MARTIN CLEARWATER & BELL LLP

DEFENSE PRACTICE UPDATE

WINTER 2008

ENFORCEABILITY OF RESTRICTIVE TERMS IN PHYSICIANS' EMPLOYMENT CONTRACTS

BY: STEVEN M. BERLIN

Despite stating they are loath to do so, courts in New York and New Jersey typically enforce agreements that limit a physician's ability to practice his or her profession after an employment relationship has ended, provided the restrictions are reasonable. Broadly referred to as "restrictive covenants", these agreements typically take one or all of the following forms:

- Covenants Not to Compete – restricting a physician from some level of practice, usually for a period of time within a geographic area, among a patient base, or within certain facilities;
- Non-Solicitation Agreements – restricting a physician's right to solicit former patients, employees, or referral sources for a period of time;
- Confidentiality Agreements – limiting a physician's right to disclose or use confidential information or trade secrets.

Many physician practices and hospitals will require doctors to agree to one or all of these post-employment restrictive covenants as a condition of employment. Covenants not to compete are useful, for example, when an employer invests time and money in developing a physician's skills, and the doctor develops strong relationships with patients or has a strong following. Non-solicitation agreements could be useful if a doctor has a patient list or strong relationships with employees of the practice or hospital, and could influence his or her decision not to make a move. Confidentiality agreements are always beneficial to protect non-public information about a practice or hospital.

The enforceability of restrictive covenants is generally raised in an action, typically brought by the prior employer, requesting the court to order the formerly employed physician to stop engaging in an activity the employer claims violates the parties' agreement, such as to restrain the doctor from opening a competitive practice in the same neighborhood or treating patients at the same hospital as his former practice. Alternatively, an action may be brought by the former employee, seeking an order declaring that a restrictive covenant is invalid and unenforceable, thus freeing the employee to engage in the activity restricted by the agreement. Often, these issues are presented as emergent situations, requiring the court's immediate attention to avoid imminent irreparable injury, and result in preliminary determinations pending a complete resolution of the lawsuit, which could be months or years away. From a practical point of view, since the lawsuit frequently outlasts the length of the restriction, these preliminary determinations often effectively resolve the matter. Thus, the better time to think through the

ENFORCEABILITY... *Continued on page 2*

ENFORCEABILITY OF RESTRICTIVE TERMS IN

Continued from front page

issue of restrictive covenants and to draft the agreement in a way best designed to meet the parties' needs is when entering into an agreement with such restrictions.

As a general proposition, courts disfavor agreements tending to prevent a person from pursuing his or her vocation after termination of an employment relationship. However, courts in New York and New Jersey have held that such restrictive covenants are generally enforceable provided they are reasonably tailored to address legitimate business concerns. New York State's highest court has held that such covenants will be enforced provided they are: (1) reasonable as to time and geographic area; (2) necessary to protect legitimate interests; (3) not harmful to the public; and (4) not unduly burdensome. Furthermore, restrictive covenants will be enforceable to the extent necessary to prevent the disclosure or use of trade secrets or confidential customer information, or where an employee's services are unique or extraordinary. The reasonableness of a particular provision is determined on a case by case basis and the more narrow the restriction is tailored to protect legitimate interests, the more likely it will be enforced.

... the better time to think through the issue of restrictive covenants is when entering into an agreement...

At times, courts have declined to enforce restrictive covenants when they have found that doing so would perpetrate some harm on the public. This factor is significant in the context of physicians' contracts, where enforcing a restrictive covenant could deny a community a physician's services. In *Prime Med. Assocs. P.C. v. Ramani*, the New York court declined to enforce a non-compete clause restricting the practice of the only infectious disease specialist serving the Columbia-Greene area, as enforcement would pose a substantial risk of harm to the public. Similarly, in *Oak Orchard Community Health Center v. Blasco*, the court declined to enforce a covenant which precluded the physician from opening a practice within a ten mile radius for a period of two years from her last date of employment since the public had an interest in not enforcing the restrictive covenant as the physician would be the only pediatrician in town.

Courts also address whether the terms of a restrictive covenant are so overbroad as to be unduly burdensome on the restricted party. In *Weintraub v. Schwartz*, the court declined to enforce a non-compete covenant prohibiting a neurologist from engaging in the practice of neurology for one year within five miles of the former employer's office or any hospital at which he had worked on behalf of the employer. Notably, the court felt the restriction as to practicing in all local hospitals was unnecessarily broad, but the restriction relating to opening an office within the same geographic scope was deemed reasonable.

Despite the fact that the New York Court of Appeals has identified the necessity to protect trade secrets and the uniqueness of an employee's services as factors impacting the enforceability of restrictive covenants, many cases involving physicians' contracts have failed to reference these factors in their analyses. In *Arthur Young & Co. v. Galasso*, a trial court examined various court opinions involving enforceability of restrictive covenants in physicians' contracts that made no mention of either the uniqueness of the physicians' services or the presence of trade secrets. The court concluded that the absence of those allegations is not fatal to the enforcement of a restrictive covenant in certain professional settings, presuming the element is satisfied when dealing with a professional. Addressing the same issue years later, the court in *Oak Orchard Community Health Center v. Blasco*, appeared to assume that a physician's services are unique or extraordinary when it concluded that "there is no per se rule of reasonableness arising just because it is a physician's unique or extraordinary services that is involved; a court must still scrutinize whether the covenant [meets the other criteria]." Although there does not seem to be decisive jurisprudence as to whether this factor will and should be evaluated in the context of enforceability of restrictive covenants in physicians' employment contracts, a conservative approach suggests that including language in a contract agreeing that a physician's services are unique or extraordinary will likely contribute to its enforceability.

New Jersey courts have adopted a similar model, balancing many of the same interests as New York courts, but have more specifically defined the terms and interests that should be applied in evaluating the enforceability of such clauses as to physicians. In *Community Hosp. Group, Inc. v. More*, the New Jersey Supreme Court recently articulated the reasonableness test employed by New Jersey courts to determine the enforceability of such clauses. In that case, the court upheld the portion of a non-compete agreement between a hospital and a neurosurgeon which provided that the doctor could not engage in the practice of neurosurgery for two years. However, the court found that enforcing the limitation against practicing within a thirty mile radius from the hospital was injurious to the public. The court remanded the case to the trial court

to determine which precise limits were warranted, but held that in no event should those limits exceed thirteen miles, which would include a nearby hospital that desperately needed a neurosurgeon's services. In reaching this conclusion, the court in *Community Hospital* enunciated a three-prong test: (1) whether a restrictive covenant is necessary to protect an employer's legitimate interest in enforcement; (2) whether it would cause undue hardship to the employee; and (3) whether it would be injurious to the public. Under the first prong, a legitimate interest may include protecting confidential business information such as patient lists, protecting patient and patient-referral bases and/or protecting investment in the training of a physician. Beyond that, the court articulated three additional factors that it said should be considered in determining whether the restrictive covenant is overbroad: its duration, the geographic limits and the scope of activities prohibited. Each of those factors must be narrowly tailored to ensure the covenant is no broader than necessary to protect the employer's interest.

Nevertheless, merely because the terms of a restrictive covenant are overbroad does not necessarily mean that courts will not enforce it. Rather, when restrictive covenants are found to be overbroad, New York and New Jersey courts will sometimes alter or modify them to the extent reasonable under the circumstances. The New York Court of Appeals in *Karpinski v. Ingrasci*, held that "[i]t is within the "court's power to 'sever' the impermissible from the valid and uphold the covenant to the extent that it is reasonable." Likewise, the New Jersey Supreme Court, in *Solari Indus. v. Malady*, held that even if a covenant is found enforceable, it may be modified in its geographic scope, duration, or scope of activity. However, courts will not necessarily modify an unreasonable covenant in every case. For example, in *Carni v. Carlon*, the trial court declined to dictate the duration of the restrictive covenant where the parties failed to specify any time limit.

The analysis to determine enforceability for restrictive covenants generally employs the same factors for balancing whether the covenant is a non-compete, a non-solicit, or a confidentiality agreement. However, courts have recognized that individual physicians have a unique interest in certain confidential information that will render a non-solicit agreement unenforceable. The trial-level court in *Prohealth Care Assoc. LLP v. April*, declined to enforce a non-solicit agreement by a partnership against disassociated physicians. In so holding the court noted:

> "A partnership does not practice medicine and does not have patients. The physicians, who are partners in a medical practice, practice medicine and have patients. Therefore physicians cannot be enjoined from or prevented from notifying their patients that they are no longer associated with a partnership and providing those patients with their current office address. Similarly, medical records and notes which contain entries relevant to medical history, examination, treatment and care are the property of the doctor who provided the care or treatment. However, those physicians have no right to obtain the names and records of the patients who they did not treat, where such patients were treated by other doctors or health care professionals. Nor may they notify those patients that they have established a new office. Patient lists may be confidential information and use of confidential information may be enjoined."

...merely because the terms of a restrictive covenant are overbroad does not necessarily mean that courts will not enforce it.

As a practical matter, to ensure enforceability of restrictive covenants in employment contracts, it is important to appropriately analyze, at the time of drafting the contract, the real competition risks and concerns from which protection is sought. As a rule of thumb, the more narrowly the restrictions are drafted to address these concerns, the more likely they will be enforced by the courts. Furthermore, it is not advisable to adopt a broadly restrictive agreement, in anticipation that the courts will modify it to ensure its enforceability—to do so runs the risk that the court will decide the employment agreement is unenforceable in its entirety and thus neither party will be left with any of the protections for which they bargained.

STEVEN M. BERLIN

Steven M. Berlin is a partner at Martin Clearwater & Bell LLP and head of the Firm's Employment and Labor Practice Group. Mr. Berlin has over 20 years of litigation experience and is a frequent author and lecturer in New York and New Jersey on employment issues.

DEFENSE OF A BREAST CANCER CASE

BY: BRUCE G. HABIAN

Breast cancer is a major cause of morbidity and mortality in women; this disease — specifically, the alleged failure to timely diagnose it — is a fertile source of medical malpractice litigation against physicians in the specialties of radiology, gynecology and surgery. This article presents a brief introduction to the defense of a lawsuit incorporating these topics.

PLAINTIFF'S THEORY

A delay in diagnosis may be focused on a screening mammogram film that was misread. A delay can also incorporate a failure to adequately investigate either a perceived or actual lump in the breast, or a change in architecture of the breast tissue. As a result of such delay, plaintiffs' counsel claim that a later "stage" of the disease has resulted; this later clinical situation can result in a more serious disease state requiring more advanced surgical procedures (e.g., mastectomy versus an early therapeutic lumpectomy), as well as more complex adjuvant therapy (i.e., necessary radiation and/or chemotherapy). A more serious prognosis can result because of lymph node involvement or metastatic disease to distant organ sites, together with a claim of shortened life expectancy, and pain and suffering for the accompanying mental distress.

...careful record-keeping by the treating physician serves as a basis for a detailed scientific defense position to successfully represent the physician's interests.

THE DEFENSE

The size of the cancerous mass is crucial to whether the defendant could have diagnosed the disease either by radiographic evidence or palpation. A malignancy usually cannot be diagnosed clinically unless a tumor mass is 1 cm. in diameter. A lesion of that size is considered to have a volume of 1 billion cells and to have doubled in size 30 times from the original cancer cell. If the defense can obtain measurements at two different points in time, the doubling rate based upon the cell pathology can be used favorably for the defense through proof that the expected rate of growth would not have allowed the tumor to have been diagnosable at an earlier point in time. Expert testimony as to particular doubling time rates is based on the science of the tumor — its pathologic variety and differentiation (that is, how close the tumor cells appear related to the original breast tissue). This cellular activity analysis can determine fast and slow-growing tumors and prognosis related to nodal and distant organ spread. Well-differentiated tumors grow at a slower rate, and poorly-differentiated tumors grow at a faster rate. Further, any metastatic spread can have its own independent rate of growth as compared to the primary tumor. These are all factors relevant to adequate staging of the tumor mass.

A slow-growing cancer may have little or no effect on the size of the tumor, expected therapeutic surgery and spread of the disease. Conversely, a rapid, highly mitotic cell multiplying growth tumor can indicate a larger mass and more serious prognosis that only occurred much later in time than the claimed negligence period.

In addition to the size of the lesion, pathology analysis can determine if the spread of the cancer to distant organ sites by blood-borne expansion or lymph node route occurred prior to the breast lump being clinically apparent. The nature of the cancer cells can be studied to determine if a clear-cut calcification pattern would be absent per mammogram study. Many times, an infiltrating breast cancer can develop without a discrete lump being present.

CONCLUSION

Pertinent questions raised at trial include not only whether the disease was diagnosable, but whether on a scientific basis, an elapsed time period made any appreciable difference in the prognosis of the disease and the five-year survivability index. As always, careful record-keeping by the treating physician serves as a basis for a detailed scientific defense position to successfully represent the physician's interests.

BRUCE G. HABIAN

Bruce G. Habian is a senior partner and trial attorney at Martin Clearwater & Bell LLP who has represented the Firm's core clients in medical malpractice and professional liability defense litigation for more than 30 years. Mr. Habian specializes in the defense of severe infant neurological injuries, with their attendant high financial exposure and risk, spinal pathology cases and cancer medicine. He has lectured and written extensively concerning breast cancer. Mr. Habian is a member of the American College of Trial Lawyers.

MCB NEW PARTNER SPOTLIGHTS:

Martin Clearwater & Bell LLP is pleased to announce that Charles S. Schechter and Timothy M. Smith have been named Partners of the Firm as of January 1, 2008.

CHARLES S. SCHECHTER

Charles S. Schechter joined Martin Clearwater & Bell LLP in 2003 and became a partner in 2008. Mr. Schechter focuses his practice on the defense of civil actions, including medical malpractice, healthcare, products liability and insurance matters. Prior to joining the Firm, Mr. Schechter was the Deputy Bureau Chief, Trials, of the Gangs Bureau of the Kings County District Attorney's Office. While at the District Attorney's Office, Mr. Schechter was the lead prosecutor on several homicide cases, including the landmark murder case, *People v. Lydell Harris*. He has been a frequent guest commentator on Court TV.©

Mr Schechter received his J.D. from Hofstra University School of Law in 1996 and his B.A. from Yeshiva University in 1993. He is admitted to practice before the New York State Courts and the United States District Courts for the Southern and Eastern Districts of New York.

TIMOTHY M. SMITH

Timothy M. Smith joined Martin Clearwater & Bell LLP in 2002 and became a partner in 2008. His practice encompasses all areas of medical malpractice litigation and personal injury defense. Prior to joining MCB, Mr. Smith worked as an attorney within the Social Security Administration and as in-house trial counsel for a national insurance carrier. His legal experience includes handling toxic tort, employment and labor law, products liability and workers' compensation matters. Mr. Smith's ability to handle complex legal matters is highlighted by his participation in the litigation of the novel First Amendment gender discrimination case of *Ganzy v. Allen Christian School*, 995 F.Supp. 340 (E.D.N.Y. 1998).

Mr. Smith received his J.D. from St. John's University School of Law in 1995 and his B.A. from the State University of New York at Albany in 1991. He is admitted to practice before the New York and Connecticut state courts, and the United States District Courts for the Southern and Eastern Districts of New York.

New Public Health Law Provisions

BY: ELLEN B. FISHMAN

According to the Committee on Quality Assurance in Office-Based Surgery, there are ten million office-based surgical procedures performed in the United States annually. On July 18, 2007, Governor Eliot Spitzer signed into law a three-page bill which incorporates two new statutes that greatly affect these types of procedures in New York State. The first requires practices that conduct office-based surgical and invasive procedures to be accredited by an approved outside agency for these practices. The second essentially provides that most types of adverse events following such procedures will need to be reported to the New York State Department of Health (DOH) within 24 hours. The accreditation requirement will go into effect on July 14, 2009, and the reporting obligation became effective on January 14, 2008.

A licensee may only perform office-based surgery in a setting that has obtained and maintains full accredited status.

Legislative History

In 1997, the New York State Public Health Council (part of the DOH) established the Committee on Quality Assurance in Office-Based Surgery. The Committee, consisting of consumers and representatives from several different medical specialties, formulated various recommendations with respect to office-based surgery and, in particular, with respect to the administration of anesthesia in office settings. The recommendations were adopted as DOH guidelines in December 2000. The guidelines were challenged on procedural grounds by a group representing nurse anesthetists (NYSANA); however, in March 2004, the New York Court of Appeals ruled that NYSANA did not have standing to challenge the guidelines. Notwithstanding this decision, the DOH decided to obtain new recommendations regarding uniform standards of quality in office-based surgery.

In October 2005, the Committee on Quality Assurance in Office-Based Surgery, chaired by Bernard Rosof, M.D., M.A.C.P., Senior Vice President of the North Shore-Long Island Jewish Health System, reconvened with representatives from additional medical specialties, as well as nurses, dentists, administrators and attorneys. The Committee met four times in 2005 and 2006, and published its report in January 2007.

The Committee's recommendations were adopted almost verbatim into the law that Governor Spitzer signed last July. In a press release, Arthur A. Levin, M.P.H., stated, "Patients in New York can only benefit from this new law regulating doctors' offices where surgery is performed. The New York State Legislature and the State Health Department are to be commended for following the recommendations of the workgroup that crafted the proposal."

Understanding the Law

The newly-enacted statute on office-based surgery, New York Public Health Law §230-d, lists the obligations with respect to accreditation status which will become effective July 18, 2009, and the reporting requirements, which are now in effect. The subsection of §230-d that is likely to have the greatest impact is a mere 19 words long and provides that "A licensee may only perform office-based surgery in a setting that has obtained and maintains full accredited status." This sentence gives rise to major questions, which are answered in part by the definitions section of §230-d.

Q. Who is a "licensee"?

A. The term "licensee" refers to a physician, physician's assistant or a specialist's assistant. The new law does not apply to dentists, nurses and podiatrists, who are regulated by the State Education Department, rather than DOH.

Q. What is the meaning of the term "office-based surgery"?

A. "Office-based surgery" means any surgical or invasive procedure requiring general anesthesia, deep sedation or moderate sedation. It also includes liposuction of more than 500 cc of fat or liposuction of any amount performed under sedation heavier than local anesthesia. It does not include procedures performed under local or topical anesthesia where "the likelihood of complications requiring hospitalization is minimal." It also does not include procedures performed under "minimal sedation" – i.e., where the sedation administered allows the patient to respond "normally" to verbal commands and where ventilatory and cardiovascular functions are unaffected.

Q. How does a medical office obtain "accredited status"?

A. Section 230-d places responsibility on individuals who own medical practices by providing that "Licensee practices in which office-based surgery is performed shall obtain and maintain full accredited status." Three accreditation organizations provided information to the Committee on Quality Assurance in Office-Based Surgery during the deliberation stage: the American Association for Accreditation of Ambulatory Surgery

Facilities, Inc. (AAAASF), Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In December 2007, DOH Commissioner Richard F. Daines designated these same organizations as the agencies to which licensees can submit applications for accreditation.

Q. When must an affected practice apply for accreditation?

A. It is anticipated that the accreditation process will take at least several months. Compliance with the accrediting agencies' requirements may require changes in office personnel, practices and, in some cases, the physical plant. Therefore, those in charge of affected offices need to familiarize themselves with the various agencies' requirements for accreditation and begin the potentially costly process in time to secure accreditation by July 14, 2009. Those who perform office-based surgery within the meaning of the statute must complete the accreditation process by that date, after which the covered procedures may only be performed in an accredited office.

Q. What reporting requirements are now in effect?

A. The second oversight imposed by this new law went into effect on January 14, 2008. It requires any licensee directly or indirectly involved with an adverse event to report the following to the DOH Patient Safety Center within one business day of the event: any patient death that occurs within 30 days of treatment, any unplanned transfer to a hospital, any unscheduled admission to a hospital for more than 24 hours that begins within 72 hours of the office-based surgery, and any other serious or life-threatening event. Hospitals are encouraged to report such adverse events of which they become aware. The accrediting agencies are to report aggregate data on adverse events. Those who are not in compliance with the above provisions may be exposed to professional discipline. The licensee's failure to comply with these reporting requirements will be deemed professional misconduct subject to sanctions ranging from censure to revocation of a license.

Q. Will the required reports be confidential?

A. The reports of adverse events sent to the DOH Patient Safety Center are confidential and exempt from disclosure under the Freedom of Information Law or from discovery in civil proceedings, such as malpractice actions. When appropriate, the report may be referred by the Patient Safety Center to the Office of Professional Medical Conduct, however.

Reports sent by licensees to accrediting agencies may not be subject to the same confidentiality protections. DOH is expressly authorized to disclose reports of aggregate data to the public.

Physicians who perform office-based surgery should be prepared and contact their counsel to discuss these requirements.

ANALYSIS

One very significant issue that is not fully addressed by the legislation is exactly which types of office-based surgery will be subject to the new provisions. For example, whether procedures requiring "moderate sedation" have to be performed at an accredited facility will depend, in part, on whether the procedure is considered to involve "a minimum of discomfort."

DOH has posted on its website examples of procedures that it anticipates will be covered by the new law, including most types of gastrointestinal endoscopy, bronchoscopy, rhinoplasty, augmentation or reduction mammoplasty and herniorrhaphy.

Although there are several questions that remain unanswered with this new law, it is important to be aware of these new requirements. Physicians who perform office-based surgery should be prepared and contact their counsel to discuss these requirements. Martin Clearwater & Bell LLP will continue to follow the developments and, as always, keep clients informed of any changes or new information that will affect their practices.

ELLEN B. FISHMAN

Ellen B. Fishman is a partner at Martin Clearwater & Bell LLP and head of the Firm's Appellate Department. Ms. Fishman has handled hundreds of complex appeals at every level of the state and federal courts, including numerous cases of first impression.

MCB NEWS:

MCB Mourns the Loss of Partner Leslie Lapham

Martin Clearwater & Bell LLP is saddened by the loss of our partner, colleague and friend, Leslie Harasym Lapham in October 2007. Ms. Lapham spent her entire legal career at MCB, joining the Firm in 1988. She was respected and cherished by her clients and colleagues. Ms. Lapham is survived by her husband, her parents and her sister.

Fall CLE A Success

On Thursday October 18, 2007, MCB presented a CLE for clients entitled "The Role of the Defendant as a Trial Witness." The CLE took place at the Helmsley Hotel from 8:30 a.m. – 12:30 p.m. Senior trial partners John L.A. Lyddane and Bruce G. Habian spoke on a variety of topics, including the legal parameters governing the role of the defendant as a witness for the plaintiff, the cross-examination of the defendant by counsel for the plaintiff using prior testimony of the defendant, the use of medical literature on cross-examination, the defendant's testimony on the liability of other parties, testimony of defendants who profess no recollection of events and who have missing records, as well as other topics. Attendees received 4 New York State CLE credits.

MCB Partner Presents Lead Poisoning Seminar

Senior trial partner William P. Brady and well-respected physician, Katherine Szema, M.D., presented a program on the screening for lead poisoning for the New York City Health and Hospitals Corporation and Lincoln Medical and Mental Health Center's Department of Pediatrics. The program took place on November 2, 2007 and was accredited for 2 AMA PRA Category 1 credits.

MCB Added to AIG's Approved Defense Panel in the Area of Employment & Labor

The Firm is pleased to announce that it has been added to AIG's approved panel for the defense of Employment and Labor cases in New York and New Jersey. Clients with AIG as an insurance carrier may now request that MCB defend them.

SAVE THE DATE

MCB's Spring CLE Program
"Obstetrical Liability: Creating the Successful Defense"

Wednesday, June 4, 2008 from 8:30 a.m. – 12:30 p.m.
at the New York Helmsley Hotel.

Information about this program will be sent out shortly.

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