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Physicians May Be Free to Compete

Recent court actions and changing health-care landscape may signal the end of restrictive covenants for physicians

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During the last year, much was written and spoken about the New Jersey Supreme Court's highly anticipated decision in *Maw v. Advanced Clinical Communications, Inc.*, 179 N.J. 439 (2004). Many commentators saw that decision as a reaffirmation of New Jersey courts' traditional willingness to enforce restrictive covenants in employment contracts, so long as certain conditions, developed over the years in a long line of cases, were satisfied. See, e.g., *Solari Indus. Inc. v. Malady*, 55 N.J. 571 (1970); *Whitmyer Bros. v. Doyle*, 58 N.J. 25 (1971); *Ingersoll-Rand v. Ciavatta*, 110 N.J. 609 (1988). Recent developments in restrictive covenant cases involving medical practitioners, however, perhaps signal an increased reluctance by New Jersey courts to enforce such restrictions where doctor/patient relationships could be adversely affected.

In *Maw*, the New Jersey Supreme Court rejected a whistleblower challenge under the Conscientious Employee Protection Act and common law to the enforcement of a restrictive covenant in an employment agreement. The Court, in essence, held that the issue presented was a private contractual dispute that did not trigger public policy concerns sufficient to state a claim under CEPA. Whether the Court would have reached the same conclusion if the plaintiff, Karol Maw, had been a physician rather than a graphic designer cannot be known. However, while *Maw* may indeed signal the Supreme Court's endorsement of non-compete agreements in the general commercial context, more recent cases may be a harbinger of a significant curtailment, if not the outright elimination, of their enforceability in contracts involving physicians and other health care professionals.

In the leading New Jersey physician restrictive covenant case, *Karlin v. Weinberg*, 77 N.J. 408 (1978), the Supreme Court held that restrictive covenants between physicians are generally enforceable — including the five-year, 10-mile restriction at issue — provided they protect a legitimate interest of the employer, impose no undue burden on the physician, and are not injurious to the public. Id. at 417.

The *Karlin* test has withstood numerous attacks over the last quarter century, and continues to be the standard for judging the enforceability of restrictive covenants among physicians and other medical professionals. Now, however, there are signs of cracks in its armor. Last year, for example, in *Pierson v. Medical Health Centers, P.A.*, 2004 WL 1416265 (App. Div. Mar. 4, 2004), the Appellate Division affirmed the dismissal of a cardiologist's suit to enjoin his former practice group's enforcement of a restrictive covenant in his employment agreement. Id. at *1. In his appeal, Pierson argued that, in light of the changing health-care landscape over the past 25 years, the factual basis upon which the *Karlin* court relied no longer existed. Id. He pointed out that the restriction in his employment agreement, which prevented him from practicing medicine within a 12-mile radius of the group's office, would preclude him from practicing at a hospital at which he maintained staff privileges, which he argued was a violation of public policy. Id.

In apparent sympathy with Pierson's argument, the Appellate Division

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observed that, in recent years, the American Medical Association has taken a "dramatically different view," of restrictive covenants than it did when *Karlin* was decided. Id. at *3. Based on its finding that noncompetition agreements "restrict competition, disrupt continuity of care, and potentially deprive the public of medical services," the AMA now "*discourages* any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of employment." American Med. Ass'n Council on Ethical and Judicial Affairs, *Restrictive Covenants and the Practice of Medicine*, §E-9.02 (1989) (updated June 1994 and June 1998) (emphasis added). By contrast, at the time *Karlin* was decided, the AMA's position was not hostile to restrictive covenants, a fact noted in the *Karlin* decision. See *Karlin*, 77 N.J. at 421, n.6.

More notably, the Appellate Division stated that Pierson's contention that "*Karlin* should be repudiated because of the present health-care landscape may have some merit." Id. The health-care landscape has, indeed, changed dramatically since *Karlin* was decided in 1978. Such recent trends as the legal movement to expand patients' autonomy, privacy and rights of self-determination — as reflected, for example, in the HIPAA privacy regulations — as well as the managed care phenomenon, were either unknown or in a very nascent state at the time *Karlin* was decided. These trends seem inconsistent with the concept that patients "belong" to physician/employers, part of the rationale underlying *Karlin* and its progeny. See Paula Berg, *Judicial Enforcement of Covenants Not to Compete Between Physicians: Protecting Doctors' Interests at Patient's Expense*, 45 Rutgers L. Rev. 1, 46 (l992).

The Appellate Division in *Pierson* invited the New Jersey Supreme or the legislature to address this issue. See *Pierson*, 2004 WL 1416265, at *3. Apparently accepting that invitation, in June 2004, the New Jersey Supreme Court granted Pierson's petition for certification. *Pierson v. Medical Health Centers, P.A.*, 181 N.J. 336 (2004).

In what may be a related development, the Supreme Court has recently granted interlocutory review in another physician restrictive covenant case to determine whether an employment agreement between a hospital and a neurosurgeon, which prohibits the neurosurgeon from practicing within 30 miles of the hospital for a two-year period, is enforceable. *Community Hospital Group, Inc. v. More*, 365 N.J. Super. 84 (App. Div. 2003), leave to appeal granted (A55,713) (Mar. 11, 2004). The Appellate Division had granted the hospital's request for a preliminary injunction against More — enforcing what appears to be the largest restricted practice area ever upheld by a New Jersey court against a physician in a reported decision.

In a more recently decided case, the Appellate Division may have foreshadowed the direction in which the Supreme Court might head in deciding *Pierson* and *More*. In *Comprehensive Psychology System, P.C. v. Prince*, 2005 WL 275822 (Feb. 7, 2005), the Appellate Division affirmed the Chancery Division's order refusing to enforce a restrictive covenant against a licensed psychologist. Id. at *3. The employment agreement prohibited the defendant psychologist from practicing within 10 miles of the plaintiff's neuropsychological facility. Id. at *1. In support of its conclusion that the restriction was unenforceable, the court relied heavily on a recently amended regulation adopted by the New Jersey Board of Psychological Examiners, N.J.A.C. 13:42-10.16. Id. As amended on April 15, 2004, the regulation currently reads: "A licensee shall not enter into any business agreement that interferes with or restricts the ability of a client to see or continue to see his or her therapist of choice." Id. at *1 (quoting N.J.A.C. 13:42 10.16). On the basis of this regulation, the court distinguished *Karlin*: "[P]laintiff contends the principles of *Karlin* apply equally to psychologists and make this agreement enforceable. We disagree ... *Karlin* dealt with general rules as to restrictive covenants in the absence of special regulations governing the profession involved." Id. at *2.

Against this backdrop, including the Appellate Division's acknowledgment in *Pierson* that the health-care landscape has changed in recent years, it seems likely that the Supreme Court in *Pierson* and/or *More* will at least re-examine the rationale underlying the *Karlin* holding, and might announce new rules for determining whether and to what extent restrictive covenants involving medical practitioners are enforceable. The court might even go so far as to announce a blanket rule that certain types of restrictions involving certain licensed medical personnel are per se unenforceable.

In addition, it is possible, following the decision in *Prince*, that the New Jersey Board of Medical Examiners might adopt new anti-restrictive covenant regulations similar to N.J.A.C. 13:42-10.16. The AMA's revised guidance concerning restrictive covenants, noted by the court in *Pierson*, certainly would provide support for such action by the Board of Medical Examiners. In fact, in response to the AMA's revised guidelines, at least one state medical association, the Indiana State Medical Association, passed a resolution declaring restrictive covenants between physicians to be unethical. See ISMA Resolution 93-5.

Finally, even if neither the New Jersey Supreme Court nor the New Jersey Board of Medical Examiners acts to curtail the enforceability of restrictive covenants among physicians, it is possible that the New Jersey legislature might weigh in on the subject. Just last year, one day after the United States Supreme Court's decision in *Aetna Health Inc. v. Davila*, 124 S.Ct. 2488 (2004), which declared unconstitutional laws in several states that held health maintenance organizations liable for harm caused by claim denials, legislation to create a Patient's Bill of Rights was introduced in the Untied States House of Representatives. New Jersey legislators might follow suit and seek to enact New Jersey's own patient's rights legislation, which could include restrictions on or preclusions against restrictive covenants involving physicians.

Several other states, including Delaware, as far back as 1983, have passed similar legislation. Delaware's statute, Del. Code Ann. Tit. 6 § 2707 — like a similar one in Colorado, Colo. Rev. Stat. Ann. § 8-2-113 — allows an action for damages but precludes injunctive relief in the enforcement of covenants not to compete ancillary

to physician employment agreements. See also Ala. Code §8-l-l(a); Cal. Bus. & Prof. Code §16600; Fla. Stat. Ann. §542.33(1); La. Rev. Stat. Ann. §23:921; Mont. Code Ann. § 28-2-703; N.D. Cent. Code §9-08-06; Okla. Stat. Ann. Tit. 15, §217; Tex. Bus. & Com. Code Ann. §15.50-15.52, all of which expressly prohibit contractual restraints upon the practice of a "profession." Those statutes have been interpreted as rendering unenforceable all restrictive covenants ancillary to employment contracts between or among physicians. See Berg, supra, 45 Rutgers L. Rev. at 12 & nn.55-62; see also Report of the Patient Safety Subcommittee of the Commission on Excellence in Health Care of the Indiana General Assembly, 27 n.58 (Aug. 2004), available at www.ismanet.org/pdf/pat_safe_sub_report04.pdf.

It appears possible, if not likely, that, before the end of this year, the enforceability of restrictive covenants among physicians and other licensed medical personnel will be curtailed in some way or perhaps even be precluded as a result of action taken by the New Jersey Supreme Court, the Board of Medical Examiners and/or the legislature. ■