

## COMMENT

### THE DOCTOR WILL SEE YOU NOW—FROM 100 MILES AWAY: NAVIGATING PHYSICIAN NON-COMPETE AGREEMENTS IN THE AGE OF TELEMEDICINE

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Telemedicine is revolutionizing healthcare by breaking down geographical barriers and increasing access to complex care. Patients in rural populations can “see” a doctor via videoconferencing over 150 miles away eliminating costly visits to larger cities. While the success of telemedicine is evidenced by its recent growth, this expansion has brought to light a number of legal concerns.

This Comment analyzes one of those legal issues, the use of restrictive covenants in telemedicine, and considers whether they are enforceable under existing doctrine. Specifically, this Comment argues that non-compete law is inadequate to deal with the unique aspects of physicians providing telemedical services. The possibility of an expansive (or even limitless) geographic scope of employment challenges the traditional “rule of reason” test used to evaluate non-compete agreements. This is further complicated by specialization and licensure requirements for those practicing in the medical field. Perhaps most concerning is the fact that patients, particularly those in rural communities, are severely impacted by these restrictive covenants.

To address the law’s inadequacies and public policy concerns, this Comment proposes that telemedicine non-competes be presumed unenforceable, rebutted only by clear and convincing evidence that the employer’s interests greatly outweigh those of the physician and patients. To avoid judicial confusion, it is also suggested that state legislatures, guided by the American Medical Association, enact laws to address this issue.

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#### INTRODUCTION

It is a Saturday in rural northern Wisconsin and an elderly man suffering from chronic liver disease awakes with abdominal pain. He is worried that the pain may be something serious and travels to the nearest available healthcare facility. This facility provides only a rudimentary level of care due to its remote location, but the elderly man has no other option. Upon review of his history, the facility providers know that his care needs cannot be addressed at their location. In the past, this problem would require a 200-mile drive to access a subspecialist physician. However, in the age of telemedicine, within minutes the elderly man is face-to-face with a hepatologist discussing his chronic liver disease over videoconference. A three-hour trip to the doctor has turned into a thirty-minute hassle free encounter.

Recent technological advances have transformed the healthcare industry by breaking down geographical barriers and enhancing access

to complex care.<sup>1</sup> Due to these advantages, this manner of care has risen significantly in recent years.<sup>2</sup> However, there have also been growing concerns about how courts will address the complex legal issues that arise in this industry.<sup>3</sup> One such issue will be determining the enforceability of non-competes for physicians practicing telemedicine.<sup>4</sup> Non-compete agreements for physicians providing traditional, face-to-face healthcare highlight a clash of competing interests, rights, and freedoms.<sup>5</sup> Courts that enforce traditional physician non-competes have balanced these opposing claims by narrowing the definition of “reasonableness” and allowing only those non-competes that are limited in geographical and durational scope.<sup>6</sup> Analyzing telemedicine non-competes in this way may not be possible given the employer’s necessity for a broad, or perhaps limitless, geographical restriction.

This Comment argues that the existing doctrine on the enforceability of non-compete agreements is unworkable in the context of physicians practicing telemedicine. It addresses the concern that telemedicine non-competes could have considerably large geographical terms and argues that although courts have tailored the traditional reasonableness approach to find such terms enforceable for other non-compete agreements, the licensing and specialization requirements for physicians make these doctrines inapplicable. Further, telemedicine non-competes raise important public policy arguments which make it important for a court to consider the effects on patients first and foremost. The traditional non-compete doctrine often balances the public interests last in the enforcement analysis; however, the important

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1. See Kip Poe, *Telemedicine Liability: Texas and Other States Delve into the Uncertainties of Health Care Delivery via Advanced Communications Technology*, 20 REV. LITIG. 681, 683 (2001).

2. See Nate M. Lactman, *Five Telemedicine Trends Transforming Health Care in 2016*, 18 J. HEALTH CARE COMPLIANCE, Jan.–Feb. 2016, at 43, 43.

3. J. Kelly Barnes, *Telemedicine: A Conflict of Laws Problem Waiting to Happen—How Will Interstate and International Claims Be Decided?*, 28 HOUS. J. INT’L L. 491, 492 (2006).

4. KATHERINE BENESCH, UPDATE ON COVENANTS NOT TO COMPETE: WILL THEY SURVIVE IN THE HEALTHCARE INDUSTRY? 1 (2006). “As medical practices increase their geographic range by the use of telemedicine services, courts may find it increasingly difficult to justify enforcement of physician non-competes.” *Id.* at 12.

5. Kevin D. Koons, Note, *Physician Employee Non-Compete Agreements on the Examining Table: The Need to Better Protect Patients’ and the Public’s Interest in Indiana*, 6 IND. HEALTH L. REV. 253, 254 (2009).

6. See Elizabeth Wilborn Malloy, *Physician Restrictive Covenants: The Neglect of Incumbent Patient Interests*, 41 WAKE FOREST L. REV. 189, 192, 208 (2006) (stating that the “average geographic scope for restrictive covenants that are enforced is 33.9 miles”).

implications for patients demand that these interests be given more attention.

Because the existing legal framework is unworkable, this Comment proposes that telemedicine non-competes be presumed unenforceable. Not only do non-competes limit the provision of care to the underserved, they also generate a complicated dynamic of professional certification and service area limitations. It is not practical to depend on courts to manage their way around these complicated features of telemedicine under existing non-compete law. A presumption of unenforceability relieves courts of this burden and perhaps, more importantly, it addresses public policy concerns surrounding patient care. However, in an effort to acknowledge the importance of non-competes to protect legitimate business interests, this presumption should be made rebuttable. Allowing employers to rebut with clear and convincing evidence that certification, licensing, and specialization limitations do not apply to a particular employee is an important caveat in order to garner acceptance of this proposal. While many judicial opinions and statutes clearly state that non-competes are unfavorable, history has shown that these agreements are here to stay.

There are three parts to this Comment. First, an overview of telemedicine is provided in order to conceptualize this unique profession. This summary is important as telemedicine deviates much from what is considered traditional medical practice. Next, a brief background on existing non-compete doctrine is provided to offer a backdrop against which the argument of this Comment is based. This background focuses on traditional physician (in-person medical practice) non-competes to provide a point of comparison as there is little case law on the enforcement of telemedicine non-competes. Lastly, this Comment will evaluate the problems likely to arise in the analysis of a telemedicine non-compete agreement. In doing so, it will argue that existing doctrine is not equipped to deal with the unique facets of telemedicine and accordingly, these restrictive covenants should be presumed unenforceable. This Comment also suggests that state legislatures and the American Medical Association (AMA) are positioned best to set forth policy arguments for changes in this area of law.

#### I. TELEMEDICINE: SAVING MONEY AND LIVES FROM A DISTANCE

Telemedicine can be defined as “the use of electronic communication and information technologies to provide or support

clinical care at a distance.”<sup>7</sup> This type of medical practice operates in a variety of ways, ranging from a phone conversation, to videoconferencing, to performing medical procedures.<sup>8</sup> The complexity of telemedicine systems varies greatly, but one of the most sophisticated systems simulates a remote patient examination.<sup>9</sup> Interactive systems transmit two-way audio and video and can be “configured to transmit the signals for electronic diagnostic equipment such as electronic stethoscopes, otoscopes, endoscopes, microscopes, electro and echo-cardiograms and sonograms among others.”<sup>10</sup>

Telemedicine models differ in their utilization and are often situation or practice-dependent. Modern day utilization of telemedicine ranges from in-home telemedicine consults by primary care doctors, provider-to-provider “eConsults,” and inter-facility telemedicine provided by subspecialists to outlying medical centers.<sup>11</sup> While the exact practice of telemedicine varies in context, about forty-two percent of hospitals in the United States use some form of telemedicine, indicating its mainstream utilization in the country’s healthcare market.<sup>12</sup>

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7. U.S. DEP’T OF HEALTH AND HUMAN SERVS., 2001 TELEMEDICINE REPORT TO CONGRESS 13 (2001) [hereinafter 2001 TELEMEDICINE REPORT] (quoting U.S. DEP’T OF COMMERCE, 1997 TELEMEDICINE REPORT TO CONGRESS 1 (1997)) [http://armtelemed.org/resources/24-US\\_DHHS\\_TM\\_report-to-congress\\_2001.pdf](http://armtelemed.org/resources/24-US_DHHS_TM_report-to-congress_2001.pdf) [https://perma.cc/B8X3-TSKW].

8. See Barnes, *supra* note 3, at 497.

9. Daniel McCarthy, *The Virtual Health Economy: Telemedicine and the Supply of Primary Care Physicians in Rural America*, 21 AM. J.L. & MED. 111, 114 (1995).

10. *Id.*

11. See Kathryn H. Bowles et al., *Clinical Effectiveness, Access to, and Satisfaction with Care Using a Telehomecare Substitution Intervention: A Randomized Controlled Trial*, 2011 INT. J. TELEMEDICINE & APPLICATIONS 1, 1 (discussing telephone care); Ardis Davis et al., *Advancing the Primary/Specialty Care Interface Through eConsults and Enhanced Referrals*, 13 ASS’N DEP’T FAMILY MED. 387, 387–88 (2015) (discussing the use of eConsults); Jui-chien Hsieh & Meng-Wei Hsu, *A Cloud Computing Based 12-Lead ECG Telemedicine Service*, 12 BMC MED. INFORMATICS & DECISION MAKING 77 (2012) (discussing inter-facility telemedicine).

12. This percentage was derived from a sample of 2,891 hospitals surveyed. Julia Adler-Milstein et al., *Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption*, 33 HEALTH AFFAIRS 207, 210 (2014).

*A. Accessing the Inaccessible: Telemedical Advancement of Rural Healthcare*

A number of benefits flow from telemedicine including improved healthcare access, continuity of care, and decreased healthcare costs.<sup>13</sup> Perhaps most important for the purpose of this Comment, telemedicine technologies have the ability to eliminate certain problems associated with rural medicine.<sup>14</sup> Populations in rural America are sparsely distributed over large geographic areas where there is little to no public transportation.<sup>15</sup> Further, rural populations often include a large percentage of elderly individuals who are likely to have health problems.<sup>16</sup> These problems are compounded by an inadequate supply of healthcare services.<sup>17</sup> Not only are health facilities scarce, but an additional issue arises when physicians choose not to practice in these areas.<sup>18</sup> These communities are known as “Health Professional Shortage Areas” (HPSA) and are “areas with a primary care provider-to-client ratio of 1 to 3,500, or worse.”<sup>19</sup>

Telemedicine can alleviate many problems that arise with HPSAs. For example, a patient may be examined with a small camera attached to the examination instruments.<sup>20</sup> The video then gives a consulting physician, who is 150 miles away, a clear view of the patient. The result is an instantaneous consultation without the need to travel great distances.<sup>21</sup> The patient is free from experiencing any of the unique difficulties of rural medicine that discourage both the patient and the physician.<sup>22</sup>

*B. Growing Pains: Changes and Growth in the Telemedical Market*

The benefits of telemedicine are difficult to ignore and accordingly, the market has grown significantly in the last decade.<sup>23</sup> In

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13. Barnes, *supra* note 3, at 498–99.

14. See Christopher J. Caryl, *Malpractice and Other Legal Issues Preventing the Development of Telemedicine*, 12 J.L. & HEALTH 173, 177–79 (1997–98).

15. Patricia C. Kuszler, *Telemedicine and Integrated Health Care Delivery: Compounding Malpractice Liability*, 25 AM. J.L. & MED. 297, 303 (1999).

16. *Id.*

17. *Id.*

18. Caryl, *supra* note 14, at 175–76.

19. *Id.* at 175.

20. McCarthy, *supra* note 9, at 114.

21. *Id.* at 115.

22. Caryl, *supra* note 14, at 178.

23. Barnes, *supra* note 3, at 499; see also David Pratt, *Telehealth and Telemedicine in 2015*, 25 ALB. L.J. SCI. & TECH. 495, 508–12 (2015).

fact, one study found that roughly seventy-five percent of patients in the United States are willing to use telemedicine services.<sup>24</sup> Almost the same number of patients ranked access to care as more important than in-person interactions.<sup>25</sup> As patients become more and more tech-savvy, we will only see these numbers grow. The utilization of telemedicine is expected to keep growing “with revenue projected to increase from \$240 million in 2013 to \$1.9 billion in 2018.”<sup>26</sup>

With growth comes challenges. In particular, physicians practicing telemedicine have been hindered by licensing complications.<sup>27</sup> In order to practice across state lines, physicians must be licensed in those specific states.<sup>28</sup> While some states have attempted to facilitate telemedicine with special laws, others have narrowed its laws to restrict physicians engaged in this model of practice.<sup>29</sup> In addition to licensure issues, telemedicine physicians face a variety of legal implications.<sup>30</sup> Reimbursement, malpractice, and privacy concerns are all exacerbated by the use of telemedicine.<sup>31</sup> Additionally, this Comment suggests that another legal challenge exists with the enforcement of telemedicine non-competes. Before identifying these challenges in Part III, the following section provides a general framework for non-competes, particularly as they operate within the medical field.

## II. ENFORCEMENT OF PHYSICIAN NON-COMPETE AGREEMENTS

A non-compete agreement is a “promise in . . . [an] employment contract, not to engage in the same type of business for a stated time in the same market as the . . . employer.”<sup>32</sup> Although non-compete agreements have historically been viewed as “contrary to the ideals of free competition and the ability of an individual to choose his or her profession,”<sup>33</sup> these restrictive covenants are enforceable in nearly all fifty states.<sup>34</sup> To determine whether the covenant is reasonable and

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24. Hana Sahdev, *Can I Skype My Doctor? Limited Medicare Coverage Hinders Telemedicine's Potential to Improve Health Care Access*, 57 B.C. L. REV. 1813, 1814 (2016).

25. *Id.*

26. *Id.* at 1819.

27. *Id.* at 1816.

28. *Id.*

29. *Id.*

30. Caryl, *supra* note 14, at 179–92.

31. *Id.* at 179.

32. *Covenant Not to Compete*, BLACK'S LAW DICTIONARY (10th ed. 2014).

33. Malloy, *supra* note 6, at 195.

34. Forty-seven states permit the use of non-competes while only California, North Dakota, and Oklahoma restrict such agreements. *See* BECK REED RIDEN LLP,

therefore enforceable, courts will consider the following factors: (1) whether the employer has a legitimate business interest; (2) whether the restrictive covenant is reasonably designed to protect that interest; (3) whether enforcement will unduly burden the employee; and (4) whether the enforcement of the agreement will violate public policy.<sup>35</sup> While there is some variation among states, this “rule of reason” test is the “dominant judicial approach to enforceability.”<sup>36</sup> One might assume that physician non-competes should be analyzed separately from the traditional test given the uniqueness of the physician-patient relationship but that is not the reality. Physician non-competes are typically analyzed in the same manner as commercial non-competes using the rule of reason test.<sup>37</sup>

In applying the rule of reason test, courts will often analyze the factors in the order they are listed above.<sup>38</sup> First, a court identifies whether a legitimate business interest exists that is worth protecting.<sup>39</sup> Next, the court determines whether the agreement is reasonably designed to protect that interest.<sup>40</sup> Most courts focus non-compete analysis on this factor.<sup>41</sup> In effect, the last two factors have been largely ignored in non-compete doctrine. Often the hardship on the employee and the effect on the public is overlooked.<sup>42</sup> This is particularly problematic in the context of telemedicine as physicians face unique hardships based on their licensure and specialization, and because patients are greatly affected by the enforcement of non-competes.<sup>43</sup>

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EMPLOYEE NONCOMPETES: A STATE BY STATE SURVEY (2016), <http://www.beckreedriden.com/wp-content/uploads/2016/07/Noncompetes-50-State-Survey-Chart-20160731.pdf> [<https://perma.cc/KB82-ATZR>].

35. Malloy, *supra* note 6, at 192.

36. *Id.* at 198.

37. *Id.* at 192.

38. See Arthur S. Di Dio, *The Legal Implications of Noncompetition Agreements in Physician Contracts*, 20 J. LEGAL MED. 457, 458–64 (1999).

39. *Id.* at 458.

40. *Id.* at 456, 461.

41. *Id.*

42. “As long as the covenant is reasonable in its specific restraints, courts are not likely to find undue hardship on the part of the physician-employees. In addition, public policy considerations offer little protection against enforcement, only coming into play when a shortage of specialists exists in a particular market area.” *Id.* at 464.

43. See Caryl, *supra* note 14, at 179–92; see also Barnes, *supra* note 3, at 500–01.

*A. Patients, Providers, and the Public: Protected Interests in Physician Non-Competes*

The first hurdle in non-compete enforcement is to identify the employer's legitimate business interests. This determination provides the justification for non-compete use and requires a finding that the employer would be wrongfully injured if the interests were not protected by the agreement.<sup>44</sup> Traditionally, these interests include protecting the goodwill and trade secrets of an employer.<sup>45</sup> In the context of medical practice groups, courts have also recognized the need to preserve referral systems and protect physician training investments.<sup>46</sup> Patients are considered a highly valuable asset for medical employers and many jurisdictions take little issue with recognizing referral systems and patient bases as legitimate protectable interests.<sup>47</sup> Similarly, courts often enforce physician non-competes if employers have trained or taught unique skills to their employees.<sup>48</sup> For example, this may include newly graduated physicians that will be proctored in procedures by well-versed practice partners. A non-compete agreement "provides a mechanism by which employers can 'recapture their investment by temporarily restricting the employees' ability to use that training competitively after the employment relationship has been terminated."<sup>49</sup>

A court's evaluation of a physician's interest is far less thorough in comparison to the analysis of the employer's interest. It is commonly understood that every employee has an interest in her own job mobility and marketability.<sup>50</sup> This interest is not unique to the healthcare industry, as mobility and marketability are often asserted by all employees in non-compete litigation.<sup>51</sup> Courts have recognized the legitimacy of this interest based on the need for a physician to provide

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44. Richard E. Kaye, *Cause of Action to Enforce Noncompetition Covenant in Employment Contract*, 36 CAUSES OF ACTION 103, 162 (2008).

45. Alina Klimkina, Note, *Are Noncompete Contracts Between Physicians Bad Medicine? Advocating in the Affirmative by Drawing a Public Policy Parallel to the Legal Profession*, 98 KY. L.J. 131, 133 (2009–2010).

46. Hazel G. Beh & H. Ramsey Ross, *Non-Compete Clauses in Physician Employment Contracts Are Bad for Our Health*, 14 HAW. B.J. 79, 86 (2011).

47. Di Dio, *supra* note 38, at 459–60.

48. *Id.* at 460.

49. *Id.* (quoting Paula Berg, *Judicial Enforcement of Covenants Not to Compete Between Physicians: Protecting Doctors' Interests and Patients' Expense*, 45 RUTGERS L. REV. 1, 20 (1992)).

50. Michael J. Garrison & John T. Wendt, *The Evolving Law of Employee Noncompete Agreements: Recent Trends and an Alternative Policy Approach*, 45 AM. BUS. L.J. 107, 115 (2008).

51. *Id.*

for her family and to advance her career.<sup>52</sup> Practically speaking, however, acknowledging this interest has only prevented employers from requiring non-competes simply to eliminate competition per se.<sup>53</sup> Beyond this narrow restriction, courts rarely accept job mobility and marketability as sufficient justification to deny the enforcement of a non-compete agreement.<sup>54</sup> Instead, the inquiry turns on whether the agreement unduly burdens the physician.<sup>55</sup> Yet again, an employee is unlikely to succeed in arguing that an otherwise reasonable covenant is unduly burdensome.<sup>56</sup> Courts place significant emphasis on the freedom to contract in non-compete disputes and accordingly, hardship must be extraordinarily high in order to interfere with longstanding contract principles.<sup>57</sup> This is no less true of physicians, as one court has held that the “interest in medical services is subservient to the public interest in the freedom of individuals to contract . . . .”<sup>58</sup>

The third interest considered in the enforcement of non-compete agreements is the public interest.<sup>59</sup> Determining whether a non-compete is injurious to the public well-being is something taken into account by a majority of jurisdictions, regardless of the profession in question.<sup>60</sup> However, physician non-competes arguably have greater effects on the public due to the unique physician-patient relationship. By enforcing physician non-competes, patients may experience a disruption in the continuity of care, and they may also lose the ability to make their own choices as it relates to healthcare.<sup>61</sup> It is an important aspect of

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52. *See Delaval, Inc. v. Schmitt*, 944 F. Supp. 2d 883, 886 (W.D. Mich. 2014) (quoting *Whalen Sec. Co. v. Kennebrew*, 379 S.W.3d 834, 841 (Mo. 2012)).

53. *See Mattern & Ass’n, LLC v. Seidel*, 678 F. Supp. 2d 256, 267 (D. Del. 2010) (quoting *Hess v. Gebhard & Co.*, 808 A.2d 912, 918 (Pa. 2002)).

54. *Di Dio*, *supra* note 38, at 463.

55. *Id.* at 462–63.

56. *Id.* at 463.

57. *Id.* *See also Weber v. Tillman* where a court held that the rationale for enforcing a non-compete agreement was the freedom to contract. Although the court recognized that the reasonableness of the contract and the public interest were important, “the paramount public policy is that freedom to contract is not to be interfered with lightly.” 913 P.2d 84, 96 (Kan. 1996).

58. *Norlund v. Faust*, 675 N.E.2d 1142, 1153 (Ind. Ct. App. 1997).

59. *See Gateway 2000, Inc. v. Kelley*, 9 F. Supp. 2d 790, 795 (E.D. Mich. 1998) (quoting *Phone Connection, Inc. v. Harbst*, 494 N.W.2d 449 (Iowa Ct. App. 1992)).

60. *See* Cathy Packer & Johanna Cleary, *Rediscovering the Public Interest: An Analysis of the Common Law Governing Post-Employment Non-Compete Contracts for Media Employees*, 24 CARDOZO ARTS & ENT. L.J. 1073, 1108 (2007) (“In many courts’ analyses, the final piece of the reasonableness assessment when examining post-employment non-compete contracts was whether the employer’s interest was outweighed by harm to the public.”).

61. *Malloy*, *supra* note 6, at 204.

healthcare that a patient is able to choose her physician and to build a lasting relationship with that physician.<sup>62</sup> “Continuity of care has been linked to improved patient satisfaction, and patients who are more satisfied with their physician are more compliant with suggested treatment regimens.”<sup>63</sup> While some states have acknowledged the importance of continuity of care, thereby ruling physician non-competes unenforceable, most states have not found the potential harm to patients to be substantial enough to rescind the contracts.<sup>64</sup> The AMA has commented on how restrictive covenants placed on physicians negatively affect continuity of care and other various aspects of the physician-patient relationship, though these statements have not yet trickled into any telemedicine discussions.<sup>65</sup>

*B. For How Long? Where? And Doing What? Defining  
“Reasonableness” and the Extent of Non-Competes*

A physician non-compete will not be enforced if it is unreasonable as to time, geographic scope, and activity.<sup>66</sup> The reasonableness of these terms is highly fact-specific and not amenable to uniform standards.<sup>67</sup> However, there are well-established guidelines that a majority of jurisdictions use to guide their analysis.<sup>68</sup> First, the duration of a non-compete is reasonable if it is no longer than necessary for the employer to replace the former physician and “for the employer to demonstrate effectiveness to [its] customers.”<sup>69</sup> Time limitations that have been accepted for physician non-competes range from a few months to five years.<sup>70</sup>

Next, the geographic extent of a restraint must be “designed to protect the employer’s interest in customer relationships developed by a [physician] whose contact with customers occurred.”<sup>71</sup> If the geographic terms of a non-compete are broader than necessary to protect the

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62. *Id.*

63. *Id.* at 205.

64. *See id.* at 200–02.

65. *See* SUSAN DORR GOOLD, REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS 3 (2014), <https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/ceja-3a14.pdf> [<https://perma.cc/WV52-2HY3>].

66. BENESCH, *supra* note 4, at 6.

67. *Id.* at 7.

68. *See generally* Di Dio, *supra* note 38, at 461–62.

69. *Id.* at 462.

70. *See* Di Dio, *supra* note 38, at 462.

71. BENESCH, *supra* note 4, at 7.

employer, the agreement may be found invalid.<sup>72</sup> Jurisdictions disagree on the permitted distance that a physician non-compete may cover, however, the average distance deemed reasonable is 33.9 miles.<sup>73</sup>

Lastly, the scope of a physician non-compete is enforceable “only to the extent that it prevents a departing physician from practicing a specialty that directly competes with the physician’s former employer.”<sup>74</sup> If the activity restrained exceeds the practice of the former employer, the court may hold the agreement unenforceable.<sup>75</sup> In short, the activities restrained by the covenant must be proportional to the protected interest of the employer.<sup>76</sup> If the geographic scope, duration, or activity restraint are determined to be unreasonable, the court may rule the entire agreement unenforceable.<sup>77</sup>

### C. Non-Competes in Telemedicine

There is little to no case law on the use of non-competes in telemedicine specifically. This may be due to a number of reasons, including the mere fact that telemedicine has not been extensively practiced until the late 1990s, with thirty-five percent of health system executives claiming to be utilizing it by 1998.<sup>78</sup> It may also be because many physicians do not practice telemedicine full-time. Rather, physicians often engage in a hybrid practice involving both in-person and telemedicine visits.<sup>79</sup> Although this hybrid practice has been the model for many physicians to date, the expansion and growth of the telemedical market is likely to change the time commitment and division of labor in telemedicine practices.<sup>80</sup> An increased commitment to the industry may lead to greater legal challenges.<sup>81</sup>

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72. *Id.*

73. Malloy, *supra* note 6, at 204.

74. Di Dio, *supra* note 38, at 461.

75. *Id.*

76. *See Fields Found., Ltd. v. Christensen*, 309 N.W.2d, 125, 133 (Wis. App. 1981) (reasoning that a non-compete was enforceable only by prohibiting a departing physician from performing first trimester abortions rather than practice obstetrics and gynecology because his practice under the former employer was limited to performing the abortions).

77. Di Dio, *supra* note 38, at 461–62.

78. Mary Moore, *The Evolution of Telemedicine*, 15 FUTURE GENERATION COMPUTER SYS. 245, 246 (1999).

79. For example, many physicians have active office practices but find they have extra time in their schedules. Telemedicine provides them with added flexibility in creating a perfect part-time schedule. AMERICA’S HEALTHCARE TRANSFORMATION: STRATEGIES AND INNOVATIONS 170–71 (Robert A. Phillips ed., 2016).

80. *See generally* Lackman, *supra* note 2, at 43. “The quick market adoption of telemedicine is fueled by powerful economic, social, and political forces — most

Legal scholars also anticipate problems within the telemedicine industry based on the fact that the practice is opening up markets and more competition.<sup>82</sup> Increased competition will undoubtedly create a need for non-compete agreements by employers. Balancing this need with the welfare of physicians and patients will bring about a clash of competing interests.<sup>83</sup>

Lastly, healthcare attorneys consider physician shortages to be a major factor in determining the impact that non-competes have on the public interest.<sup>84</sup> If access to care is jeopardized by a non-compete, the agreement may be unreasonable. Issues surrounding access are exacerbated in the context of telemedicine in rural areas. Accordingly, it is likely that a telemedicine non-compete would be challenged in a court of law. Part III explores this legal challenge and identifies the current shortfalls of non-compete law.

### III. ANALYZING THE DIFFICULTIES OF NON-COMPETE AGREEMENTS IN TELEMEDICINE

This Part will examine how the current doctrine on the enforceability of non-compete agreements is inadequate in the context of telemedicine. First, it will argue that determining the reasonableness of a geographical limit in the field of telemedicine is nearly impossible. Next, it will argue that even if the terms of an agreement are deemed reasonable, the agreement will likely fail due to the detrimental impact on the public well-being. Lastly, this Part will suggest that state legislatures should apply a rebuttable presumption to all non-compete agreements used in telemedicine.

#### *A. Geographical Scope: Attempting to Limit the Unlimited*

The geographic restrictions included in a non-compete cannot be more broad than necessary to protect a legitimate business interest of an

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notably, the growing consumer demand for more affordable and accessible care. These forces are pushing health care providers to grow and adapt their business models to the new health care marketplace.” *Id.*

81. See generally Kimberly Lovett Rockwell, *The Promise of Telemedicine: Current Landscape and Future Directions*, 96 MICH. B.J. 38, 42 (2017). “Telemedicine laws are changing rapidly with new legislation being evaluated at the state and federal levels every year. Attorneys must stay apprised of the changing legal and regulatory landscape to advise healthcare clients who are interested in engaging in this expanding and exciting healthcare industry.” *Id.*

82. JOEY HAVENS & ROY W. BREITENBACH, AHLA-PAPERS P02050716, NON-COMPETES: ENFORCEABLE OR NOT? 10 (2007).

83. See *supra* Part II.A.

84. See *supra* Part I.A.

employer.<sup>85</sup> Although this standard appears to be relatively straightforward, its application in a technologically advanced society can get quite complicated. Advances in technology have enlarged markets and consequently, the scope of an employer's legitimate business interest has expanded.<sup>86</sup> Employers have responded to this expanded interest by drafting non-competes that do not comport with the traditional rule of reason.<sup>87</sup> Employers sidestep the "reasonable geographic scope" rule by incorporating a list of major competitors instead of an actual geographic distance, or they will disregard the rule in its entirety by leaving out a geographic provision.<sup>88</sup> Courts have altered the common law approach to analyzing geographic reasonableness in an effort to uphold these terms and to reconcile for the law's inadequacies. The rationale set forth by these decisions, however, cannot be applied in telemedicine. The analysis of telemedicine non-competes must account for the unique facets of the profession.

#### 1. THE TRADITIONAL APPROACH IN ASSESSING LARGE GEOGRAPHIC RESTRICTIONS

A geographic limit is "reasonable to the extent that it bears a relationship to the scope of the work performed by the party being restrained."<sup>89</sup> In *Fisher/Unitech, Inc. v. Computer Aided Technology*,<sup>90</sup> the court expanded upon this by stating:

[C]ourts generally look to whether the restricted area is coextensive with the area in which the employer is doing business . . . the employee should only be excluded from doing business in the territorial zone in which relationships

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85. See *supra* Part II.B.

86. See Emily J. Kuo, *The Enforceability Gap of Covenants Not to Compete in Telecommuting*, 1996 U. CHI. LEGAL F. 565, 568 (1996).

87. "Employers with nationwide or worldwide markets have protected themselves by circumventing the reasonable geographic requirement in noncompete agreements. Many courts, therefore, have modified their traditional conception of a reasonable geographic area to create a legal rule for noncompete covenants with nationwide, worldwide, or no geographic limits." *Id.* at 573-74.

88. See *infra* Part III.A.2.

89. Saleem W. Raza, *Non-Compete Agreements in the United States, Europe, and Australia*, 29 ACC DOCKET 78, 82 (2011).

90. *Fisher/Unitech, Inc. v. Computer Aided Tech., Inc.*, No. 13 C 02090, 2013 WL 1446425 (N.D. Ill. Apr. 9, 2013).

with the employer's customers could have been established in ways that could be detrimental in the hands of a competitor.<sup>91</sup>

For many employers, the "territorial zone" in question can be as large as an entire state. In particular, business that is conducted over the internet, including telemedicine, can reach customers far and wide. This creates difficulty not only with defining what a telemedical physician's geographic reach is, but also with limiting this reach in a manner that makes sense. The majority of cases support the rule that the mere fact that a non-compete extends its territorial scope over an entire state or jurisdiction does not render the agreement ipso facto unenforceable.<sup>92</sup> However, in order to justify such an expansive geographical restriction, "the reasonableness of the restrictive covenant must be considered in its entirety in the light of all the relevant circumstances of the particular case."<sup>93</sup>

The relevant circumstances involved in telemedicine will almost always be problematic due to physician licensure requirements. Traditionally, physicians are required to be licensed in the state in which they practice medicine.<sup>94</sup> This requirement is no less true for doctors practicing telemedicine.<sup>95</sup> While some state medical boards have issued special telemedicine licenses to allow for practice across state lines, the majority require that physicians engaging in telemedicine are licensed in the state in which the patient is located.<sup>96</sup> Additionally, practice regulations may also impose barriers on telemedicine physicians.<sup>97</sup> Many state medical boards require an in-person consultation before the initiation of any telemedicine services.<sup>98</sup>

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91. *Id.* at \*7 (quoting *Cambridge Eng'g, Inc. v. Mercury Partners 90 Bl, Inc.*, 879 N.E.2d 512, 523 (Ill. App. Ct. 2007)).

92. C. T. Drechsler, *Enforceability of Restrictive Covenant, Ancillary to Employment Contract, As Affected by Territorial Extent of Restriction*, 43 AM. L. REP. 94, 116 (1955).

93. *R. L. Guttridge, Inc. v. Wean*, 73 A.2d 284, 286 (N.J. Ch. 1950).

94. Barnes, *supra* note 3, at 501.

95. However, legislation known as the Telemedicine for Medicare Act has been introduced in Congress and could affect licensure requirements in telemedicine.

96. See FED'N OF STATE MED. BDS., TELEMEDICINE POLICIES (2014), [https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL\\_Telemedicine\\_Licensure.pdf](https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_Telemedicine_Licensure.pdf) [<https://perma.cc/QU3G-EM7W>]; see also Pratt, *supra* note 23, at 535. "Every state imposes a policy that makes practicing medicine across state lines difficult . . . D.C., Maryland, New York, and Virginia, are the only states that allow licensure reciprocity from bordering states. Alabama, Louisiana, Minnesota, Montana, Nevada, New Mexico, Ohio, Oregon, Tennessee, and Texas are the only states that extend a conditional or telemedicine license to out-of-state physicians." *Id.*

97. Pratt, *supra* note 23, at 534.

98. *Id.*

Since the territorial zone covered in a telemedicine non-compete could span across an entire state, licensure and other requirements may prevent a doctor from practicing medicine in her preferred location if bound by this expansive geographical restriction. This possibility is likely given that the purpose of telemedicine is to provide healthcare in remote locations. In this way, a non-compete agreement would truly limit a practice model intended to be unlimited. Although a physician could move or obtain a license to practice in another state, such a requirement would be unduly burdensome and quite expensive.<sup>99</sup> Further, some providers may have personal or professional impetus for providing care in specific geographic areas (i.e. family, friends, etc.) which also deserves consideration. Therefore, applying the traditional approach to determine the reasonableness of a large geographic restriction is inadequate to handle the complications that arise with physician licensing and practice.

## 2. DOING AWAY WITH THE MAP: SURROGATES FOR GEOGRAPHIC RESTRICTIONS

Many employers whose services span great distances have protected themselves in non-compete agreements by circumventing the reasonable geographic requirement altogether.<sup>100</sup> One might assume that the lack of geographic terms would be fatal to the enforcement of a non-compete, but in fact, a number of judicial decisions have proved otherwise.<sup>101</sup> Courts “have modified their traditional conception of a reasonable geographic area” in order to find these provisions enforceable.<sup>102</sup> An accepted modification has been a shifting of the focus from the geographical restraint to the activity restraint. For example, in *Eichmann v. National Hospital & Health Care Services, Inc.*,<sup>103</sup> the court found that a lack of geographical restriction does not automatically invalidate a post-employment restraint where the geographical prohibition is qualified by an activity restraint.<sup>104</sup> In other words, “if the scope of the prohibited competitive behavior is narrow enough . . . the covenant may be reasonable even if it has no territorial limitations . . . .”<sup>105</sup> However, the determination of “whether the

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99. Caryl, *supra* note 14, at 185.

100. Kuo, *supra* note 86, at 573.

101. See *Rollins Burdick Hunter of Wis., Inc. v. Hamilton*, 304 N.W.2d 752, 754–55 (Wis. 1981).

102. Kuo, *supra* note 86, at 574.

103. 719 N.E.2d 1141 (Ill. App. Ct. 1999).

104. *Id.* at 1147.

105. *Azzouz v. Prime Pediatrics*, 675 S.E.2d 314, 319 (Ga. Ct. App. 2009) (quoting *Chaichimansour v. Pets Are People Too, Inc.*, 485 S.E.2d 248, 250 (Ca. Ct.

prohibition of future activity is no broader than necessary” is highly dependent on the specific job the employee has held.<sup>106</sup> Restraints on specialized and highly-skilled personnel will be carefully scrutinized.<sup>107</sup> This scrutiny is necessary because they have made a considerable investment into their education and training and to force them out of their areas of expertise may severely affect them.<sup>108</sup> As such, a future restraint in this context must be confined to a particular department or activity that the former employee engaged in.<sup>109</sup>

However, this is the point where the activity restraint as a substitute for a geographical limitation is no longer feasible in the context of telemedicine. Specialization in the field of medical practice goes beyond training and education—it requires maintenance of certification in specific areas of care.<sup>110</sup> In this way, board certification circumscribes a provider’s scope of practice to the area in which they are licensed. The consequences of practicing outside this scope entail legal ramifications, insurance availability, and hospital privilege restrictions. This parameter, inherent to the medical profession, would render a restraint in a particular department or activity to be unduly burdensome as it may leave the physician unable to practice in their chosen field. The alternative for the physician is to invest significant resources to retrain and obtain certification in a new practice area. This alternative may weigh heavily against the employer’s legitimate business interest.

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App. 1997)); *see also Samuel Bingham Co. v. Maron*, 651 F. Supp. 102, 105 (N.D. Ill. 1986) (“[I]n the cases approving unlimited geographic restrictions, the covenant not to compete at issue applied only to limited activities. That is, former employees were not prohibited from working for their former employees’ competitors in any capacity; they were only prohibited from engaging in certain activities . . . .”). However, in *Estate of Schroeder v. Gateway Transp. Co.*, the Wisconsin Supreme Court reviewed an activity restraint with no geographic limitation that prohibited the former transportation company employee from working elsewhere in the transportation industry. The court found that a non-compete with no geographic limitation that bars someone from working within an entire industry is an unacceptable activity restraint. 191 N.W.2d 860, 865–66 (Wis. 1971).

106. Harlan M. Blake, *Employee Agreements Not to Compete*, 73 HARV. L. REV. 625, 675–76 (1960).

107. *Id.* at 676.

108. *Id.* “For example, it would almost never seem reasonable for a large manufacturer active in every field of industrial chemistry to attempt to restrain an industrial chemist from working for any competitor for even a relatively short period, for such a covenant would bar the chemist from virtually all activity.” *Id.*

109. *Id.* Accordingly, the problem posed with the industrial chemist is solved by “confining the restraint to future work in the particular department or special activity of the present employment.” *Id.*

110. Christine K. Cassel & David B. Reuben, *Specialization, Subspecialization, and Subsubspecialization in Internal Medicine*, 364 NEW ENG. J. MED. 1169 (2011).

The lack of a geographical restraint in a telemedicine non-compete forces courts to review the activity restraint when determining the reasonableness of the agreement. However, the specialty certification requirements imposed on physicians limit their ability to practice in other areas of medicine. The practical reality of physician certification is that a geographical limitation is necessary to determine the reasonableness of a non-compete because the activity restraint will almost always interfere with the ability to practice in the area in which they are board certified.

### 3. IT'S NOT WHERE YOU WORK, BUT WHO YOU WORK FOR: THE MAJOR COMPETITOR ANALYSIS

The standard of “reasonable geographic scope” has been transformed to include a rule of “reasonable competition.”<sup>111</sup> The reasonable competition standard allows an employer to include provisions that carve out specialty markets or list competitors explicitly.<sup>112</sup> For example, a Georgia statute expressly allows for non-compete provisions that list specific competitors of an employer for which an employee cannot work for.<sup>113</sup> In *Bed Mart v. Kelley*,<sup>114</sup> an Arizona court of appeals also permitted the “carving out” of major competitors.<sup>115</sup> In *Bed Mart*, a salesman for a mattress specialty store signed a non-compete which stated that he could not work for “any business for which the sale of mattresses accounts for more than fifty percent (50%) of sales revenue” following the termination of his employment.<sup>116</sup> While the trial court found that the geographic scope was overly broad and the carving out provision could not save it, a unanimous court of appeals overruled.<sup>117</sup> The court of appeals found that by carving out *Bed Mart*’s major competitors, it limited the reach of the non-compete and allowed Kelley to find work as a salesman for other products.<sup>118</sup> Under this rationale, “it should not matter where the

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111. Michael S. Green & Laura P. Chiasson, *Covenants Not to Compete: An Old Dog with a New Bite*, ARIZ. ATT’Y, Feb. 2003, at 18, 20.

112. *Id.*

113. GA. CODE. ANN. § 13-8-56(2)(b) (2017).

114. *Bed Mart v. Kelley*, 45 P.3d 1219 (Ariz. Ct. App. 2002).

115. Green & Chiasson, *supra* note 111, at 20.

116. *Bed Mart*, 45 P.3d at 1220. The non-compete in this case did include a 10-mile geographic restriction, but the court addressed carving out competitors when Kelley argued that the 10-mile limit essentially precluded him from selling mattresses in the entire Phoenix metropolitan area. *Id.* at 1222.

117. *Id.* at 1222–23.

118. The court found that Kelley was “not precluded from obtaining employment in his specific area of sales expertise . . . .” *Id.* at 1223.

‘prohibited’ employers are located as long as there is a sufficient number of ‘permissible’ employers within the employee’s desired working area.”<sup>119</sup>

The permissible employer standard is difficult to apply in the context of telemedicine. Often telemedicine providers are subspecialist physicians that practice their profession primarily to increase specialty healthcare access to underserved areas.<sup>120</sup> Subspecialties that have embraced rural outreach care include psychiatrists, radiologists, and pulmonologists.<sup>121</sup> As an example, a special health needs pediatrician may have molded her professional niche to include telemedicine care involving management of children with complex care needs.<sup>122</sup> If a non-compete agreement were to limit her employment mobility by including a major competitor restriction, there may be an issue regarding the availability of positions that offer a similar scope of subspecialty practice. In other words, not all telemedicine firms or healthcare systems would have a need to employ more than a certain number of subspecialty complex care pediatricians. In this way, the number of permissible employers would be restricted based on the often subspecialized nature of telemedical practice.

The caveat to this dynamic is that many physicians practicing telemedicine are general practitioners and primary care providers. These physicians would be less impeded by a non-compete that restricts work at major competitors, as many employers utilizing telemedicine would have the need for a generalist physician.

### *B. If I Hurt, You Hurt: Limiting Telemedicine Care and Injury to the Public*

Even if a telemedicine non-compete was held valid as to the geographical limits, it should fail as a matter of public policy. “Even

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119. Green & Chiasson, *supra* note 111, at 21.

120. See Curtis L. Lowery et al., *Distributing Medical Expertise: The Evolution and Impact of Telemedicine in Arkansas*, 33 HEALTH AFF. 235, 235 (2014); James P. Marcin et al., *Addressing Health Disparities in Rural Communities Using Telehealth*, 79 PEDIATRIC RES. 169–76 (2016).

121. See Donald M. Hilty et al., *Evolution of Telepsychiatry to Rural Sites: Changes over Time in Types of Referral and in Primary Care Providers’ Knowledge, Skills, and Satisfaction*, 28 GEN. HOSP. PSYCHIATRY 367, 368 (2006); Tim B. Hunter & Elizabeth A. Krupinski, *University-Based Teleradiology in the United States*, 2 HEALTHCARE 192, 198 (2014); Tasleem Raza et al., *Pulmonary Telemedicine—A Model to Access the Subspecialist Services in Underserved Rural Areas*, 78 INT. J. MED. INFORMATICS 53, 54 (2009).

122. James P. Marcin et al., *Using Telemedicine to Provide Pediatric Specialty Care to Children with Special Health Care Needs in an Underserved Rural Community*, 113 PEDIATRICS 1, 1 (2004).

though a contract be fair and reasonable between the parties, yet, if the effect of it is so injurious to the public interest that the public policy requires that it shall not be enforced, it will be held void.”<sup>123</sup> In *May v. Young*,<sup>124</sup> the court stated, “[o]f the principal considerations affecting the validity of restrictive contracts on grounds of public policy, one is injury to the public by being deprived of the restricted party’s industry or services . . . .”<sup>125</sup> One industry in which non-competes have received greater scrutiny is the healthcare industry. Courts have found that the public has a right to choose a physician and the right to continue care with that particular physician.<sup>126</sup> It is obvious that these findings would apply to physicians practicing in telemedicine, but even more, the ability for telemedicine to provide care to the underserved heightens the public interest scrutiny further.

#### 1. FIRST, DO NO HARM: NEGATIVE EFFECTS OF PHYSICIAN NON-COMPETES ON PATIENT CARE AND THE PUBLIC INTEREST

In recent years, we have seen a flood of public policy arguments against the enforceability of physician non-competes. Opposition to these agreements largely centers around the belief that a patient has a right to choose their physician in order to ensure continuity of care. For many patients, it is more important that they are able to choose their physician than it is for them to select their health insurance plan.<sup>127</sup> By choosing their own doctor, patients often have greater satisfaction with their medical care.<sup>128</sup> It is important that this interest be protected

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123. *Smithereen Co. v. Renfro*, 59 N.E.2d 545, 548 (Ill. App. Ct. 1945).

124. 2 A.2d 385 (Conn. 1938).

125. *May*, 2 A.2d at 387.

126. See Clark Spoden, *The Public Interest Nullifies Another Health Care Non-Competition Agreement*, TENN. B.J., July 2010, at 18, 20 (2010) (discussing a Tennessee Supreme Court decision in which the court “cited the public’s right to freedom of choice in physicians, [and] the right of patients to continue an on-going relationship with a physician . . . .”).

127. See Koons, *supra* note 5, at 277. This also applies to subspecialist physicians, not just primary care physicians. See Marcin, *supra* note 122, at 1. “Pediatric subspecialty telemedicine consultations can be provided to CSHCN [Children with Special Health Care Needs] living in a rural, medically underserved community with high satisfaction among local providers and parents/guardians. Telemedicine should be considered as a means of facilitating care to CSHCH that, relative to the customary delivery of health care, is more accessible, family-centered, and coordinated among patients and their health care providers.” *Id.*

128. Koons, *supra* note 5, at 277. In addition, the freedom of choice can also mean that “patients . . . are willing to pay more out of their own pockets for health insurance if doing so means they can have an unrestricted choice of physicians.” *Id.*

because patients have a large stake in the relationship.<sup>129</sup> Even more concerning, patients have much at stake and yet no bargaining power in a physician's employment agreement.<sup>130</sup>

Many states have protected patients' interest in continuity of care by ruling physician non-competes unenforceable. For example, Rhode Island recently passed a law which renders void and unenforceable "any restriction of the right . . . to practice medicine."<sup>131</sup> To date, five states have limited the use of physician non-competes either by judicial decisions or through legislation.<sup>132</sup> It is likely that there may be an increase in state legislation on physician non-competes based on a recent report issued by the United States Department of Treasury.<sup>133</sup> The report presented economic effects of non-compete agreements as well as policy implications.<sup>134</sup> In response to the report, the White House issued a brief entitled *Non-Compete Agreements: Analysis of the Usage, Potential Issues, and State Responses* and specifically expressed concern for physician non-competes.<sup>135</sup> The report encourages states to adopt best practices in non-compete enforcement and to limit the use of these agreements in occupations that promote public health and safety.<sup>136</sup> Historically, courts have only rarely considered the public interest when ruling on the enforceability of a non-compete.<sup>137</sup> However, this report suggests that greater emphasis must be placed on

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129. *Id.* Many patients are "more intimately affected in matters of life and death by the non-compete agreements than either the physician-employee or the employer . . ." *Id.*

130. *Id.*

131. 5 R.I. GEN. LAWS § 5-37-33 (2017).

132. See WHITE HOUSE REPORT, NON-COMPETE AGREEMENTS: ANALYSIS OF THE USAGE, POTENTIAL ISSUES, AND STATE RESPONSES 15 (2016) [hereinafter WHITE HOUSE REPORT], [https://obamawhitehouse.archives.gov/sites/default/files/non-competes\\_report\\_final2.pdf](https://obamawhitehouse.archives.gov/sites/default/files/non-competes_report_final2.pdf) [<https://perma.cc/5JUK-L2S8>] ("Several states will not enforce non-competes where a 'public interest' exists in the consumption of critical goods and services. Depending on the state, courts have recognized the importance of preserving the physician-patient relationship and have exempted them from being bound by a non-compete agreement (Delaware, Illinois, Tennessee, Texas, and Massachusetts).").

133. See U.S. DEP'T OF TREASURY, OFFICE OF ECON. POLICY, NON-COMPETE CONTRACTS: ECONOMIC EFFECTS AND POLICY IMPLICATIONS 16-17, 24-25 (2016) [hereinafter U.S. DEP'T. OF TREASURY. REPORT], <https://www.treasury.gov/resource-center/economic-policy/Documents/UST%20Non-competes%20Report.pdf> [<https://perma.cc/JN23-L3JN>].

134. See *id.*

135. "In the case of consumer choice for health care services (i.e. physicians, nurses, psychologists, social workers, and other medical professionals), non-competes have the potential to interfere with the quality of care." WHITE HOUSE REPORT, *supra* note 132, at 14.

136. *Id.* at 14-16.

137. Packer & Cleary, *supra* note 60, at 1108-10.

public policy arguments in the context of healthcare.<sup>138</sup> Because telemedicine offers access to healthcare in a fashion that traditional medicine cannot, public policy arguments are even more persuasive and powerful. So powerful, in fact, that the analysis may shift away from the reasonableness of terms and will largely focus on the effect on patients.

One can understand that by and large, telemedicine is an altruistic endeavor blended with practicality and convenience. There is inherent weakness to an argument for inserting boundaries between patients and providers when the model of telemedicine was designed to lift those boundaries.

## 2. UNIQUE PUBLIC POLICY ARGUMENTS OF TELEMEDICINE: CURTAILING OUTREACH AND LIMITING ACCESS

The benefits of telemedicine are quite remarkable. Benefits range from reduced healthcare costs to the prevention of communicable diseases. However, it is increased access to care in underserved areas that is arguably the greatest benefit of telemedicine. Residents of rural areas can receive care through remote consultations with their physicians by utilizing videoconferencing equipment.<sup>139</sup> For many rural residents, telemedicine is the only alternative to receiving insufficient care or no care at all.<sup>140</sup>

The restriction of a patient's access to healthcare through the enforcement of a non-compete has been noted in another White House brief titled *Non-Compete Reform: A Policymaker's Guide to State Policies*.<sup>141</sup> The *Policymaker's Guide* concluded that the case for reform in the healthcare industry has a strong policy basis because "enforcing non-compete clauses could further limit patients' access to medical providers in areas where only very few are available."<sup>142</sup> Patients utilizing telemedicine services could be the most adversely affected by the enforcement of a physician non-compete because they may have no other alternatives in their healthcare provision. A court would take

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138. WHITE HOUSE REPORT, *supra* note 132, at 14–16.

139. See Bradley J. Kaspar, *Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 841 (2014).

140. *Id.* at 858.

141. WHITE HOUSE BRIEF, NON-COMPETE REFORM: A POLICYMAKER'S GUIDE TO STATE POLICIES 1, 7 (2016) [hereinafter POLICYMAKER'S GUIDE], [https://obamawhitehouse.archives.gov/sites/default/files/competition/state-by-statenoncompetesexplainer\\_unembargoedfinal.pdf](https://obamawhitehouse.archives.gov/sites/default/files/competition/state-by-statenoncompetesexplainer_unembargoedfinal.pdf) [https://perma.cc/XT3Y-6TST].

142. *Id.* at 7.

issue with this burden and may give it significant consideration when determining the enforceability of a non-compete.

*C. Where Do We Go from Here? The Solution of a Rebuttable Presumption*

While many court opinions declare non-compete agreements highly unfavorable, the reality is that they are generally enforced throughout the country.<sup>143</sup> Despite the policy concerns regarding healthcare, this is even true for physician non-competes. Concern for continuity of care and access to healthcare do not completely overcome the legitimate business interests of healthcare providers. These interests include protecting confidential business information (patient lists), referral bases, and the investment of training a physician.<sup>144</sup> It may become even more important to protect these interests when employing physicians who practice telemedicine as the patient lists become longer and the scope of training expands dramatically.

Although the use of non-competes may be justified by employers offering telemedicine services, the current doctrine used to analyze these agreements is ill-equipped to deal with the unique facets of the industry. Assumptions underlying existing models of the enforceability of non-competes are complicated by large geographic territories, medical licensure, and specialization requirements.<sup>145</sup> Even more, the public policy arguments against telemedicine non-competes are highly persuasive and will have a significant effect on the enforceability of these agreements. Because of these realities, non-competes in the context of physicians practicing telemedicine should be presumed unenforceable, saved only by clear and convincing evidence that the employee's ability to practice telemedicine is not unduly burdened and that patients are not negatively impacted. This standard does not radically change existing doctrine, but rather places a higher burden on the employer to prove that its interests supersede those of the employee and public. Demanding a higher burden is consistent with the traditional common law approach to non-competes in which courts were highly protective of an employee's interest in mobility and society's interest in free competition.<sup>146</sup> Further, this method of analysis is

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143. See generally Spoden, *supra* note 126, at 18 ("While most Tennessee court opinions say that covenants not to compete are disfavored in Tennessee and are construed strictly in favor of the employee, the reality is that generally speaking noncompete covenants will be enforced . . .").

144. Di Dio, *supra* note 38, at 458.

145. See Kuo, *supra* note 86, at 588; see generally *supra* Part II.

146. Garrison & Wendt, *supra* note 50, at 122.

consistent with more modern cases in which courts employ a balancing test in non-compete analysis.<sup>147</sup> However, many courts that employ this balancing test do so in a way “that is more deferential to employers despite their stated adherence to the common law.”<sup>148</sup> The modern approach to non-compete enforceability, therefore, accepts a wide range of “legitimate business interests” held by the employer but rarely acknowledges the impact on the employee and public.<sup>149</sup>

This Comment suggests that by requiring clear and convincing evidence by the employer, a court will be forced to retreat to traditional common law principles and place the employee and public first. As argued above, this is particularly important in the context of telemedicine where the stakes are high for the public and a physician who may be severely limited by a non-compete. It is important to note that determining the reasonableness of the agreement is not obsolete in this approach. Rather, evaluating the terms of the agreement has relevance, but only after the court engages in a balancing test. If the employer can prove under the higher burden that its interest outweighs that of the particular physician and patient community, then the court should determine whether the geographical, durational, and activity restraints are valid.

Allowing an employer to rebut the presumption of unenforceability is necessary, as there may be instances in which the employer’s interests truly do supersede those of the physician and patient. This Comment acknowledges that telemedicine takes many forms and seeks to achieve many purposes. It is not always the case that a non-compete agreement would prevent a physician from providing services to a patient in a rural area with limited access to healthcare. Nor is it always the case that a physician practicing telemedicine works in a specialized capacity, therefore limiting his ability to work for other “carved out”

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147. See *Borg-Warner Protective Servs., Corp. v. Guardsmark Inc.*, 946 F. Supp. 495, 501 (E.D. Ky. 1996).

148. Garrison & Wendt, *supra* note 50, at 123.

149. The current common-law standard of reasonableness for reviewing a physician non-compete is a “tolerant one.” Courts are likely to find a legitimate protectable interest and they then move on to the reasonableness of the terms. As long as the terms are reasonable:

[C]ourts are not likely to find undue hardship on the part of the physician-employees. In addition, public policy considerations offer little protection against enforcement, only coming into play when a shortage of specialists exists in a particular market area. The common-law approach has been criticized because it inadequately protects against employee and public interests. Inadequate protection results from courts enforcing the reasonable terms of the agreement rather than invalidating the covenant, and failing to adequately consider employee hardship and the public interest.

Di Dio, *supra* note 38, at 464.

competitors.<sup>150</sup> Acknowledging differences that can arise in the employment of a physician engaged in telemedicine requires that the presumption be rebuttable. An outright ban on telemedicine non-competes would not account for the important differences that encompass this practice. Further, a rebuttal to the presumption of unenforceability is not inconsistent with the concerns raised in Part III.A. If an employer is able to demonstrate that there is no significant burden on the employee's interests, then it can be assumed that reasonable terms may exist. For example, if a physician has multiple state licenses to practice medicine, an employer would argue that the physician's interest in practicing telemedicine is not burdened by a state-wide non-compete restriction. A court's inquiry would then turn on the reasonableness of the specific geographical restriction in the non-compete agreement.

Taking the analysis above into consideration, an example statute on telemedicine non-competes may be as follows:

**State Stat. § 12-34-56 Physician Restrictive Covenants Generally; Presumptions**

In determining the validity of a physician restrictive covenant that restricts competition after a term of employment, the court shall make the following presumption:

(1) Any contract or agreement that restricts the right of a physician to practice telemedicine shall be void and unenforceable with respect to said restriction subject only to exemptions listed herein under subsection (a).

(a) Notwithstanding section (1), the prohibition on telemedicine non-competes shall not apply if the employer can demonstrate clear and convincing evidence that its interest supersedes that of the employee and public interests. Review of this burden shall be conducted in accordance with section (2).

(2) Review of physician non-competes shall include a balancing-of-interests test in which the court weighs the interests of the employee, public, and employer. If the employer's interests supersede that of the employee and public, the specific terms of the agreement shall be reviewed as set forth in section (3).

(3) Restrictions shall be deemed unenforceable if the following terms are found unreasonable:

(a) The geographic terms of the restrictive covenant shall not be greater than necessary to protect the employer's interest in customer relationships developed by a physician's contact with customers. In a traditional physician non-compete, this shall include no greater than twenty-five miles. Telemedicine non-competes may allow greater restraints.

(b) The durational terms of the restrictive covenant shall not be longer than one year.

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150. See *supra* Part III.A.3.

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(c) The scope of activity restraint in a restrictive covenant shall not exceed the practice of the former employer.

*D. Striking the Balance: Rectifying Roles for State Legislatures and the American Medical Association*

State legislatures, rather than courts, should enact statutes to address the concerns raised with telemedicine non-competes. Existing frameworks for the evaluation of non-competes have been developed primarily by courts, and the result is a current state of law that reflects conflicting standards and an inconsistent patchwork of divergent judicial approaches.<sup>151</sup> By enacting legislation that provides clear and coherent standards, courts may be able to avoid the nearly impossible task of identifying the reasonableness of a telemedicine non-compete agreement. Judicial decisions will be reached with appropriate consideration and weight given to the unique interests of physicians practicing telemedicine and patients receiving their services. Further, legislative action will clarify the state's public policy position towards non-competes in this particular industry.<sup>152</sup> Perhaps most importantly, a statute requiring that the hardship faced by the physician and patient be analyzed with greater scrutiny would force courts to comport with the traditional view that non-competes are against public policy except in rare occasions.<sup>153</sup>

From a policy perspective, the AMA should also take action to address concerns of patient care in the telemedicine context. Through its Council on Ethical & Judicial Affairs, the AMA is able to comment on current policy and practice philosophies that affect the fair, reasonable, and humanistic provision of healthcare. This division of medicine's largest governing body is uniquely placed to influence both legislation and health insurance doctrine. In fact, the AMA's original goals outlined during its foundation in 1847 included improving the public health and maintaining ethical provisions of care, both of which could be threatened by over-restrictive covenants on telemedicine efforts.<sup>154</sup>

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151. See Jon P. McClanahan & Kimberly M. Burke, *Sharpening the Blunt Blue Pencil: Renewing the Reasons for Covenants Not to Compete in North Carolina*, 90 N.C. L. REV. 1931, 1931 (2012); see also Viva R. Moffat, *Making Non-Competes Unenforceable*, 54 ARIZ. L. REV. 939, 939 (2012).

152. McClanahan & Burke, *supra* note 151, at 1976–77.

153. See *id.* at 1977 (explaining that statutes can affirm common law rules and how non-competes should be evaluated and enforced).

154. See *AMA History*, AM. MED. ASS'N, <https://www.ama-assn.org/ama-history> [<https://perma.cc/7A97-G3SL>].

Currently, the AMA's code of ethics strongly discourages physician non-compete agreements based on the fact that they disrupt continuity of care and may deprive the public of medical care.<sup>155</sup> However, the AMA only states that restrictive covenants which are excessive in scope, duration, or fail to make reasonable accommodation of patients' choice are outright unethical.<sup>156</sup> This policy stance only repeats existing non-compete doctrine and does not adequately address the issues that arise in telemedicine non-competes. The AMA code of ethics should incorporate language that speaks to the technological changes taking place in the industry. Thus far, the only reports generated by the AMA regarding telemedicine have centered on fiduciary obligations, protected health information access, responsible disclosure of conflicts of interest, and technology utilization.<sup>157</sup> While unrelated to non-compete agreements, these early AMA doctrines can easily serve as a catalyst for further discussion on telemedicine non-compete agreements.

In its role as the primary educational and governing power behind the medical profession, the AMA is perfectly situated to act as a translator of sorts between telemedicine providers and state legislatures. The appropriate drafting and application of non-compete agreements will depend on a fair balancing of the interests in concert with a nuanced understanding of how telemedicine has changed the healthcare employment landscape. Further, the AMA would also be in a position to provide parameters to state legislatures that would be applicable on a state-by-state basis, as they are well versed in the differences between medical practice across the country. Finally, in its continued mission of the betterment of public health, the AMA would also have a stake in increasing the weight of the injury to public wellbeing in non-compete analysis.

#### CONCLUSION

The current state of non-compete law is inadequate to deal with agreements made in the telemedicine industry. Existing doctrine focuses on the reasonableness of terms, particularly the durational, geographical, and activity restraint terms. Such terms may be irrelevant in the context of telemedicine due to the fact that no geographical limitation exists. Although some jurisdictions have altered the common

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155. Koons, *supra* note 5, at 272.

156. *Id.*

157. RONALD A. CLEARFIELD, OPINIONS OF THE COUNCIL OF ETHICAL AND JUDICIAL AFFAIRS 85–87 (2016) <https://www.ama-assn.org/sites/default/files/media-browser/i16-ceja-reports.pdf> [<https://perma.cc/F5D7-YXQR>].

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law approach to deal with non-competes that lack specific geographical terms, doing so is not possible in the medical industry. Physicians are limited by licensure requirements and specialization in their practice of medicine. By focusing on the reasonableness of these specific terms, judicial decisions may overlook these particular facets of medicine that place greater burdens on the physician.

Similarly, if a court gives its attention only to the reasonableness of the terms, the effect on patients receiving telemedical care is largely overlooked. We have seen growing opposition to traditional physician non-competes as they limit a patient's ability to choose their physician and ensure continuity of care.<sup>158</sup> State courts and legislatures alike have recognized this opposition and many have chosen to hold physician non-compete agreements unenforceable.<sup>159</sup> While telemedicine non-competes raise the same concerns as traditional physician restrictive covenants, there are other important effects on the patient population implicated specifically in the telemedicine industry. Many patients receiving telemedical care do so because they are residents of rural communities. Receiving care via videoconferencing equipment may be the only option available to someone living in a remote area. Acknowledging situations such as these are important to truly understand the impact of enforcing a telemedicine non-compete. Looking to the reasonableness of the specific agreement terms does not truly capture these important public policy implications.

Because telemedicine non-competes do not comport with existing common law standards and because patients may be negatively impacted by such agreements, these restrictive covenants must be presumed unenforceable. Establishing unenforceability will prevent courts from making decisions that they are not well-equipped to make. However, there may exist scenarios in which courts can manage a proper analysis of this type of restrictive covenant and accordingly, the presumption of unenforceability should be rebuttable. In such cases, the analysis of telemedicine non-competes must begin with a balancing-of-interests test. Courts should not immediately jump to a review of the reasonableness of terms. In effect, courts should keep these two inquiries separate and should not be tempted to combine them as one.

Ultimately, state legislatures should be responsible for declaring the policy of telemedicine non-competes and adopting a statutory response. Current non-compete doctrine includes conflicting standards and the development of telemedicine is only going to exacerbate confusion if it is not dealt with directly. Telemedicine is now a key component in the healthcare industry as it generates additional revenue,

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158. WHITE HOUSE REPORT, *supra* note 132, at 14–16.

159. *See supra* Part II.A.

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cuts costs, and enhances patient satisfaction.<sup>160</sup> In fact, it is expected that the global market will “expand at a compound annual rate of 14.3 percent through 2020.”<sup>161</sup> This growing industry cannot be ignored and the legal challenges that come with it must be addressed head on, including the implications of telemedicine non-competes. State legislatures and any other stakeholders, such as the AMA, should provide coherent standards and expectations as they relate to this area of law. Doing so will not only alleviate judicial confusion, but will give acknowledgment to the importance of this unique and growing industry.

This Comment contemplates each side of the argument surrounding telemedicine non-competes and proposes a solution that allows all stakeholders to have a say. The unique and substantial benefits of telemedicine are far too significant to allow impediments by non-compete agreements. However, it is also recognized that medical providers may in fact have a legitimate business interest that supersedes that of the physician and patient community at stake. In those situations, courts will be well-equipped under this proposed solution to handle the legal dispute. Courts may look to enacted statutes and AMA policies to guide them as they employ a balancing test that properly considers the effect of the non-compete on all parties.

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160. Lactman, *supra* note 2, at 43.

161. *Id.*