"Banning Noncompete Agreements: Benefits for Workers, Businesses, and the Economy"

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Before the Subcommittee on Economic Policy
United States Senate Committee on Banking, Housing and Urban Affairs

July 30, 2024
2:30 PM ET
Dirksen Senate Office Building 538

Good afternoon Chair Warren, Ranking Member Kennedy, and members of the committee. Thank you for inviting me. I am here to discuss my experience with noncompete agreements from a physician's perspective. It is an honor to share my story with you today.

My name is Rull James Toussaint. I have spent two years at the University of Florida where I am an orthopaedic surgeon. I would like to state for the record that the opinions expressed herein are my own and do not reflect the views or positions of the University of Florida or University of Florida Health.

I was born in Haiti, and emigrated to Florida where I learned to speak English while excelling in academics. I achieved the American dream when I was the first in my family to be accepted to college at the University of Chicago. Thereafter, I went to work on Wall Street in an effort to pay off my student loans. After an additional four years of hard work, I was blessed to be accepted to medical school at NYU where I was among the top of my class. As a result, I matched at Harvard University's prestigious orthopaedic surgery residency program and subsequently completed an orthopaedic foot and ankle fellowship at Ortho Carolina in Charlotte, North Carolina. At this point, my life goal was simple: to return to Florida as a well-trained orthopaedic surgeon who would treat his community, including the underserved.

In 2014, I returned to Florida and joined a private practice multispecialty musculoskeletal group as their only foot/ankle-trained orthopaedic surgeon. In fact, at the time, I was only one of two orthopaedic surgeons with this expertise across a dozen mostly rural counties in Florida, serving over 850,000 people.

Over the next few years, the partners of my practice and I felt the pressures of decreasing reimbursements from insurance companies coupled with the increased burden of pre-approval requirements from insurers, as well as intense competition from other practices. We felt that an infusion of capital was necessary to remain competitive. As a result, the partners entered into a purchase agreement with a private equity firm headquartered in California. The deal closed in 2017.

Although I am legally bound from disclosing the terms of the transaction, I can say that it included a restrictive covenant (i.e., a noncompete clause). Per the noncompete, I would be restricted from practicing orthopaedic surgery within 25 miles of:

(1) any facility in which the group is currently providing medical services;

(2) any facility in which the group has previously provided medical services;

(3) any facility in which the group has targeted for expansion within the entire state of Florida or;

(4) any facility the group was in discussions with related to a potential acquisition.

This noncompete clause was valid for 2 years from the date of termination of employment for any cause.

At this point, one might wonder why we would sign such a deal. The reality is that the nuances of the noncompete were not known until we, the doctors, had spent hundreds of thousands of dollars in transaction expenses related to the acquisition. As a group, we felt backed into a corner and believed our only choice was to proceed with the transaction in good faith.

Unfortunately, one of the private equity group's first actions after the deal was set was to install its own board and management team. The private equity group promised us that the new management team would have years of orthopaedic expertise. Unfortunately, none of the new leadership had any notable experience with running an orthopaedic practice.

Within months after the deal's closing date, the morale of the physicians and their staff changed for the worse. Many of the long-time employees were laid off or fired to make room for new hires by the private equity group. This led to patient dissatisfaction and significant disruptions in the physicians' day-to-day clinical practice.

Next, instead of cost savings, the practice's overhead expenses increased significantly. The increase was due to more layers of administrators, management fees, and millions of dollars of debt. The overhead increased so substantially that some physicians not only did not receive a paycheck, but instead actually paid the group to work, despite the physician taking on all the risks and responsibilities of patient care. After endless complaints from the physicians about the insurmountable overhead expenses, the private equity group finally responded. To the physicians' dismay, one of the methods of cost savings was to change malpractice coverage to a lower-tier, less-expensive insurance carrier.

Furthermore, the physician take-home pay decreased dramatically. As previously mentioned, some doctors indeed had to pay for the privilege to work. Unfortunately, some doctors were tempted to find other ways to pay their overhead. All the while, the cost to the patients continued to rise while they noticed their quality of care decreased. I had many patients complain to me about surprise billing and unexpected increases in their medical bills, as well as how they were unhappy with their treatment outcomes from overworked surgeons.

Since the private equity deal closed, nearly half of the group's original partners left the group. To save face, the private equity group's management team would lie to patients and say that the

doctor retired, even though the doctor had not actually stopped practicing medicine. In my case, I was disillusioned by private equity's mismanagement of the practice and the group's focus on dollars instead of the quality of healthcare. I eventually put in my resignation letter highlighting my intention to leave private practice and enter academic medicine at the nearby nonprofit state-run institution. This decision made sense given that the only other orthopaedic foot and ankle subspecialist in the entire region was retiring, and I would be able to help educate the next generation of surgeons in my specialty. Despite this, the private equity group quickly sued to enforce the noncompete agreement to prevent me from practicing medicine at another facility.

It did not matter to the private equity group that the local community and entire region – an already underserved community -- would not have a specialist surgeon to care for their injured patients.

It did not matter to the private equity group that the academic medical center was the only provider of orthopaedic care for the Medicaid patients in the region and without me, the Medicaid patients would have to travel hours away for treatment.

And finally, it didn't matter to the private equity group that the State of Florida had enacted a statute (Chapter 542 Section 336) stating that if one entity employs all physicians who practice a particular medical specialty in a county, then restrictive covenants the entity enters into with those physicians are void and unenforceable.

Despite all of what I stated, within days of my leaving the practice, the private equity group threatened legal action to prevent me from entering academic practice. Despite the existing State of Florida statute negating the enforceability of the non-compete, the private equity firm's goal was clear. Their goal was to wage an expensive and prolonged legal battle in the hopes that I would capitulate and leave my community even before a final judgment was rendered.

After a four-month dispute, a legal settlement was achieved, and I was able to join the faculty at the university. Not surprisingly, many patients from the private practice who seek my care at the university tell me of the frustrations they encountered when they called the old practice trying to find me. They said that the private equity group lied to them and stated I retired from medicine or left the state.

Because of my concerns with PE and healthcare, including their use of non-compete agreements, I'm a member of the Coalition for Patient-Centered Care (CPCC). CPCC represents a diverse group of healthcare industry stakeholders who stand together in opposition to private equity's acquisition and influence over independent physicians that can result in an emphasis on profits and revenue growth over patient interests. We call on other stakeholders who share our concerns about PE to visit our website at www.patientcenteredcare.com, follow us on Twitter/X @CPCC_America and our LinkedIn page to join our cause.

Unfortunately, I have experienced the negative consequences that noncompete agreements have on patients, physicians and communities. My noncompete agreement restricted my ability to care for patients, and restricted patients' ability to seek medical care. I have concluded that these restrictive covenants negatively impact patient access to physicians, limit the quality of care, and

increase costs to all parties. I look forward to the FTC's Noncompete Rule going into effect, because I know firsthand that banning noncompete agreements will benefit both physicians and their patients.