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Commentary

Much Ado About Nothing

Despite predictions, Court declines to overrule *Karlin*

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For the better part of two years, the employment bar has predicted the death knell for physicians' restrictive covenants, first declared enforceable in *Karlin v. Weinberg*, 77 N.J. 408, (1978).

The legal pundits have pointed to the changing healthcare landscape since *Karlin*, the American Medical Association's dramatically different view of restrictive covenants since *Karlin* and several recent New Jersey decisions that refused to enforce covenants between a variety of medical practitioners, including pediatricians (*Sunder v. Mandalupu*, ATL-C-171-00, June 16, 2003) and licensed psychologists, (*Comprehensive Psychology Systems, P.C. v. Prince*, 2005 WL 275822, Feb. 7, 2005).

When the Appellate Division in *Pierson v. Medical Health Centers, P.A.*, 2004 WL 1416265 (App. Div. March 4, 2004), invited the New Jersey Supreme Court or Legislature to address the issue of whether *Karlin* should be repudiated, and the Supreme Court granted certiorari on June 17, 2004, all signs pointed to the end of enforceable restrictive covenants between physicians in New Jersey.

As it turns out, the reports of the death of *Karlin* proved to be greatly exaggerated in light of the New Jersey Supreme Court's two rulings on April 5 in *Community Hospital Group v. More*, A-75/76-03, and *Piersen v. Medical Health Centers*, A-10-04, which reaffirm *Karlin*'s ruling that post-employment restrictive covenants between physicians are not per se void and are enforceable. The *More* and *Piersen* decisions end the debate whether *Karlin* remains viable.

More involved a dispute between the employer medical center and a neurosurgeon who had been employed for eight years, and, during that time, had signed three agreements with a restrictive covenant that prohibited his practice of neurosurgery for two years post-employment within 30 miles of the medical center.

Each agreement contained affirmations by the medical center and the physician that the restrictions were reasonable. The neurosurgeon voluntarily left the medical center's employ, and, forgoing offers of employment outside the 30-mile zone, instead took employment with a group that covered neurosurgery at a competing medical center 13 miles away. He also removed patient demographic information, solicited patients and successfully took part of his patient base to his new employment.

On appeal from the Appellate Division's entry of injunctive relief enforcing the covenant, the Supreme Court rejected the argument that physician restrictive covenants are against public policy, and affirmed that the restrictive covenant in question protected legitimate interests of the medical center (confidential information, patient and referral bases, and investment in the training of physicians).

The Court agreed that the covenant's two-year time frame was reasonable, and found that the covenant did not impose undue personal hardship on the physician (since he voluntarily left and had available employment outside the restricted zone). However, the Court reversed the Appellate Division's judgment, finding that the 30-mile zone was too broad. The Court sent the matter back to the trial court to determine the precise geographic limit that would be reasonable and preserved the medical center's right to seek damages for violations that had occurred within the zone.

Piersen involved a two-year, 12-mile restrictive covenant that had been arbitrated, resulting in a monetary award in favor of the employer against the departing physician who had violated the covenant. The sole issue before the Court was whether the covenant was per se unreasonable and against public poli-

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cy. Consistent with its decision in *More*, the Supreme Court held that the restrictive covenant was not per se unreasonable or void as against public policy.

More and *Piersen* end the ongoing debate over whether physician restrictive covenants should be permitted in New Jersey. Enforcement of these covenants will continue on a case-by-case determination, heavily dependent on a variety of equitable factors. These include the circumstances of the physician's departure, the potential for new employment by the departing physician and the public interest in access to care, taking into account the particular specialty and demographics of physician representation in the relevant market.

As such, the predicted end of *Karlin* proved to be much ado about nothing. ■