Restrictive Covenants vs. the Right to Practise: What the Court of Appeal of Quebec's Rulings Mean for Health Care Professionals

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Restrictive covenants are frequently included in contracts that govern business practices and relationships. They are intended to protect the legitimate interests of the parties, such as goodwill, confidential information, team stability and—more broadly—the value of a business.

That said, more often than not, restrictive covenants that apply to health care professionals need to be modified. A so-called "professional-patient" relationship differs from an ordinary business relationship, as a clientele consisting of patients has its own distinct characteristics. Indeed, the Court of Appeal of Quebec has repeatedly reiterated that restrictive covenants—namely non-compete and/or non-solicitation clauses—cannot, directly or indirectly, compromise the continuity of care or restrict a patient's free choice. Therefore, the analysis must extend beyond financial protection alone to include public order considerations relating to access to care and continuity of care.

The challenge thus lies in drafting clauses that are both useful and enforceable. This requires a focus on what actually needs to be protected, while avoiding restrictions that would dissuade a health care professional from continuing treatment or prevent patients from receiving care from their physician of choice.

The most common restrictive covenants

The purpose of a non-compete clause is to prevent individuals from engaging in competing activities after a contractual relationship has ended. With regard to employment, article 2089 of the *Civil Code of Québec*[1] requires that the clause be limited as to time, place and type of employment, to what is

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necessary for the protection of the legitimate interests of the party in whose favour the “protection” is established.[2]

A non-solicitation clause does not necessarily target the practice of the profession as such, but rather actions intended to actively attract individuals or entities associated with the business, including patients, referrals or employees. Although it is often presented as less intrusive, it can nonetheless have effects comparable to those of a non-compete clause if it is worded so broadly that it effectively prevents a professional from seeing patients who wish to be under their care.

Unique characteristics of the health care sector: patients, continuity of care and public order

One particular restriction applies in the health care sector: a non-compete clause must neither treat patients as a commercial asset nor place the professional in a position of having to choose between: (i) complying with the clause; or (ii) ensuring the continuity of care required by a patient’s medical condition. Patients are not parties to the contract between the employer, the clinic or the purchaser and the health care professional, and are not considered objects in commerce.[3] It is therefore risky to attempt to govern their conduct by way of a contract, as if they were parties to the agreement.[4]

It should be noted that this premise is considered when covenants are assessed.[5] The law and various codes of ethics generally require professionals, in particular, not to “abandon” a patient, to ensure a secure transfer of records, and to uphold—within the limits of the regulatory framework—the patient’s freedom to choose their service provider.[6] The contract, therefore, cannot be drafted as though the protection of goodwill alone justified restrictions that compromise continuity of care.

Jurisprudential insights from the Court of Appeal of Quebec

Where a health care professional practises at a clinic, a non-compete clause between the clinic and the professional must not prevent a patient from continuing to receive care from the professional of their choice should the patient-professional relationship be terminated. A clause that violates this rule is especially vulnerable to being deemed invalid if it directly or indirectly prohibits practitioners from treating or taking on patients connected to a clinic—particularly where it makes no exceptions for emergency care or the continuation of treatment.[7] Thus, a clause that prohibits treating former patients of a clinic or accepting patients “originating” from it, with no exceptions—particularly regarding ongoing care—may exceed what is required to protect goodwill and may conflict with the continuity of care. Similarly, a non-solicitation clause that treats the mere act of responding to a patient’s request as solicitation may, in practice, turn a prohibition on solicitation into a prohibition on providing treatment,[8] which should be avoided.

The issue does not lie solely in explicit prohibitions. It can also stem from a mechanism designed to deter professionals from accepting patients in order to avoid penalties. In this regard, a penalty clause triggered by the act of treating a patient may exert economic pressure that could affect the patient’s choice and the continuity of care, even if the provision does not expressly refer to the discontinuation of care.[9]

Professional context vs. commercial context

From a structuring perspective, one often useful approach is to draw a clear distinction between clinical practice and commercial involvement.[10] A prohibition against providing clinical care is the measure that most directly affects the continuity of care, as it prevents the professional from providing care precisely when a patient wishes to continue treatment.[11] The stronger the pre-existing therapeutic relationship and the longer the course of treatment, the greater the risk of hindering the patient’s freedom of choice and the continuity of care.[12] In other words, discontinuing treatment is generally more problematic in long-term care (e.g., orthodontics, psychiatry) than in

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one-off procedures (e.g., dental cleanings). Where restrictive covenants result in the disruption of the continuity of care, their consequences are too serious to be left to the vagaries of the market.[13]

Conversely, certain restrictions relating to the leadership, management, operation or control of a competing business may sometimes be more justifiable where they protect a specific legitimate interest without actually preventing the continuity of care. While this approach does not ensure a clause's validity, it does reduce the likelihood that the clause will be deemed invalid, provided that the clause is carefully worded in terms of time limit, scope and definition of protected activities, and that it accurately reflects what is actually observed in clinical practice.

Five recurring issues with drafting

Territory

The issue of territory continues to come up frequently as a point of contention. In health care, territory must be defined based on the actual service area and the legitimate interest to be protected, while considering the impact on access to care.[14] A territory that is too big could mean less services,[15] particularly in specialized fields, whereas a territory that is too small could render the clause commercially ineffective.[16] It is also important to note that territorial scope must be assessed on a case-by-case basis. A standard clause provided by a recognized association may even be deemed ineffective if it does not reflect the legitimate interests of the business in question.[17] That said, even in the absence of an established territory, a restrictive clause may be valid, provided that the target clientele is clearly defined.[18]

Time limit

The time limit must be clearly established and reasonable. A clause with no time limit—or one with an ambiguous start date—is particularly problematic.[19] Even where the time limit has been clearly established, it must be based on a defensible business rationale and must not exceed what is necessary, especially where the restriction affects clinical practice rather than specific conduct.

Activities

The definition of prohibited activities is often crucial. Broadly worded provisions—such as a general prohibition against providing "similar" services—become difficult to enforce without conflicting with clinical requirements.[20] In practice, it is generally more prudent to focus on identifiable and verifiable conduct rather than prohibiting a physician from treating a patient who wishes to be under their care. Where treatment is ongoing, it may be necessary to include an explicit provision regarding continuity of care to reduce the likelihood that the clause will be deemed invalid.[21]

Non-solicitation clause

A non-solicitation clause requires a particularly careful definition of the concept of "solicitation". A non-solicitation clause that would prevent a professional from earning a living would likely be deemed invalid and unreasonable.[22] The recurring point of contention remains the distinction between actively and specifically trying to attract patients, and responding to a patient's request to seek care from a particular professional. The degree of precision in targeting the clientele is also

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very important.

Penalty clause

The penalty clause must be handled with caution. In a health care context, the amount of a penalty or the form it will take can dissuade professionals from continuing treatment. Imposing a penalty simply for providing treatment—regardless of whether active solicitation or unfair conduct[23] occurred—could be perceived as indirect coercion that infringes the patient's freedom of choice.[24] The penalty is more likely to fulfill its purpose when it targets specific and quantifiable acts, while remaining proportionate to the anticipated commercial prejudice.

It is also important to note that if any one of these analytical criteria is deemed unreasonable, that alone may be sufficient to render the restrictive covenant invalid in its entirety.[25]

Conclusion

The rulings of the Court of Appeal of Quebec[26] underscore a crucial point, namely that the protection of goodwill or an investment, however legitimate it may be, cannot result in a restriction on a patient's freedom of choice or in an infringement—indirect or otherwise—on the continuity of care. When drafting clauses, the soundest approach is generally to target conduct that is genuinely problematic from a business perspective—such as active solicitation, the use of confidential information and unfair competition—rather than imposing a general prohibition against treating patients.

Where more significant restrictions are being contemplated, distinguishing between clinical practice and commercial involvement may help reduce the likelihood that the clause will be found invalid, provided that it remains reasonable as to duration, territory and scope of activities, and that it is consistent with the clinical imperatives established by case law.

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1. CCQ-1991.
2. *Payette* c. *Guay inc.*, 2013 CSC 45, para. 61.
3. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 46.
4. *Mirarchi* c. *Lussier*, para. 43.
5. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 27.
6. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 29-35.
7. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 50-53.
8. *Pitl* c. *Grégoire*, 2018 QCCA 1879.
9. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 52.
10. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 35.
11. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 29.
12. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 49.
13. *Mirarchi* c. *Lussier*, 2007 QCCA 284, para. 51.
14. *Gestion Philippe Girard inc.* c. *Clinique de réhabilitation prosthodontique de Québec inc.*, 2022 QCCA 1146, para. 103.
15. *Gestion Philippe Girard inc.* c. *Clinique de réhabilitation prosthodontique de Québec inc.*, 2022 QCCA 1146, para. 104.
16. *Pitl* c. *Grégoire*, 2018 QCCA 1879, para. 60.
17. *Pitl* c. *Grégoire*, 2018 QCCA 1879, para. 64-69.
18. *Services financiers Bertrand Lapointe inc.* c. *Groupes financiers Claude Grefford inc.*, 2026 QCCA 98, para. 9.; *Payette* c. *Guay inc.*, 2013 CSC 45.
19. *Pitl* c. *Grégoire*, 2018 QCCA 1879, para. 79.
20. *Gestion Philippe Girard inc.* c. *Clinique de réhabilitation prosthodontique de Québec inc.*, 2022 QCCA 1146, para.

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102 and 104.

21. *Théberge* c. *Lévesque*, 2007 QCCA 898, para. 52.
22. *Pitl* c. *Grégoire*, 2018 QCCA 1879, para. 43.
23. *Théberge* c. *Lévesque*, 2007 QCCA 898, para. 59.
24. *Théberge* c. *Lévesque*, 2007 QCCA 898, para. 54.
25. *Pitl* c. *Grégoire*, 2018 QCCA 1879, para. 70-71.
26. and the Supreme Court of Canada

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