Utilizing Telehealth to Practice Medicine across State Lines: The Enforceability of Physician Non-Compete Agreements and Non-Solicitation Clauses

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UTILIZING TELEHEALTH TO PRACTICE MEDICINE ACROSS STATE LINES: THE ENFORCEABILITY OF PHYSICIAN NON-COMPETE AGREEMENTS AND NON-SOLICITATION CLAUSES

INTRODUCTION

Healthcare delivery has been drastically changed in the United States as a result of the COVID-19 pandemic. As government and health officials advised individuals to limit face-to-face interactions in an attempt to slow the spread of the virus, almost all non-urgent in-person patient visits were cancelled. Telehealth played a crucial role in the continuance of patient care during the pandemic. Most simply defined, telehealth allows physicians to conduct appointments with patients over the phone or through video conferences just as they would during in-person visits. Organizations such as the Center for Disease Control and Prevention urged physicians and healthcare facilities to implement widespread telehealth usage. Thus, despite the cancellation of in-person

1. See generally Alex Spanko, Telehealth Claims Spike More than 8,000% Amid Covid-19 Pandemic, Government Waivers, SKILLED NURSING NEWS (July 8, 2020), https://skillednursingnews.com/2020/07/telehealth-claims-spike-more-than-8000-amid-covid-19-pandemic-government-waivers/ (discussing the increase in telehealth claims at the start of the pandemic). This study did not include claims for patients that use Medicaid or Medicare services. Id.


6. See Lisa M. Koonin et. al., Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic – United States, January-March 2020, CTR. FOR DISEASE CONTROL &
doctor appointments, physicians and other healthcare providers were able to continue providing care to many patients by using virtual telehealth services. Telehealth was also used as a form of triage during the height of the pandemic as it allowed healthcare providers to perform an initial patient consultation to determine the necessity of seeking further care.

The appeal of telehealth visits, by both patients and physicians, has raised drastically amidst COVID-19. Telehealth is an effective solution to social-distancing protocols as it allows physicians to continue providing effective care for many patients. As a result, the telehealth industry saw more than an 8,000% increase in claims to private insurers for medical services provided via telehealth in early 2020 as compared to claims in 2019. A Board Member of the Physicians Foundation opined that “[w]ith the evolving COVID-19 pandemic and its impact on access to medical care, there is no better time to help physicians navigate and implement telemedicine into their practices and enhance their ability to care for patients.” However, the implementation and utilization of telehealth in the medical field may be impaired by legal boundaries as the United States shifts out of the pandemic.

As telehealth continues to grow, the sudden explosion of the market will exacerbate the legal issues that were of great concern as courts began addressing telehealth. This note addresses the legal issues that arise with the inconsistencies between state enforcement of non-compete agreements and non-solicitation clauses for physicians and argues that

9. See id.
10. See id.
11. Spanko, supra note 1.
12. AM. MED. ASS’N, supra note 5, at 5 (quoting a statement made by Dr. Russell Libby, M.D.).
13. See infra Part I.B.
15. See generally J. Kelly Barnes, Comment, Telemedicine: A Conflict of Laws Problem Waiting to Happen—How Will Interstate and International Claims Be Decided?, 28 HOUSTON J. INT’L L. 491, 519 (2006) (analyzing the choice-of-law issues that may arise as courts began addressing the practice of telehealth). Specifically, this comment looked at three “legal situations [that may arise for physicians practicing telehealth]: (1) a medical malpractice claim . . . (2) a physician licensure claim where a telemedicine provider is not licensed in the jurisdiction in which the patient is located, and (3) a federal statutory claim.” Id.
16. See infra Part II.B.-III.
the current laws are inadequate when applied to physicians practicing telehealth.\footnote{See infra Part IV.} Non-compete agreements and non-solicitation clauses are subsets of restrictive covenants, and it is very common for employers to ask employees (physicians) to sign both.\footnote{See David J. Clark, \textit{Non-Compete Laws Affecting Health Care Professionals in Various U.S. Jurisdictions}, \textit{Nat'l L. Rev.} (July 5, 2018), https://www.natlawreview.com/article/non-compete-laws-affecting-health-care-professionals-various-us-jurisdictions.} For the purposes of this note, "restrictive covenants" will be used to describe both non-competes and non-solicitations clauses, unless a designation is specifically stated.

Generally, non-competes are enforced through the rule of reason test to determine if the restrictions are reasonable as to time, geographic location, and scope.\footnote{See S. Elizabeth Wilborn Malloy, \textit{Physician Restrictive Covenants: The Neglect of Incumbent Patient Interests}, \textit{41 Wake Forest L. Rev.} 189, 195 (2006). Non-solicitation agreements are enforced in a similar framework, with slight differences. \textit{See infra} Part II.F.} Telehealth poses a challenge with the geographic restriction component of restrictive covenants because providers may practice across state lines creating a large geographic area of practice.\footnote{See e.g., \textit{Telemedicine Policies: Board by Board Overview}, \textit{Fed'n of State Med. BDS.} 1, https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf (last updated June 2021); \textit{A Faster Pathway to Physician Licensure, Interstate Med. Licensure Compact}, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ (last visited Oct. 10, 2021).} This is especially relevant in the wake of COVID-19 as licensing regulations have been relaxed and waived to increase the usage of telehealth services.\footnote{See \textit{Waiver or Modification of Requirements Under Section 1135 of the Social Security Act, Pub. Health Emergency} (Mar. 13, 2020), https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx.} Now more than ever, physicians are able to practice in an almost limitless geographic territory due to relaxed telehealth regulations.\footnote{See infra Part I.B.4.}

The increased geographic scope of practice for many physicians practicing telehealth will create issues as courts try to enforce restrictive covenants.\footnote{See infra Part II.D.} This expanded territory of practice may result in telehealth employers having business interests in an almost unlimited geographic location.\footnote{See \textit{Employment-Related Considerations for Health Care Providers Providing Telehealth Services During the COVID-19 Pandemic}, \textit{Tannenbaum Helpern Syracuse & Hirschtitt LLP} (July 29, 2020), https://www.thsh.com/publications/employment-related-considerations-for-health-care-providers-providing-telehealth-services-during-the-covid-19-pandemic.} Because of the uniqueness of the telehealth industry, non-competes and non-solicitation clauses for physicians practicing telehealth should be distinguished from typical physician restrictive covenants.\footnote{See infra Part II.D.}
There is currently little judicial guidance on how to enforce restrictive covenants in the telehealth industry as this issue is a recent development. Therefore, a new method for determining the enforceability of physician restrictive covenants in the telehealth industry is needed.

This note will argue that federal legislation should be passed in order to make clear and consistent regulations for the enforcement of physician non-competes and non-solicitation clauses in the telehealth sector. This note’s model framework in an effort to create uniformity for providers practicing telehealth. This is especially relevant as state barriers for physician licensure continue to be removed and telehealth regulations are relaxed. These changes will allow for increased usage of telehealth visits for more individuals, and as a result increase access to healthcare. The expansion of the telehealth market should not be impeded by restrictive covenants.

There are four Parts to this note. Part I will provide a brief background of the telehealth industry and the changing regulations that surround it. Part II will look at the current laws surrounding the enforcement of physician non-competes and non-solicitation clauses in the traditional in-person healthcare field. Throughout Part II there will be a discussion of the issues that arise when applying the traditional restrictive covenant analysis to enforce telehealth physician non-competes and non-solicitation clauses. Part III will analyze the inconsistencies in state enforcement of restrictive covenants and compare the different approaches that are taken.

Part IV will offer solutions to these issues and suggest possible language for federal legislation involving the enforcement of telehealth physician restrictive covenants. The proposed federal statute will place the burden of proving the validity of the restrictive covenants on the employers. This will increase the likelihood that the restrictive covenants are necessary to protect employer’s legitimate business.

26. TANNENBAUM HELPERN SYRACUSE & HIRSCHTRIT LLP, supra note 24.
27. See infra Part III.
29. See infra Part I.B.2.
30. See infra Part I.A.
31. See infra Part I.
32. See infra Part II.
33. See infra Part II.
34. See infra Part III.
35. See infra Part IV.
36. See infra Part IV.
interests. It will also increase the public health benefits that are gained through the usage of telehealth services, and it will allow patients more autonomy in selecting their physicians.

I. ADVANCEMENTS IN THE TELEHEALTH INDUSTRY AND THE REGULATIONS SURROUNDING IT

This Part provides background on the telehealth industry. Section A explores the early history of telehealth, and the effect COVID-19 has played in the explosion of the telehealth market. Section B explores the regulations and legal limitations on the practice of telehealth.

A. The History of Telehealth and the Rapid Expansion During COVID-19

Telemedicine has previously been defined as the “use of telecommunications technologies to transmit medical information to support clinical care.” Throughout its existence, the terms “telemedicine” and “telehealth” have often been used interchangeably, with slight differences. In 2020 the American Medical Association (herein after “AMA”) distinguished the meanings, and for the purposes of this note, the following definitions will be used. Telemedicine describes the various online tools and platforms that healthcare providers use to facilitate patient care, connect with other providers, remotely monitor patients, and to collect medical data. Telehealth more specifically refers to the real-time audio and video technology that

37. See infra Part III.
38. See infra Part IV.A.
39. See infra Part I.
40. See infra Part I.A.
41. See infra Part I.B.
43. INST. OF MED., THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 3 (2012). Telehealth and telemedicine were both used to describe any exchange of medical information over electronic communications. Id. Specifically, telemedicine was used for “direct patient clinical services,” while telehealth was used as the broader term to describe “remote health care services.” Id.
44. See AM. MED. ASS'N, supra note 5, at 10.
45. Id.
connects patients and physicians, and can be used as an alternative to an in-person visit.\textsuperscript{46}

The concept of telehealth can be traced back to as early as 1879.\textsuperscript{47} One of the earliest mentions was when a news article suggested telephone calls could be used to reduce the number of patient visits to the doctor’s office.\textsuperscript{48} Telehealth has since been used to greatly increase access to medical knowledge and care.\textsuperscript{49} Throughout its history, it has been used to provide both in-home patient care and clinician-to-clinician consulting.\textsuperscript{50} Virtual telehealth visits now allow patients to meet with physicians as a replacement for in-person visits for services such as consultations, diagnoses, care management and the filling of prescriptions.\textsuperscript{51} Preliminary research has shown that the use of telehealth can improve health outcomes and reduce health care costs as it leads to fewer hospitalizations and emergency room visits.\textsuperscript{52}

In 2020, telehealth saw rapid growth.\textsuperscript{53} One telehealth provider alone conducted 2.8 million virtual health visits in the second quarter of the year.\textsuperscript{54} While telehealth was on a steady incline over the last few decades, COVID-19 played a large role in the drastic spike of its usage, and growth is predicted to continue post-pandemic.\textsuperscript{55} It is speculated that there is approximately $250 billion of current U.S. healthcare spending that can be switched to virtual health platforms instead of using traditional in-person care.\textsuperscript{56}

\textsuperscript{46} Id.  This note will focus on telehealth patient-provider visits.
\textsuperscript{47} INST. OF MED., supra note 43, at 11.
\textsuperscript{48} Id.
\textsuperscript{49} See id. at 11-13.
\textsuperscript{50} See id.  Clinician-to-clinician consulting occurs when a physician with little to no experience in how to treat a patient or perform a certain procedure calls a physician who is an expert in the topic to walk them through the treatment. Id. at 11. It is commonly used in rural locations because physicians there may not experience as many unique illnesses. Id.
\textsuperscript{51} See Jones, supra note 8.
\textsuperscript{52} Victoria L. Elliot, Telehealth and Telemedicine: Description and Issues, CONG. RSCH. SERV. 2 (Mar. 29, 2016), https://www.senate.gov/CRSpubs/757e3b90-ff10-497c-8e8c-acl1bbdb3aaaf.pdf.
\textsuperscript{54} Id.  The provider also reported that there were three times more telehealth visits in 2020 compared to the same quarter in 2019. Id.
\textsuperscript{56} Bestsennyy, et al., supra note 7.
Currently, almost fifty percent of physicians now incorporate telehealth in their practices. In 2018, only eighteen percent of physicians were conducting telehealth visits which shows a large spike as a result of the pandemic. Most patients that are utilizing telehealth had their first ever visit during the pandemic. Patients report high satisfaction with telehealth and many plan to continue using these virtual visits as part of their regular healthcare routine. Support for overall telehealth expansion has come from physicians, medical organizations, Congress, Health and Human Services (hereinafter “HHS”), and former president Donald Trump’s administration. However, it should be noted that the rapid growth and satisfaction with the usage of telehealth services may be impeded by the many regulations surrounding its usage.


58. Id. The researchers used the same study in 2018 as they used in 2020, showing the increase in telehealth usage. Id.

59. KYRUUS, supra note 3, at 3. Researchers surveyed 1,000 patients of all age ranges in order to get data on patient perspectives of telehealth. Id. at 2.

60. Id. at 3.


62. See KYRUUS, supra note 3, at 3.

63. See generally Medicare Telemedicine Health Care Provider Fact Sheet, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet (outlining the effect that the CARES Act, as passed by Congress, has on the expansion of access to telehealth services through Medicaid and Medicare reimbursement).


66. See infra Part I.B.
B. Legal Limitations on Telehealth

Despite the increased usage and overall user satisfaction, telehealth services are complicated by several regulatory matters including physician licensing, the Health Insurance Portability and Accountability Act privacy and security rules, and Medicaid and Medicare reimbursement. This note will discuss complications with the enforcement of telehealth non-competes and non-solicitation clauses. Telehealth regulations are further complicated by the drastic changes made during COVID-19 and the lingering uncertainty of the application of new regulations.

1. The Interplay of Physician Licensing and Practicing Telehealth

To practice medicine, physicians must obtain a medical license in the state in which they wish to practice. Physician licensing standards and


68. See Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, U.S. DEPT OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html (last updated Jan. 20, 2021). Normally, physicians practicing telehealth have to use HIPAA compliant videoconferencing software in order to ensure the privacy of patients. Id. Due to the necessary increase in telehealth services, the HIPAA regulations will not be enforced as long as physicians use their professional judgment when conducting telehealth visits over platforms like Zoom, Google Hangouts, Apple FaceTime or Skype. Id.

69. See CTRS. FOR MEDICARE & MEDICAID SERVS., supra note 63. The use of telehealth services is usually limited as Medicare beneficiaries are often unable to be reimbursed for these visits. Id. However, as a response to COVID-19, the Centers for Medicare & Medicaid Services has broadened the services that it will reimburse allowing many beneficiaries to begin using telehealth. Id.

70. See generally infra Part II.

71. See Exec. Order No. 13941, 85 Fed. Reg. 47881, 47882 (Aug. 6, 2020); CTRS. FOR MEDICARE & MEDICAID SERVS., supra note 63; PUB. HEALTH EMERGENCY, supra note 21; U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19, FED’N OF STATE MED. BDS. 1, https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf (last updated Aug. 23, 2021); see generally Wester, supra note 53 (highlighting changes in the enforcement of telehealth regulations during COVID-19 and the uncertainty as to whether the changed regulations will still be enforced after the pandemic).

requirements are controlled by state law and state medical boards. Many states then have separate licensing requirements for the practice of telehealth. Traditionally, physicians practicing telehealth must be fully licensed in the state in which their patient is located during the virtual consult. A physician located in New York may be treating a patient, via telehealth, who lives in New Jersey. In order to comply with licensing requirements, this physician must obtain two medical licenses — both in New York and New Jersey. However, there are currently twelve states that offer limited licenses specifically for interstate telehealth practice. For example, the Texas Medical Board offers an Out-of-State Telemedicine License that allows non-resident physicians to provide telehealth services in Texas, but with this limited license the physician would be excluded from in-person practice.

2. The Increase of Interstate Medical Practice and Licensing

As telehealth popularity grows, physician licensing complicates its expansion and efforts have been made to ease regulations. Recognizing that telehealth advancements would allow physicians to practice across state lines, the Interstate Medical Compact (hereinafter “Compact”) was created in 2013 by various state medical boards with the intention of streamlining the process of obtaining multiple state physician licenses. There are currently thirty states in the Compact and there are more states that have introduced bills to join. While state medical boards have started to take matters into their own hands, others have urged that Congress take action and enact a federal physician licensing scheme to increase access to healthcare and increase telehealth practice.

73. Id.
74. See FED’N OF STATE MED. BDS., supra note 20.
75. See id.
76. See id.
78. See INTERSTATE MED. LICENSURE COMPACT, supra note 20.
79. Id. The Compact was drafted by state medical boards, attorneys, and state legislatures. Id. Physicians are allowed to apply once through the Compact and as long as they meet the requirements, they can receive multiple state licenses in one transaction, rather than applying to each state individually. Id.
81. See generally Gabriel Scheffler, Unlocking Access to Health Care: A Federalist Approach to Reforming Occupational Licensing, 29 HEALTH MATRIX 293, 298-99 (2019) (arguing that the
Multistate practice was further advanced in response to COVID-19, as the Secretary of HHS encouraged states to waive their state licensure requirements and allow any physician with a valid license to practice across state lines. As a result, forty-five states implemented telehealth licensure waivers in various ways temporarily allowing out-of-state physicians to practice virtually in their respective states. However, these waivers were meant to be temporary; some have already lapsed, while other states have more ambiguous language saying that the waivers will expire after the end of the pandemic. Physicians and medical organizations have expressed concerns with the repercussions that are likely to occur as the telehealth waivers expire—most significantly they predict a disruption of patient care. The American College of Physicians urges that the physician interstate licensure flexibility be made permanent in order to allow the continuous expansion of telehealth and increase patient access to healthcare services.

3. Federal Legislation Introduced to Make Telehealth Regulations Permanent

Actions were taken under the Trump Administration to make the new telehealth regulations permanent, specifically the portions of the Coronavirus Aid, Relief, and Economic Security Act (hereinafter "CARES Act") that allow Medicaid and Medicare reimbursement. The Knowing the Efficiency and Efficacy of Permanent Telehealth Options Act of 2020 was introduced to Congress to study the usage of telehealth during COVID-19 and assess the possibility of making the temporary telehealth regulations permanent. The Telehealth Act was also introduced to Congress with the intentions of creating uniform telehealth guidelines. One section of the Telehealth Act focuses on the interstate practice of telehealth. If enacted, the Secretary of HHS is expected to

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current licensing system for physicians and other healthcare professionals impedes access to healthcare and that the federal government can and should take action to preempt the state laws).

82. PUB. HEALTH EMERGENCY, supra note 21.
83. See generally FED'N OF STATE MED. BDS., supra note 71.
84. See id.
85. Fincher, supra note 4.
86. Id.
90. Id. § 501.
consult with a variety of healthcare entities (such as technology and data security experts, primary care/specialty/mental health providers, academic medical center, health departments, federal agencies, consumers, and etc.) to create a “Uniform Best Practices” guideline to create uniformity for healthcare providers practicing telehealth across state lines.\(^{91}\) Despite the proposed legislation, nothing permanent has been decided as to which regulations or waivers will still be in place when the pandemic comes to an end.\(^{92}\) As it stands, healthcare providers and physicians are currently left to navigate the uncertain and changing telehealth regulations on a day-to-day basis.\(^{93}\)

4. Practicing Telehealth While Still Complying with Restrictive Covenants

One obstacle that has yet to be addressed is the enforceability of restrictive covenants for physicians that practice telehealth across state lines.\(^{94}\) As physicians continue to practice telehealth at growing rates and increasingly practice across state lines, an almost limitless geographic scope of practice will be created.\(^{95}\) The current state of non-compete law is inadequate to address these issues.\(^{96}\) This will further be complicated by the enforcement inconsistencies between the states by both state statutes and court made rules.\(^{97}\)

The following sections will explain the current law surrounding non-competes and non-solicitation clauses in general, and the intricacies of these clauses when physicians are involved.\(^{98}\) There is currently little to no case law regarding the enforcement of restrictive covenants for physicians practicing telehealth as this is a relatively new issue.\(^{99}\) As telehealth regulations continue to rapidly change in the wake of COVID-19,\(^{100}\) the need for a uniform regulatory scheme for physician restrictive covenants is a pressing issue.\(^{101}\)

\(^{91}\) Id.


\(^{93}\) See supra Part I.B.1-2.

\(^{94}\) See TANNENBAUM HELPERN SYRACUSE & HIRSCHTRITT LLP, supra note 24.

\(^{95}\) Id.

\(^{96}\) Id.

\(^{97}\) See infra Part III.

\(^{98}\) See infra Part II.

\(^{99}\) TANNENBAUM HELPERN SYRACUSE & HIRSCHTRITT LLP, supra note 24.

\(^{100}\) See supra Part I.B.

\(^{101}\) See infra Part II.
II. DIFFICULTIES WITH PHYSICIAN RESTRICTIVE COVENANTS AS APPLIED TO TELEHEALTH

This Part looks at the current landscape that healthcare providers and physicians must navigate in order to enter into employment agreements that contain non-compete agreements and non-solicitation clauses. Section A discusses non-competes in general and the legal theory courts use in enforcing them as applied to physicians. Physician restrictive covenants, including both non-competes and non-solicitation clauses are especially difficult to enforce as there are strong competing interests which will also be discussed. Section B analyzes the different approaches that states take in enforcing physician covenants. Throughout there will be a discussion of the added difficulties that telehealth creates and how the existing legal theory is insufficient.

A. The General Application of Non-Competes and the Push for Federal Action

A non-compete agreement is, "[a] contract limiting a party from competing with a business after termination of employment." More than 36 million private-sector employees in the United States are bound by non-compete agreements. Traditionally, a non-compete clause will prohibit both current and terminated employees from performing specified competitive activities in a certain geographic location for a set period of time. A very basic non-compete agreement may contain a provision stating, "for [time period] following the termination of Employee’s employment, Employee will not . . . become employed by . . .

102. See infra Part II.
103. See infra Part II.A.
104. See infra Part II.C.
105. See infra Part II.B.
106. See infra Part II.
The enforceability of non-compete agreements have been governed by state law for almost 200 years. Most states have statutory provisions addressing whether non-competes are allowed, any limitations, and any exemptions. Over the years, many states have modified regulations about non-competes. Some states have strengthened them, others have segmented the regulations based on the employment sector involved, and others have considered banning them all together. These differences will be discussed in-depth in Section E, more specifically analyzing the effect of non-compete agreements on physicians.

The inconsistency in non-compete regulations has sparked federal interest in creating federal statutory regulations. Three separate bills have been introduced in Congress to change current non-compete regulations in different industries and create federal regulation. The Mobility and Opportunity for Vulnerable Employees Act sought to prohibit employers from requiring low-wage employees to sign restrictive covenants, and the Workforce Mobility Act of 2018 was introduced to ban restrictive covenants in their totality. While neither of these bills passed, there remains an interest in creating federal uniform regulations, particularly in the medical field.

In states that allow non-competes, the enforceability of the agreement is determined by the courts, with most using the rule of reason

110. Non-Compete, Customer and Employee Non-solicitation, and Confidentiality Agreement, § 5(a), LEXIS (last updated July 22, 2021), https://plus.lexis.com/practice-advisor-home (search in search bar for “Non-Compete, Customer and Employee Non-solicitation, and Confidentiality Agreement”; then click “content type” on the left menu and select “templates;” then click the first result).


113. See Beck & Hahn, supra note 111.

114. Id.

115. See infra Part II.E.

116. See Beck & Hahn, supra note 111.

117. Id.


120. See Beck & Hahn, supra note 111.
In order to satisfy the rule of reason test, the restrictive covenant cannot be broader than necessary to protect the employer’s business interests, cannot unduly burden the employee, and lastly cannot cause harm to the public. The rule of reason test then looks at four factors to determine enforceability of restrictive covenants: (1) whether the employer has a legitimate and protectable business interest; (2) whether the restrictive covenant is reasonably protecting that interest; (3) whether it unduly burdens the employee; and (4) whether it harms the public. The time and geographic area restricted by a non-compete must also be reasonable. Generally non-competes are determined on a case-by-case basis. Because disputes over the validity of non-compete agreements are fact centered and determined by the court, they are very time-consuming and can be very costly to resolve. Despite these drawbacks, non-competes are used at an increasing rate. The enforcement of non-competes against physicians is particularly hard to determine because there are strong interests on all sides: the employer, the physician, the public, and the patients.

B. Non-Compete Agreements as Enforced Against Physicians

The use of physician non-compete agreements has been harshly criticized for years and by many organizations. For example, the AMA cautions physicians from entering into non-competes that unreasonably restrict competition and disrupt the continuity of patient care, but recognizes that there may be some legitimate business interests that

121. Malloy, supra note 19, at 192.
122. Id.
123. Id. at 196.
124. Id. at 195.
125. Id. at 196.
126. Id. at 235.
128. Id.
employers are trying to protect. Enforcing physician non-competes is a very costly and lengthy process in almost all jurisdictions. Despite the criticism, physician non-competes are being used at an increasing rate, with one study finding that approximately forty-five percent of primary care physicians are bound by such an agreement.

Physician non-competes and non-solicitation clauses are unique because they must weigh not only the employer and employee interests, but also the interests of patients. Enforcement of a non-compete may lead to the possible disruption of patient care if a physician is no longer allowed to treat a patient. The majority of states and courts still enforce physician non-competes. However, a few states have restricted the use of physician non-competes making them harder to enforce, while some have even prohibited them altogether. Former President Trump’s administration recommended that all states scrutinize their current policies and enforcement procedures for physician non-competes so that physicians can provide better patient care.

Integral to the healthcare system is the creation of the physician-patient relationship, which once formed creates a series of duties on both the physician and the institutional employer. A physician-patient relationship is formed on the mutual consent of the patient and physician when the physician begins providing medical care. One duty that is created by the physician-patient relationship is the duty not to abandon a

3.1.%2C%20fees%2C%20or%20credit%20terms.&text=Do%20not%20make%20reasonable%20accommodation%20for%20patients%20of%20physician (last visited Oct. 14, 2021).
132. See Troutman, supra note 127.
133. Id.
135. See infra Part II.C.
136. See Marshall, supra note 130.
137. Id.
138. See id.
patient with whom a treatment relationship has been formed. This duty owed by the physician is complicated by the enforcement of non-competes and non-solicitation agreements. Courts in different jurisdictions have enforced non-competes that have hindered the physician-patient relationship, disrupted patient continuity of care, and have stopped physicians from treating their patients. Enforcing these non-competes can be harmful to both patients and physicians. The interruption of physician-patient relationships is just one of the reasons why enforcing non-compete agreements is so hard.

C. Balancing the Needs of Patients, Providers, Employers, and the Public

In jurisdictions that allow non-compete agreements to be enforced against physicians, a court that applies the rule of reason test will first look at the interests of the employer. Employers using non-compete agreements and non-solicitation clauses are usually trying to prevent their employees from leaving to go work for a competitor, poaching customer contacts (or patients), sharing confidential business practices, sharing unique business strategies, and more. As for business interests in the healthcare industry, courts have found that the following are valid and subject to being protected: "the patient base, training of physicians, trade secrets, confidential business information, goodwill, reputation, and patient referral sources." After identifying a valid business interest, courts will then apply the reasonableness test to determine whether the enforcement of the non-compete will actually protect the employer's business interests.

142. FURROW ET AL., supra note 140, at 95.
143. See infra Part II.B.
144. Clausen, supra note 129, at 116-18.
145. See id. at 116.
146. See id. at 129.
147. See Malloy, supra note 19, at 196.
149. Clausen, supra note 129, at 130 (citing Wichita Clinic, P.A. v. Louis, 185 P.3d 946, (Kan. Ct. App. 2008)).
150. See id.
Next, courts will evaluate the physician’s interests and whether the enforcement of the non-compete will unduly burden them. Unfortunately, courts do not evaluate the interests of the physician as thoroughly as they evaluate the interests of the business. The undue burden imposed on a physician rarely leads to a court rendering the restrictive covenant void. This is especially troublesome as reports have shown that non-competes are often overly burdensome and place restrictions on the physicians bound by them.

While many employees involved in non-compete litigation will advance the argument that they have an interest in job mobility and the need to make a living for their family, courts are unlikely to accept such an argument. Instead, courts place more weight on an individual’s right to contract over their right to change jobs, even as applied to physicians being prevented from providing medical services. Thus, most courts will not find that a physician is unduly burdened by the enforcement of a non-compete agreement and this argument will fail. Interestingly, Florida has a statute that expressly bans courts from considering the undue burden and economic burden a restrictive covenant may have on an individual and the economic hardship that may result from enforcing the non-compete agreement. Because of the hardships that may be imposed on physicians if a non-compete agreement is enforced, some doctors and organizations recommend that telehealth be used as a way to get around their non-compete agreement. However, this option may not be viable because of the current state of enforcing non-compete agreements for physicians practicing telehealth.

Public interest and likelihood of harm is the last interest that courts will look at in determining the reasonableness of enforcing a non-compete

151. See Malloy, supra note 19, at 196.
153. Clausen, supra note 129, at 131.
154. HHS Report, supra note 139, at 62.
155. Megna, supra note 152, at 1015-16.
156. Id. at 1016.
157. See id.; Clausen, supra note 129, at 131.
158. FLA. STAT. ANN. § 542.335(1)(g)(1) (West 2020).
160. See infra Part III.
agreement. ¹⁶¹ It is fairly clear that the public has a strong interest in whether a physician will be restricted from practicing because that enforcement may interfere with the quality of care and cause a disruption of the patient-provider relationship. ¹⁶² Reports done during both the Obama presidency ¹⁶³ and the Trump presidency scrutinize the enforcement of physician non-competes as they have the potential to decrease access to care which in turn harms the public. ¹⁶⁴ These reports indicate that the restrictive covenants limit job mobility, which reduces employee bargaining power and may limit the supply of providers. ¹⁶⁵ This in turn may cause an inflation in healthcare costs. ¹⁶⁶

While the job mobility argument may not succeed when raised by an individual physician, ¹⁶⁷ it holds more weight when many physicians are restricted leading to public health issues. ¹⁶⁸ Public health arguments are also stronger when advocating against not restricting providers from practicing telehealth. This is because telehealth increases access to health care providers, especially in underserved communities and in rural areas. ¹⁶⁹ Public health concerns are even more prevalent right now amidst the COVID-19 pandemic, and it is incredibly important that physicians are allowed to continue seeing patients with telehealth platforms. ¹⁷⁰

Public policy arguments are gaining strength as courts are considering harm to the public at an increasing weight when analyzing the enforceability of physician non-competes. ¹⁷¹ Some courts pay particular attention to “the public’s right to freedom of choice among physicians, the right to continue an ongoing relationship with a physician and the benefits derived from having an increased number of physicians in any given community.”¹⁷² These patient rights likely stem from evidence that shows continuity of care with the same provider is a crucial aspect to patient satisfaction and adherence with treatment.¹⁷³

¹⁶¹ Malloy, supra note 19, at 196, 200.
¹⁶³ Id. at 2.
¹⁶⁴ See HHS Report, supra note 139, at 63.
¹⁶⁵ Id. at 62.
¹⁶⁶ Id.
¹⁶⁷ See Megna, supra note 152, at 1015-16; Clausen, supra note 129, at 131.
¹⁶⁸ See HHS Report, supra note 139, at 62.
¹⁶⁹ INST. OF MED., supra note 43, at 11.
¹⁷⁰ See supra Introduction.
¹⁷¹ Benesch, supra note 148, at 2.
¹⁷² Id.
¹⁷³ Malloy, supra note 19, at 204.
Despite the growing strength of public policy arguments, the right to have uninterrupted physician-patient relationships is not being considered with as much weight as it should be.\textsuperscript{174} This is likely because some courts still ignore the importance of having an ongoing physician-patient relationship on a patient’s health.\textsuperscript{175} Courts still enforce non-competes that break apart physician-patient relationships.\textsuperscript{176} Rather, courts focus on general access to care in the area, instead of patient access to a specific physician.\textsuperscript{177} Courts look at the number of alternative physicians in an area that a patient may be able to utilize if they can no longer see their original physician.\textsuperscript{178} When a court does this, it disregards the health benefits associated with a continuous relationship with a specific physician.\textsuperscript{179} For example, in *Dickinson Medical Group v. Foote*, the court enforced a restrictive covenant against a physician that was the only board-certified oncologist in the hospital and prevented her from continuing chemotherapy treatment with her patients after she left the hospital.\textsuperscript{180} Although the doctor argued that she had a professional and ethical duty to keep treating her patients, and the court sympathized with her patients, the court still found the restrictive covenant enforceable.\textsuperscript{181}

Once a court looks at the interests of all parties involved (the employer, physician, and patient), it will draw a conclusion as to whether to enforce the restrictive covenant.\textsuperscript{182} Even when courts are balancing the same opposing interests, they reach different conclusions on enforceability depending on the jurisdiction.\textsuperscript{183} These inconsistencies surrounding physician non-competes likely stem from the wide range of state approaches in determining enforceability.\textsuperscript{184} For example, harm to the public has led to some states prohibiting physician non-competes all together, while others have not.\textsuperscript{185}

\textsuperscript{174} See Clausen, *supra* note 129, at 132.
\textsuperscript{175} Id.
\textsuperscript{176} Id.
\textsuperscript{177} See id.
\textsuperscript{178} Id.
\textsuperscript{179} Id.
\textsuperscript{181} Id. at *2.
\textsuperscript{182} See id. at *3.
\textsuperscript{183} See *supra* Part II.C.
\textsuperscript{184} See *infra* Part II.E.
\textsuperscript{185} See *supra* Part II.B.
D. The Reasonableness Test Applied to Time and Geographic Scope

1. Typical Application to Traditional Physician Restrictive Covenants

After a court analyzes the reasonableness of business interests, the undue burden on the physician, and potential harm to the public, it will again apply the reasonableness test to the geographic area being restricted and the length time of the non-compete. While there is great variation jurisdiction-to-jurisdiction, and it is dependent on the facts of each case, a common market definition for enforceable physician non-competes are those that “include the county containing the practice or a 20-mile radius around the practice . . . and two to three years [of restriction] is often deemed reasonable.” While time restricted is assessed on a case-by-case basis, courts have enforced physician non-competes ranging from two years in length to as high as five years. In determining the reasonableness of the time restricted, courts should not enforce lengths of time that are longer than necessary for the business to fill the departing physician’s position and for the new employee to become effective.

When analyzing geographic scope, the area restrained cannot be arbitrary. Rather, to be enforceable it must be drawn in a location designed to protect the specific area in which the employer has shown business interests. The geographic scope is often defined as “the area in which the former employee did business on behalf of the employer.” For physicians, the geographic territory consists of the area where most of the physician’s patients come from and the area of practice. Courts will often analyze a restrictive covenant’s time and geographic restriction in tandem; a longer time restriction may be accepted only if a small geographic area is listed and vice versa. For example, one court enforced a restrictive covenant that prohibited a physician from practicing

186. See Malloy, supra note 19, at 197 n.41.
189. Id. at 24-25.
190. See Benesch, supra note 148, at 7.
191. Id.
194. Kuo, supra note 192, at 573.
for ten years after rewriting it to only restrict the geographic area of city of the practice plus a radius of five miles.195

2. Applicability, or Lack Thereof, of Geographic Scope to Physicians Practicing Telehealth

The geographic boundary analysis creates problems for the application of non-competes to telehealth providers.196 As telehealth breaks down state licensing regulations and physicians can practice in multiple states,197 the geographic scope that physicians are treating patients in can become almost a limitless territory.198 The current judicial landscape of evaluating non-competes under a reasonableness standard simply does not apply when looking at the possible geographic territories involved with restrictive covenants in the telehealth industry.199

For telehealth providers, it is quite possible that a physician could be physically located in one state and be providing virtual visits to a patient that is 500-miles away in another state. Attempting to enforce a non-compete over such a vast territory could prevent a physician from practicing in the entire state where they reside and any other states in which they may be providing services. The possibility of multi-state practice may also create financial burdens for physicians as they currently have to maintain multiple medical licenses until the licensing scheme changes.200 An alternative approach is needed for enforcing non-compete agreements against physicians in telehealth.

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195. See Foltz v. Struxness, 215 P.2d 133, 135, 139 (Kan. 1950) (upholding the trial court finding that the restrictive covenant was enforceable against the employee-physician. Originally, the restrictive covenant was for 10 years and a radius of 100 miles. The Physician argued that the entire covenant should be unenforceable based on this, but the court disagreed. The trial court found that 100 miles was too expensive but used its discretion to decrease the radius to 5 miles outside of the town where the practice was located). It is because of the small geographic radius that the longer length of time was permitted. See id. at 138.

196. TANNENBAUM HELPERN SYRACUSE & HIRSCHTRITT LLP, supra note 24.

197. See supra Part I.B.2.

198. See TANNENBAUM HELPERN SYRACUSE & HIRSCHTRITT LLP, supra note 24.


200. See supra Part I.B.1
E. Substitutes for Limitations on a Large Geographic Scope in Other Industries

The healthcare market is not the first industry that has shifted to virtual work and expanded the geographic scope of their businesses. In the 1990s, there was large growth in telecommuting, which has allowed businesses to have nationwide markets.²⁰¹ Employers and courts began modifying the geographic scope element of non-compete agreements in order to find them valid.²⁰² Some alternatives include replacing the geographic limit with “activity-based limits,” “customer-based” limits,²⁰³ and the “major competitor” limits.²⁰⁴ While some jurisdictions have updated their reasonable analysis, other courts will simply find restrictive covenants invalid if there is no geographical territory written in.²⁰⁵ As discussed previously, the practice of telehealth increases the geographic scope of practice, thus an alternative is needed if non-compete agreements are to be enforceable.²⁰⁶ However, these alternatives (activity based, customer based, and the major competitor analysis) do not work well in the healthcare industry.²⁰⁷ The jurisdictional inconsistencies will further complicate any attempted application of these alternatives.²⁰⁸

1. Activity-Based Restrictions and its Inapplicability to Physicians

Online-based employers have replaced the geographic restriction in their non-compete agreements with activity-based restrictions.²⁰⁹ An activity-based restriction typically enumerates specific services that an employee would be prohibited from performing for a competitor for the span of the non-compete agreement.²¹⁰ In order to be enforced, activity-based restrictions need to be narrowly tailored to only restrict the actual job description and tasks that the employee performs.²¹¹ A narrowly

²⁰¹ See Kuo, supra note 192, at 567-68.
²⁰² Id. at 573-74.
²⁰³ See id. at 569.
²⁰⁴ Megna, supra note 152, at 1024-25.
²⁰⁵ See Kuo, supra note 192, at 574 (citing Tamburo v. Calvin, 1995 WL 121539 (N.D. Ill. 1995) (memo)).
²⁰⁶ See supra Part I.
²⁰⁷ See infra Part II.B.E.1-2.
²⁰⁸ See infra Part III.
²⁰⁹ See Steven Cooper & Ellie A. Levy, Commentary, Non-Competition Agreements in Cyberspace, 1 No. 21 E-TRADING LEGAL ALERT 3 (Mar. 16, 2001).
²¹⁰ Id.
²¹¹ Id.
tailored activity-based restriction with a reasonable time period will likely be enforceable in industries where a geographic restriction would be inapplicable.\textsuperscript{212}

While physicians practicing telehealth are also following an online employment format with broad geographic border, activity-based restraints would be hard to enforce as it could have negative effects on public policy.\textsuperscript{213} Medicine is a highly specialized profession requiring years of education, training and licensing requirements.\textsuperscript{214} Licensing requirements already enumerate the scope of practice and activities that a physician can perform.\textsuperscript{215} Enforcing an activity-based restriction against physicians that are already highly regulated would drastically hinder not only where they can practice, but also the types of medical procedures that they can perform.\textsuperscript{216} This would negate the public health benefits of the increased usage of telehealth, such as increased access to care and increased access to specialized physicians.\textsuperscript{217} Thus, this alternative fails in the telehealth industry.

2. Major Competitor Restrictions and its Inapplicability to Physicians

The major competitor restriction, also known as the rule of reasonable competition, is another alternative that employers have used in attempting to restrict large geographic areas.\textsuperscript{218} Instead of restricting employees from working in a specific geographic area, under this approach an employer can enumerate its major competitors and explicitly state that its employee cannot work for that specific competitive company.\textsuperscript{219} The employer cannot make an exhaustive list, but rather must leave a sufficient number of “permissible employers.”\textsuperscript{220} Using the reasonable competition approach in the telehealth industry could be complicated. The healthcare industry is a huge market with an estimated

\textsuperscript{212} Id.
\textsuperscript{213} See supra Part II.C.
\textsuperscript{214} See Megna, supra note 152, at 1023.
\textsuperscript{215} See AM. MED. ASS'N, supra note 72.
\textsuperscript{216} See Megna, supra note 152, at 1023.
\textsuperscript{217} See supra Part I.
\textsuperscript{218} See Michael S. Green & Laura P. Chiasson, Covenants Not to Compete: An Old Dog with a New Bite, 39 ARIZ. ATT'Y 18, 20 (2003).
\textsuperscript{219} Id. at 21.
\textsuperscript{220} Id.
784,626 healthcare companies in the United States. With the increase in the number of physicians and employers using telehealth, it may be difficult to enumerate and restrict competitors.

3. Client-Based Restrictions

"Client-based" restrictions are another method that employers and courts have considered when finding a substitute for geographic restrictions in non-compete agreements. As previously discussed, patients make up the main client base for healthcare providers. In the traditional reasonableness approach to analyzing non-compete agreements, an employer’s client base is often recognized as a protectable business interest. Because of this protectable interest, some courts have been willing to enforce non-compete agreements that lack geographical restrictions if the covenant applies to a narrowly defined client base. Employers also often protect their clients with non-solicitation clauses.

While restricting departing employees from contacting previous clients may work in other industries, this restriction is complicated in the healthcare industry. This is often because of the patient-provider relationship and the duty that physicians owe to their patients. Client-based restrictive covenants are not the best solution for the expanding geographic scope of the telehealth industry. These issues will be discussed in-depth in the next section when speaking of non-solicitation clauses.

F. The Application of Non-Solicitation Clauses for Physicians

Along with physicians being asked to sign non-compete agreements, it is often commonplace for employers to enforce non-
solicitation clauses.\(^{230}\) A non-solicitation clause often includes language stating that, "[an] Employee shall not ... solicit, communicate with or otherwise contact any of the Company’s customers ... [geographic limitation, if applicable], with whom Employee had material contact during Employee’s employment."\(^{231}\) In healthcare, the customers are most commonly identified as the patients.\(^{232}\) A non-solicitation clause prevents a departing physician from soliciting patients to follow the physician to a new practice.\(^{233}\)

A physician does not have to expressly ask patients to follow them after departing an employer to be in breach of a non-solicitation clause.\(^{234}\) The standard is much lower meaning that merely "providing ... information that might encourage [patients] to enroll in another health plan" is enough to breach a non-solicitation agreement.\(^{235}\) This low standard becomes an issue\(^{236}\) as physicians have a duty to give notice to their patients when the physician plans on departing.\(^{237}\)

1. Balancing Non-Solicitation Clauses with Legal and Ethical Duties

This duty to notify is both an ethical one imposed by the AMA,\(^{238}\) and a legal duty to terminate the physician-patient relationship and arrange for follow-up care if necessary.\(^{239}\) According to the AMA Code of Medical Ethics, “physicians’ [have a] fiduciary responsibility to patients [which] entails an obligation to support continuity of care,” also known as a duty not to abandon.\(^{240}\) In order to meet this responsibility, physicians withdrawing from care must give their patient advanced notice


\(^{231}\) Non-Compete, Customer and Employee Non-solicitation, and Confidentiality Agreement, supra note 110.

\(^{232}\) See Benesch, supra note 148.

\(^{233}\) See Non-Compete, Customer and Employee Non-solicitation, and Confidentiality Agreement, supra note 110.


\(^{235}\) Id.

\(^{236}\) See supra Part II.B.


\(^{238}\) Id.

\(^{239}\) See generally FURROW ET AL., supra note 140, at 95.

\(^{240}\) AM. MED. ASS’N, supra note 237.
that would allow the patient to find another physician.241 When necessary, the departing physician must assist the patient with the transfer of care by making arrangements to see a new physician.242

A physician that does not notify patients of a discontinuance of care may also be subject to medical malpractice claims and could be found liable for a breach of duty.243 If a departing physician attempts to comply with their duty not to abandon by informing patients of the time of departure and provides the name of the physician’s new practice, it is possible that the physician has breached a non-solicitation agreement.244 Thus, physicians who have signed non-solicitation agreements have to balance the fine distinction between fulfilling their legal and ethical duty to their patients with the terms of their employment contract.245

2. Courts Enforcing Non-Solicitation Clauses

When determining the enforceability of a non-solicitation clause, courts often use a four-part test.246 A non-solicitation clause must (1) not injure the public; (2) not be broader than necessary to protect the employer’s interests; (3) not create an undue hardship on the departing employee; and (4) be reasonable as to time limited and geographic scope restricted.247 This test is very similar to the one many courts apply to non-compete agreements.248

In attempting to find a balance between competing interests, one court developed a standard that would allow physicians to notify patients and to protect employer interests.249 A departing physician giving proper notification to patients (1) should supply enough information that would allow the patient to continue receiving care from the physician when they leave the practice; (2) should give the name and address of the physician’s new practice and the means to transfer a patient’s medical records to the practice (if applicable); and (3) should not include language that would encourage the patient to transfer care and follow their physician to the new

241. Id.
242. Id.
245. Id.
246. Dearden, supra note 230.
247. Id.
248. See supra Part II.A.
practice. Even with this articulated rule, physicians may still be found in breach of their non-solicitation agreements. In this case, the physician was found to be in violation of her non-solicitation clause because her notification letter talked about a higher quality of care at her new practice, thus breaking the third element of the rule.

Interestingly, although courts understand the physician’s duty to notify patients of their departure, many courts find that if a physician uses patient lists or records from their previous employer, that it would be a breach in a non-solicitation clause. It is believed that punishing physicians when they attempt to notify patients may “deter physicians from fulfilling ethical obligations, disrupt[s] continuity of care, and potentially deprive[s] patients choice of providers.” This is harmful to the public, and courts should weigh these factors heavily when enforcing non-solicitation clauses. In the realm of telehealth, the enforcement of non-solicitation clauses gets more complicated as patient lists get longer and geographic territories get larger.

In Bloomington Urological Associates, SC v. Scaglia, the court was faced with the question of whether a physician answering patient phone calls when he was present in the geographic area where his previous employer restricted his practice of medicine would constitute a breach of the restrictive covenant. The physician had left his previous employer, and in compliance with the restrictive covenant he had signed, started his own medical practice outside of the restricted geographic location. However, he lived within the area that was restricted by his previous employer and he often took patient phone calls and faxes from his home office. The previous employer enjoined the physician arguing that he was breaching the covenant by practicing at his home, and thus within the restricted geographic area. On appeal, the court found that the physician had a duty not to abandon his patients and enforcing the

250. Id. at *9-*10.
251. Id. at *10.
252. Id.
253. Id. at *6.
255. Clausen, supra note 129, at 113.
256. See id. at 132.
257. See infra Part IV.
258. See infra Part IV.B.
260. See id.
261. Id.
262. See id.
covenant would not allow him to speak with his patients just based on where he was located.\textsuperscript{263} Although this court did not use the word "telehealth," the physician here was likely practicing a version of it.\textsuperscript{264} This case highlights the difficulties in enforcing restrictive covenants against physicians practicing telehealth when the issue at hand is geographic scope and the duty not to abandon patients.

Non-compete agreements and non-solicitation clauses are often analyzed similarly,\textsuperscript{265} especially as they are both typically included in the same employment contract.\textsuperscript{266} Thus, many of the issues found with the enforcement of non-compete agreements in the telehealth industry will arise with non-solicitation agreements.\textsuperscript{267}

III. \textsc{Statutory and Jurisdictional Differences in the Enforcement of Restrictive Covenants}

This part will look at the way that states have individually addressed non-compete agreements and non-solicitation clauses. Many states have enacted statutes and taken very different approaches as to how physician restrictive covenants should be enforced, with some states prohibiting them together.\textsuperscript{268} These inconsistencies will cause issues for physicians and employers in the healthcare industry as they practice telehealth.\textsuperscript{269} A federal statute will be recommended in an effort to create uniformity as the telehealth industry continues to grow.\textsuperscript{270}

\textit{A. States with No Statutory Provisions Relating to Physician Restrictive Covenants}

The enforcement of physician non-competes varies drastically from state-to-state, making the landscape even more confusing for physicians.\textsuperscript{271} While the majority of states allow non-competes,\textsuperscript{272} these states have a wide range of statutory laws and court made rules in

\begin{itemize}
\item \textsuperscript{263} \textit{Id.} at 394.
\item \textsuperscript{264} See \textit{id.}
\item \textsuperscript{265} See \textit{supra} Part II.
\item \textsuperscript{266} Clark, \textit{supra} note 18.
\item \textsuperscript{267} See \textit{supra} Part II.
\item \textsuperscript{268} See \textit{infra} Part III.
\item \textsuperscript{269} See \textit{infra} Part III.
\item \textsuperscript{270} See \textit{infra} Part IV.
\item \textsuperscript{271} See \textit{supra} Part II.B.
\item \textsuperscript{272} See Beck, \textit{supra} note 112.
\end{itemize}
determining the enforceability.  

On one end of the spectrum, New York sees no distinction between the enforcement of physician non-competes and non-competes in other employment fields.  

Enforceability is determined on a factual basis to determine if the non-compete is reasonable as to time and geographic scope.  

Most states follow some variation of the reasonableness approach, which was previously discussed in depth.  

This approach can further be broken into three categories: (1) reasonableness with no heightened scrutiny; (2) reasonableness with heightened scrutiny; and (3) the blue pencil rule that allows courts to edit covenants to make them reasonable.  

When there is no heightened scrutiny, courts look at physician restrictive covenants the same way that they look at all other professions.  

Other courts have heightened scrutiny which leads to a more in-depth look into the interests of the physician and the public policy ramifications.  

Lastly, the blue pencil rule allows courts to modify restrictive covenants that would otherwise be unenforceable to make them compliant and thus enforceable.

B. States That Prohibit Physician Restrictive Covenants

On the other end of the spectrum, seven states have expressly banned restrictive covenants as applied to physicians. For example, Massachusetts, Delaware, and Colorado prohibit the enforcement

273. See id.
274. Marshall, supra note 130. Non-competes in New York “are enforceable as long as they are: (1) necessary to protect the employer’s legitimate interests; (2) do not impose an undue hardship on the employee; (3) do not harm the public; and (4) are reasonable in time period and geographic scope.” Id.
275. Id.  
276. Clausen, supra note 129, at 128.  
277. See supra Part II.  
278. Clausen, supra note 129, at 128.  
279. Id.  
280. Id.  
281. See id. at 135.  
282. See Mike Kreager, The Physician’s Right in § 15.50(B) To Buy Out a Covenant Not to Compete in Texas, 61 BAYLOR L. REV. 357, 370 (2009).  
283. See MASS. GEN. LAWS ANN. ch. 112 § 12X (West 2020). “Any contract... with a physician... which includes any restriction of the right of such physician to practice medicine in any geographic area for any period of time after the termination of... employment... shall be void and unenforceable.” Id.  
284. See DEL. CODE ANN. tit. 6, § 2707 (West 2020).  
285. See COLO. REV. STAT. § 8-2-113(3)(a).
C. States with Unique Statutory and Judge Made Approaches for Physician Restrictive Covenants

Other states fall somewhere in the middle; they allow non-competes against physicians but create extra protections for physicians and patients. Depending on the state, these added protections are done either through the legislative process or through their court systems. Utah, Wisconsin, and Idaho have all recently made it harder for employers to enforce restrictive covenants against physicians. For example, one court found that restrictive covenants will only be enforced against physicians when they are narrowly tailored restricting only the activity necessary to protect the employer’s interest’s and nothing more.

Florida is an example of a state with added protections in the form of statutory language. Florida expressly states in its statute that “[t]he
Legislature finds that such covenants restrict patient access to physicians, increase costs, and are void and unenforceable,” thus there needs to be restrictions on physician non-compete agreements.²⁹⁶ In most states and jurisdictions, courts will use the rule of reason test in determining whether the non-competes are reasonable as to time and geographic scope.²⁹⁷ Determining the geographic scope of physician non-competes for telehealth providers will be nearly impossible as the changes in interstate practice could lead to an almost limitless area of practice.²⁹⁸

Texas has taken a unique statutory approach in their enforcement of physician non-competes.²⁹⁹ While Texas permits physician non-competes, it expressly outlines four prerequisite requirements that must be made in order to be enforced.³⁰⁰ In order for a covenant not to compete to be enforceable against a physician it must: (1) not deny access to patient lists for patients that had been seen within one year of termination, allow access to previous patient medical records upon authorization of the patient, and the records be provided in the same format; (2) provide a buyout option for the physician at a reasonable price; and (3) the covenant must allow physicians to continue providing treatment to patients that are in the course of an acute illness even after the termination of employment.³⁰¹ Aspects of section 15.50(b) will be used later in this note in drafting the potential federal statute.³⁰²

Texas law makers drafted Tex. Bus. & Com. Ann. section 15.50(b) with the protections of the public in mind.³⁰³ Even if the non-compete is enforceable, physicians are still allowed to continue care for patients needing acute care, which combats issues with disruption of care.³⁰⁴ Texas is the only state that includes, and requires, a buyout option for physicians in order for the non-compete to be enforceable.³⁰⁵ The buyout is either determined upon signing the contract or when the non-compete becomes enforceable and will then be decided through an arbitrator.³⁰⁶ A physician who wishes to leave their employer can either make the choice of being bound to the non-compete restrictions, or physicians can choose

²⁹⁶ Id.
²⁹⁷ Malloy, supra note 19 at 195.
²⁹⁸ See supra Part II.D.
²⁹⁹ See Kreager, supra note 282, at 361.
³⁰¹ Id.
³⁰² See infra Part IV.
³⁰³ See Kreager, supra note 282, at 415.
³⁰⁴ Id.
³⁰⁵ Id.
to enact the buyout clause and pay their employer to continue seeing their past patients and practice in the geographic area they choose.\textsuperscript{307} Thus, Texas’s approach in enforcing physician non-competes balances the interests of the employer, the physician, and the public.\textsuperscript{308} Including a buyout requirement for physician non-competes for those practicing telehealth would also help with balancing those same interests.\textsuperscript{309}

IV. FEDERAL LEGISLATION TO CREATE UNIFORMITY AND ALLOW FOR CONTINUED GROWTH IN TELEHEALTH

With the push for national uniformity in physician licensing\textsuperscript{310} and uniform telehealth regulations,\textsuperscript{311} federal legislation creating guidelines for the enforcement of restrictive covenants for physicians practicing telehealth is the best way to create consistency. This will make it easier for employers to draft non-compete agreements for physicians practicing telehealth.\textsuperscript{312} Instead of having to navigate the temporary physician licensing regulations because of COVID-19 and the inconsistent enforcement of physician non-competes, a federal statute will make the requirements expressly clear.\textsuperscript{313} Clearer requirements in turn could reduce the number of court cases brought to determine the validity of a restrictive covenant.\textsuperscript{314} This would decrease litigation costs and increase time for both employers and physicians, as this litigation is often lengthy and costly.\textsuperscript{315}

A. Proposed Federal Statute

The general proposition in enforcing telehealth physician non-competes and non-solicitation clauses is that they be viewed in the light most favorable to pre-existing physician-patient relationships.\textsuperscript{316}

\textsuperscript{307} See Kraeger, supra note 282, at 363.
\textsuperscript{308} See generally id. (discussing the legislative history in enacting TEX. BUS. & COM. CODE ANN. § 15.50(b) and the intent Texas had in balancing public welfare, a physician’s interest in moving between employers, and the employer’s interest in protecting its business).
\textsuperscript{309} Id.
\textsuperscript{310} See supra notes 78-81.
\textsuperscript{311} See supra notes 89-91.
\textsuperscript{312} See supra notes 89-91.
\textsuperscript{313} See infra Part IV.A.
\textsuperscript{314} See generally Troutman, supra note 127 (discussing the costliness of restrictive covenant litigation).
\textsuperscript{315} Id. (involving the judicial system in the enforcement of restrictive covenants is expensive and having clearer restrictions would decrease the need to resolve the issues in court).
\textsuperscript{316} See supra Part II.B. (discussing physician-patient relationships).
Telehealth increases the number of patients that physicians can treat and allows greater access to care. This is especially relevant in rural geographic areas and for communities that are generally underserved. The practice of telehealth has the power to expand access to medical care and allows patients to maintain close relationships with their providers. The enforcement of restrictive covenants should not negate these public health benefits. There are strong public policy reasons to not limit patient access to the physicians of their choice and to protect patients' right to maintain physician-patient relationships. Thus, in order to enforce these restrictive covenants, employers should have the burden of supplying tangible evidence of the business interests that they are trying to protect and that the restrictive covenant actually protects those interests. The proposed framework is a best effort to balance the competing interests of healthcare employers, physicians, and patients.

The proposed federal statute is as follows.

**ENFORCEMENT OF RESTRICTIVE COVENANTS FOR PHYSICIANS PRACTICING TELEHEALTH:**

Once an employer makes an ample showing of its business interests, the following requirements must be made to enforce a restrictive covenant against a physician practicing telehealth:

1. the employer is only restricting the activities that the specific physician was conducting in the last year of employment;

2. the geographic scope restricted cannot be a blanket territory of the business itself, rather it may be the geographic location of where the specific physician was practicing;

3. departing physicians must be able to continue treating patients experiencing acute illness until reasonably resolved (or be allowed to assist in setting up follow up care);

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318. Id. at 6.
319. See supra Part I.
320. See Clausen, supra note 129, at 132.
321. See id. at 130-31.
322. See supra Part II.C.
323. Acute Illness, SEGEN'S MED. DICTIONARY (2012), https://medical-dictionary.thefreedictionary.com/Acute+Illness (defining acute illnesses as those which develop

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(4) the departing physician must be able to access the medical records for the before mentioned patients, even after departure;

(5) the departing physicians must be able to inform patients of their departure and assist prior patients in the referral process of finding a new physician, but they may not encourage patients to follow them. If the patient chooses to follow their physician to a new healthcare system, the physician may not be penalized; and

(6) the time restricted cannot be longer than one year;

(7) employers must also include a buyout provision that would allow physicians to pay a predetermined amount of money to be released from the contract.

This is a high burden for employers to meet, but it is a best effort to balance the competing interests of the employer, the physicians, the patients, and the public health interests. This high standard for enforcement ensures that patients are not losing access to their physicians due to non-compete and non-solicitation clauses, unless the employer has legitimate business interests that need to be protected. It also allows for employers to continue using restrictive covenants, but makes sure that they are reasonable.

If this proposed federal statute is enacted, it will preempt current state statutes and judge made rules. The preemption doctrine comes from the Supremacy Clause of the Constitution which allows federal statutes to preempt the conflicting state authority. Thus, preemption allows this note’s proposed federal legislation to override current state policies on the enforcement of restrictive covenants for physicians practicing telehealth.

quickly, are often severe, but typically respond to treatment. Upon completing treatment, the patient usually returns to their baseline health.).

324. See supra Part IV.A.
325. See supra Part II.
326. See infra Part IV.B.
328. Id.
B. Analysis of the Proposed Federal Statute and Why it is Better than Other Propositions

This note’s proposed statute respects employer’s interest in protecting its business investments by still allowing employers to require physicians to enter into restrictive covenants. However, the statute builds in protections for physicians and patients, as it requires employers to prove that the restrictive covenant is actually doing what it was intended to do. The statute does this by narrowly tailoring the terms of restrictive covenants and prevents employers from restricting large territories and from having long restrictions. As physicians practicing telehealth practice in larger and larger territories, requiring employers to specifically outline the geographic boundaries of their patients limits employers from implementing over-broad restrictions. The buyout provision also gives physicians the ability to not be restricted at all if they so choose, and it helps financially compensate employers for some of the money they might have invested into training and developing the physician.

This proposed statute also does its best in protecting patients, especially those in the course of acute treatment. This prevents the patient-physician relationship from being interrupted suddenly and allows a physician to finish treatment. Physicians are able to fulfill their legal and ethical duties to inform patients of their departure without punishment. However, it prevents them from encouraging their patients to follow them, but if patients choose to do some on their own accord, the patient will not be prevented, nor the physician punished. Lastly, the proposed federal statutes main purpose is to create uniformity across the United States for all physicians and healthcare provides as they enter into restrictive covenants.

Other scholars have offered different solutions for regulating physician restrictive covenants. One scholar argues that states should

329. See supra Part IV.A.
330. See supra Part IV.A.
331. See supra Part IV.A.
332. See Megna, supra note 152, at 1022.
333. See supra notes 299-306 and accompanying text discussing the buyout provisions of the Texas statute.
335. See generally Clausen, supra note 129; Megna, supra note 152. Both authors have commented on the irregularities of the enforcement of physician restrictive covenants and have offered solutions.
all enact the same statute, with the main premise being that all physician restrictive covenants be presumed void and unenforceable unless the employer meets the burden of proving business interests.\textsuperscript{336} Another argued that the enforceability of physician restrictive covenants be regulated on a nationwide basis by drafting a model statute and encouraging states to adopt it on their own accords.\textsuperscript{337} Both of these proposals fail in reaching their intended purpose of creating uniformity. Allowing states the option to opt-in, and merely encourage them to adopt a model statute, will likely still lead to the same inconsistency issues that currently exist.\textsuperscript{338} Some states may adopt the model statutes, others may adopt versions of the statutes, while others may ignore them altogether.\textsuperscript{339} States may update the statutory analysis used in enforcing physician restrictive covenants, however, there is no guarantee that all states will and there will still be inconsistencies. Thus, the best way to ensure a consistent enforcement of restrictive covenants for physicians practicing telehealth is for federal action and the adoption of this note’s proposed federal statute. This is especially important as the push for federal medical licensing increases.\textsuperscript{340}

CONCLUSION

Congress should enact this note’s proposed federal statute to create uniformity in the enforcement of restrictive covenants for physicians practicing telehealth. Physician restrictive covenants are enforced in drastically different ways varying from state to state, and jurisdiction to jurisdiction.\textsuperscript{341} With some states prohibiting physician restrictive covenants in their entirety,\textsuperscript{342} others carving out exceptions,\textsuperscript{343} and others treating physician restrictive covenants no different than other industries,\textsuperscript{344} there is great discrepancy in the enforcement. These inconsistencies will become more prevalent as physicians continue to increase their usage of telehealth services, and as state licensure regulations are relaxed.\textsuperscript{345} There is forward movement towards

\textsuperscript{336} See Megna, supra note 152, at 1031-32.
\textsuperscript{337} See Clausen, supra note 129, at 149-52.
\textsuperscript{338} See supra Part III.
\textsuperscript{339} See supra Part III.
\textsuperscript{340} See supra Part I.B.2.
\textsuperscript{341} See supra Part III.
\textsuperscript{342} See supra Part III.B.
\textsuperscript{343} See supra Part III.C.
\textsuperscript{344} See supra Part III.A.
\textsuperscript{345} See supra Part II.
a uniform physician licensing scheme and an increase in interstate medical practice. The current state of enforcing physician restrictive covenants is inadequate to deal with the telehealth industry.

The unique interests in the telehealth industry (employers, physicians, patients, and public health) all have different interests that need to be balanced.

In order to balance these opposing interests and create uniformity across the country as other aspects of the medical field move into the federal statutory spotlight, Congress should pass this note’s proposed statute.

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346. See supra notes 78-81.
347. See supra Part II.A.
348. See supra Part III.
349. See supra Part III.
350. See supra Part II.C.

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