicial Council resolution declaring that contractual provisions which interfered with reasonable competition among physicians or prevented the "free choice of physician" were "unethical."¹³ That resolution was the first AMA proclamation on contractual arrangements affecting competition among physicians or covenants not to compete. The 1933 resolution remained unchanged for nearly 30 years.

In 1960, however, the AMA's Judicial Council published an Opinion that retreated from the 1933 resolution. Rather than focusing on the impact of covenants not to compete, the revision analyzed the limitations such agreements impose on physicians' employment mobility. The 1960 Opinion stated that there is no ethical proscription against a "reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made and understood."¹⁴ In subsequent years, the AMA's House of Delegates and the AMA Judicial Council progressed toward a reconsideration of the AMA's stance on restrictive covenants. Nonetheless, the full body of the AMA continued to reject an outright ban on restrictive covenants. It was not until 1980, two years after the Supreme Court's decision in *Karlin* that the AMA House of Delegates ultimately adopted an Opinion of the Judicial Council which declared that non-competition agreements among physicians were not "in the public interest." At the 1996 annual meeting of the AMA Board of Trustees, the Council on Ethical and Judicial Affairs resolved to amend Opinion 9.02, Restrictive Covenants and The Practice of Medicine, to read:

9.02 Restrictive Covenants And The Practice of Medicine

Covenants not to compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council 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 an 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 patients' choice of physician.¹⁵

Thus, the standard relied upon by the *Karlin* Court has been replaced by an Opinion discouraging, but not denouncing entirely, the use of restrictive covenants amongst physicians.¹⁶

THE CASE OF *COMMUNITY HOSPITAL GROUP, INC. V. MORE*

The Community Hospital Group, Inc., publicly known as JFK Medical Center, is a not-for-profit hospital located in Edison, New Jersey which, in 1992, created the New Jersey Neuroscience Institute (“Institute”)—itself a not-for-profit medical care provider specializing in the diagnosis and treatment of neurological diseases and conditions. The Institute receives the majority of its patients through referrals from physicians in other specialties.

In 1994, Dr. Jay More began to work as a neurosurgeon in the Institute immediately following his residency at Mt. Sinai Hospital in New York City. More’s employment with the Institute was governed by year-to-year employment agreements that he periodically entered into with JFK Medical Center—each of which contained post-employment restrictive covenants that prohibited More from practicing within a 30-mile radius of the hospital for a period of two years after the termination of his employment with the Institute, from soliciting or inducing any employee of JFK to leave his or her employment for the same two-year period, and in which he agreed that the post-employment restraints were reasonable.

After tendering his resignation, More left JFK Medical Center on January 17, 2002. More acknowledged that he had received offers to join other practices that were located outside of the 30-mile restricted area, but that he had declined each one. More also acknowledged that he had removed documents from the Institute which identified patients’ names and addresses as well as the identity and location of the Institute’s referral sources. On July 22, 2002, More became affiliated with another neurosurgeon as an employee of Neurosurgical Associates Park Avenues, PA. (NAPA), located in Plainfield, New Jersey—which is located approximately five miles from JFK Medical Center. During this period, More also received medical staff privileges at Somerset Medical Center—a competitor of JFK Medical Center—which is located approximately 13 and a half miles from JFK Medical Center.

JFK Medical Center filed a complaint against More seeking, among other things, a preliminary injunction prohibiting him from practicing neurosurgery with NAPA or at Somerset Medical Center. On November 21, 2002, the trial court denied JFK Medical Center’s request for a preliminary injunction. However, in an opinion dated December 29, 2003, the Appellate Division reversed the lower court’s decision and awarded JFK Medical Center injunctive relief. The Appellate Division’s decision was unforeseen by many court watchers, and after a review of both the restrictive covenant and the relevant facts in the case, the reversal seemed even more stunning.

At issue was the Institute, which specializes in neuroscience and medicine and whose mission goals are “clinical care, education, and

research in the areas of neurology and neurosurgery.” It deems itself a “tertiary care provider” of neurology-related services, and as previously noted, receives the majority of its patients through referrals from physicians in other specialties.

The Institute asserted that it sought to develop an extensive clinical neurological program and invested millions of dollars in its development. Each year, the Institute also invested hundreds of thousands of dollars in advertising and promotion. At the time of his hire, More had just completed his residency and had not yet established any practice or patient base.

In support of its application for injunctive relief, JFK Medical Center stated that it paid costs related to the Institute’s efforts to develop, enhance, and maintain More’s neurosurgical practice, including his salary. JFK Medical Center also paid expenses associated with continuing education courses, costs related to keeping his medical licenses current, More’s medical malpractice insurance, tuition reimbursement, and certain reimbursement for business travel, medical society dues, medical journals, and subscriptions.

More’s practice grew each year and the number of surgeries he performed increased annually. JFK Medical Center attributed this to More’s increased visibility based on his continued employment and association with and promotion he received from the Institute. Indeed, More referred to himself as the “top producer” and “rainmaker” at the hospital.

Also relevant was the Appellate Division’s finding that at least three New Jersey institutions outside the 30-mile radius have significant numbers of neurosurgical patients, and that More did not apply for privileges at any of those institutions, nor did More apply for privileges in New York area hospitals outside the 30-mile radius. Finding that at least five other institutions delivered extensive neurosurgical care within a 30-mile radius of JFK Medical Center, the Appellate Division determined that those institutions have a “sufficient number of neurosurgeons.”¹⁷

Notably, the Appellate Division largely focused on the issue of referral bases. When the Appellate Division reversed the trial court’s decision, the court ruled that the hospital would suffer irreparable harm if injunctive relief was not granted. The Appellate Division based its ruling, in part, on the harm to the hospital’s referral bases:

Plaintiff employs entry-level physicians, such as defendant, upon whom it relies in turn to develop extensive patient and referral bases. These investments cannot be recouped through monetary damage awards because these referral networks result from relationships formed between secondary care providers and plaintiff’s specialists. This threat to the vitality of plaintiff’s institutional framework is not capable of being truly remedied by damages.¹⁸

The Appellate Division further reasoned that the harm to the Institute's reputation to maintain a sufficient patient or referral base "could have a chilling effect" on its ability to recruit.¹⁹

LIKELIHOOD OF SUCCESS ON THE MERITS

In support of its decision to grant injunctive relief in JFK Medical Center's favor, the Appellate Division determined that it would likely succeed on the merits of the case.²⁰ The Appellate Division accepted the hospital's argument that its referral base constituted a protectable interest. JFK Medical Center argued that "there is no way to calculate presently the future harm resultant from lost relationships because eventually there is a house of cards effect that can threaten the very existence of a practice, particularly for an institution that requires not only a minimum number of patients to survive but a diverse number of cases to support its research and teaching goals."²¹

The Appellate Division also rejected the contention that JFK Medical Center failed to demonstrate a likelihood of success on the merits and ruled that the lower court misapplied the *Karlin* standard. Accordingly, the Appellate Division concluded that JFK Medical Center could show that the restraints at issue were reasonable and that it would succeed on the merits of its claims.

UNDUE HARDSHIP

In its opinion, the Appellate Division focused on the issue of whether enforcing the restrictive covenants in More's agreement would cause him an undue hardship. The Appellate Division agreed with JFK Medical Center's argument that the lower court erred in finding undue hardship would result to More because:

1. The restrictive covenant does not impose a limitation on a patient's choice of physician;
2. Personal hardship alone does not constitute undue hardship under *Karlin*; and
3. More is capable of readily finding employment outside of the restricted area.²²

Applying *Karlin*, the Appellate Division found that More would not suffer any undue hardship, noting that no undue burden occurs when the employee ends his relationship with his employer—rather than from any wrongdoing by the employer—as the employee brought any hardship upon himself. The Appellate Division reiterated that "personal hardship, without more" will not prevent the enforcement of a restrictive covenant.²³

The Appellate Division explained that other New Jersey courts held that a restrictive covenant causes undue hardship “if it places substantial limitations on where an employee may work or if it prevents an employee from engaging in his or her livelihood.”²⁴

The Appellate Division restated the test established in *Maw v. Advanced Clinical Communications, Inc.*:

To determine whether the hardship is undue, consideration is given to the nature of the profession, the duration of the restriction, the geographic area of the restriction and the type of restriction. Factors include, but are not limited to, (1) the agreement’s geographic and temporal scope; (2) whether the types of activities restrained are those which would place the employee in actual competition with the former employer; and (3) whether the covenant will unduly burden the employee in finding work in his or her field.²⁵

In *More*, the Appellate Division found that the doctor’s circumstances did not rise to the level of undue hardship.

While analyzing the “undue hardship” prong, the Appellate Division reviewed both the geographic and temporal scope of the restrictions in *More*’s agreement. The Appellate Division reviewed the restriction of a 30-mile radius and focused on the nature of the practice. Since *More*’s medical practice specialized in neurosurgery, the Appellate Division believed that it was reasonable that JFK Medical Center would draw its patient base from a larger area in contrast to that of a general practitioner. Since *More* admitted that he received employment offers outside the 30-mile radius, the Appellate Division determined that he suffered no undue hardship.

Finally, the Appellate Division rejected *More*’s argument that, since the hospital was the only institute in New Jersey to perform “Gamma Knife” surgeries, he was not actually competing with them. The Appellate Division noted that Dr. *More*’s distinction was a “fine line distinction” not intended by *Karlin*. Thus, the Appellate Division found that the restrictions did not result in any undue hardship to *More*.

NO HARM TO PUBLIC INTEREST

To secure injunctive relief to enforce restrictive covenants in physicians’ agreements, an applicant must show that the restrictive covenant does not violate the public’s interest. Regarding the public interest prong, the Appellate Division explained that *Karlin* held:

If enforcement of the covenant would result in a shortage of physicians within the area in question, then the court must determine whether this shortage would be alleviated by new physicians establishing practices in the area. It should examine also the degree to which enforcement of the covenant would foreclose resort to the

services of the “departing” physician by those of his patients who might otherwise desire to seek him out at his new location. If the geographical dimensions of the covenant make it impossible, as a practical matter, for existing patients to continue treatment, then the trial court should consider the advisability of restricting the covenant’s geographical scope in light of the number of patients who would be so restricted.

The Appellate Division in *More* found that the restrictions did not violate this prong either. Although *Karlin* acknowledged that the enforcement of geographic restrictions will result in some patients having to travel farther distances, the Appellate Division noted that the restrictions may still be enforceable where these patients are not deprived of the opportunity to continue their relationship with the physician.

Here, the Appellate Division accepted JFK Medical Center’s argument that enforcement of the restrictions would not harm the public because: (a) the covenant does not restrict patient choice; (b) five hospitals provide neurosurgical care within the restricted area; and (c) the covenant would not restrict the patients from receiving neurosurgical care from other physicians at Somerset Medical Center, More’s present hospital.²⁶ The Appellate Division found that six area hospitals within the 30-mile radius had qualified neurosurgeons on staff.

Also of significant note was the Appellate Division’s conclusion that since neurosurgery is a specialty “where the number of contacts between the physician and patient are relatively infrequent,” a larger geographic restriction has less impact on the public.²⁷

BALANCE OF THE EQUITIES

The Appellate Division addressed the issue of balancing the equities pursuant to the standard set forth in *Crowe v. DeGoia*.²⁸ The hospital argued that this balance tilts in its favor when comparing its investment of time, money, and other resources in meeting its mission goals against More’s desire for personal profit. In response, More argued that any balancing of the equities favors him because a qualified neurosurgeon would be prevented from practicing in an area where 61 percent of the state’s population resides.

In noting that JFK Medical Center relied upon revenue to support its clinical, teaching, and research programs, the Appellate Division agreed with JFK Medical Center’s argument that the balance of the equities at issue favored the hospital.

When the Appellate Division remanded the case back to the lower court ordering injunctive relief in favor of the hospital, the court appeared to have expanded the holding of *Karlin* by finding that a medical practice has a legitimate interest in protecting both its patient and referral bases; that the 30-mile radius of the noncompete was rea-

sonable under the circumstances because patients are willing to travel farther for specialized care; and by indicating that a specialized practice draws its patient base from a larger geographic area in contrast to a general medical practitioner.

In finding the covenants against More largely enforceable, the Appellate Division created a buzz about the case's potential implications for medical practitioners, particularly for medical specialists, subject to non-competes throughout New Jersey. The *More* decision also affirmed the role of restrictive covenants in other employment and industry contexts and signaled a reversal of what seemed to be the trend of finding exceptions and limitations to enforcement of noncompetition agreements in the courts. Further, the *More* decision signaled to the lower courts that, even given the fact that the AMA changed its position on restrictive covenants amongst physicians—since the AMA has only discouraged but not expressly forbidden the use of restrictive covenants, at least until the legislature addresses the issue—restrictive covenants will be enforced when deemed reasonable.

More took an appeal of the Appellate Division to the New Jersey Supreme Court. Many on-lookers believed that the Supreme Court might limit or overturn *Karlin* given the change in the AMA's position toward restrictive covenants amongst physicians, the perceived trend in some courts to find ways not to enforce such agreements and the Appellate Division's apparent expansion of *Karlin* to recognize "new" legitimate interests.

THE NEW JERSEY SUPREME COURT RULING

In two companion cases—one being *More*—physicians recently asked the New Jersey Supreme Court to overrule *Karlin* and its seminal holding that non-compete covenants between doctors and hospitals or medical groups serve legitimate employer interests and are not contrary to public policy.

Based on the evidence before it, however, the Court found no reason to change its mind. The Court decided to adhere to the parameters set forth in *Karlin*, finding that its test "strikes the proper balance between an employer's and an employee's freedom to contract on one hand and the public interest on the other." The Court additionally held that it was "convinced that the *Karlin* reasonableness test with emphasis on the public interest is sufficiently flexible to account for varying factual patterns that may arise."

As for *More*, while upholding most of the restrictions, for the reasons outlined by the Appellate Division, the Supreme Court voided the 30-mile restriction as being too broad in scope. For this reason, the Court remanded the case back to the Appellate Division to determine what damages More may owe JFK Medical Center for the period between his departure and July 2003, when the agreement was to expire, and

to set a new geographical boundary no more than 13 miles in radius. Also contrary to the Appellate Division's decision, the Court held that not allowing More to treat patients at Somerset Medical Center would deprive that hospital's patients of needed neurosurgical care and would, therefore, be contrary to the public interest.

In the companion case, *Pierson v. Medical Health Centers, P.A.*,²⁹ Dr. Christopher Pierson, an interventional cardiologist, was hired by Medical Health Centers in Middletown, New Jersey, on July 1, 1997, under a three-year contract in which Pierson was to establish a patient base and referral sources at Jersey Shore Medical Center. If he were to leave the practice, the noncompete covenant prohibited him from practicing within 12 miles of the Middletown office for a period of two years and, specifically, from practicing at Riverview Medical Center, a competing hospital.

The agreement was extended in 2001, but the next year the group decided to terminate Pierson and enforce the covenants. Pierson sued, but the trial court and Appellate Division, citing *Karlin*, upheld the restrictive covenant.

In ruling on both cases, the Court observed that doctors have managed to get along with *Karlin* for 25 years and that revoking the rule now would not serve the public interest. While recognizing the importance of patient choice in the selection and continuation of the relationship with a physician—and acknowledging that the similarities between the attorney-client and physician-patient relationships are substantial—the Court refused to adopt a *per se* rule invalidating restrictive covenants between physicians or between physicians and hospitals.

IMPACT ON FUTURE RESTRICTIVE COVENANTS

By this opinion, restrictive covenants have been permitted to remain an important tool for attracting and retaining talented physicians in the State of New Jersey and to protect medical practices and hospitals at the end of the employment relationships with their physicians. The *More* decision also has important implications for employers in other fields, as a court's willingness to enforce stringent restrictive covenants against a neurosurgeon where the consideration of the public interest is heightened—and acknowledgment of the protection of referral sources to be a legitimate interest—sends a signal and instruction to lower courts that, to the extent they are reasonable, restrictive covenants in employment agreements are to be upheld.

Also significant is the decision's potential effect on businesses whose reliance on technology like telecommunication and Internet access (such as recruiting and marketing fields) require greater protection of their client and referral contacts than they require the more traditional protections of geographic territories.

Unless and until the legislature weighs in on the issue, the Court's position has been made clear—and New Jersey courts will continue

to evaluate issues of enforceability concerning restrictive covenants in physician agreements on a case-by-case basis. Thus, employers may continue to expect that well-drafted, reasonable restrictive covenants contained within their employment agreements will be upheld in New Jersey courts.

NOTES

1. See *Karlin v. Weinberg*, 77 N.J. 408 (1978).
2. See Colo. Rev. Stat. § 8-2-113(3) (West 2004).
3. See Del. Code Ann. § 2707 (West 2004).
4. See Ala. Code 1977 § 8-1-1 (West 2004); see also *Associate Surgeons, P.A. v. Wattwood*, 295 Ala. 229, 326 So. 2d 712 (1976)(surgeon); *Odess v. Taylor*, 282 Ala. 389, 211 So. 2d 805 (1968)(physician).
5. See *Magic Fingers, Inc. vs. Robins*, 86 N.J. Super. 236, 238 (Ch. Div.) (1965).
6. See *Solari Industries, Inc. v. Malady*, 55 N.J. 571, 576 (1970).
7. See *Coskey's Television and Radio Sales and Service, Inc. v. Foti*, 253 N.J. Super. 626, 634 (App. Div. 1992).
8. See *Ingersoll-Rand Co. v. Ciavatta*, 100 N.J. 609 (1988).
9. See *Ingersoll-Rand Co.*, 100 N.J. at 643.
10. See *Dwyer v. Jung*, 133 N.J. Super. 343 (Ch. Div. 1975), *aff'd o.b.*, 137 N.J. Super. 135 (App. Div. 1978).
11. See *Karlin*, 77 N.J. at 421, f.n. 6.
12. *Id.* at 424.
13. See AMA, "Digest of Official Actions, 1846-1958," at 123 (1959).
14. See AMA, "Principles of Medical Ethics, Opinions and Reports of the Judicial Council," 25 (1960).
15. See Opinion 9.02, Restrictive Covenants and The Practice of Medicine. Note that Opinion 9.02 has not been revised since 1998. The AMA's Council on Ethical and Judicial Affairs, which is responsible for the development of, and revisions to, Opinions included in the AMA's Code of Medical Ethics, intends to review Opinion 9.02 in the near future. Procedurally, amendments are made either in June or December, during meetings of the AMA's House of Delegates.
16. See also, Paula Berg, "Judicial Enforcement of Covenants Not to Compete Between Physicians: Protecting Doctors' Interests at Patients' Expense," 45 *Rutgers L. Rev.* 1, 1 (Fall 1992).
17. See *More*, 365 N.J. Super. at 94.
18. *Id.* at 100.
19. *Id.*
20. *Id.*

21. *Id.* at 101.

22. *Id.* at 102–103.

23. *Id.* at 104 (citing Karlin, 77 N.J. at 424).

24. *Id.* at 104 (citing Maw v. Advanced Clinical Communications, Inc., 359 N.J. Super. 420, 436 (App. Div. 2003)).

25. *See Id.*

26. *Id.* at 108.

27. *Id.* at 110–111.

28. *See* Crowe v. DeGioia, 90 N.J. 126, 132–134 (1982), which delineated a four-prong test for determining whether a party is entitled to injunctive relief: (1) the party must show irreparable harm; (2) a legal right to its claim that is settled as a matter of law; (3) reasonable probability of success on the merits; and (4) the court must balance the hardship to the parties.

29. *See* Pierson v. Medical Health Centers, P.A., 183 N.J. 65 (2005).