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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Are Physicians' Duties to Patients When They Sell Their Practices?

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Abstract

Physicians have fiduciary duties to respond with care to patient's clinical needs and vulnerabilities, whereas private equity (PE) companies have no such ethical or legal duties to patients and strive to maximize financial returns for their investors. This commentary on a case considers ethical conflicts of interest that arise when physicians sell their practices to PE firms and describes what physicians should consider when selling to fundamentally profit-driven entities.

Case

Dr W owns their community-based family practice, recently turned 65 years old, and will soon retire after 35 years of caring for patients. Dr W is approached with a lucrative buyout offer from a private equity (PE) company interested in primary care patient panel acquisition. Dr W is unfamiliar with the company and its practices and only has a few weeks to accept or decline the offer. Dr W wonders what they owe their many long-term patients as their career ends and how those patients will be affected by the change as they consider how to respond to the offer.

Commentary

This case is increasingly common, as PE investment in health care has grown in recent decades.[1] In 2022, more than $85 billion of deal value was announced globally, with more than 50% of buyouts attributed to the provider sector (eg, hospitals, physician offices).[2] The number of PE-owned physician practices increased 6-fold between 2012 and 2021.[3,4] Increasing PE investment has been noted across multiple specialties, including otolaryngology,[5,6] dermatology,[7,8] ophthalmology,[9,10] and others.[11,12,13] Moreover, the Medicare Payment Advisory Commission and American Medical Association advise that the true extent of PE investment in health care cannot be determined exactly, as PE firms are not publicly traded, often utilize nondisclosure agreements, and lack consistent public reporting requirements.[14,15]

PE firms have a fiduciary responsibility to their investors and portfolio companies, which has a profound impact on the ownership structure and financial incentives of medical practices. In general, PE firms aim to realize profits from acquiring, managing, and reselling businesses over holding periods of 3 to 7 years.[13,16] PE firms develop targets, or financial goals, based on achieving a return on investment of the capital that they

have invested; they typically target returns (known as multiples on invested capital) of 2.5 times the initial investment, which yields a net internal rate of return of roughly 20% at 5 years.[17] These objectives and time horizons in turn necessitate the realization of rapid growth in earnings by increasing revenue or decreasing expenses. In certain scenarios, these incentives may yield benefits to physicians or their patients through decreased administrative overhead (eg, use of shared services), increased capital investment, or economies of scale (ie, the cost savings gained by increased level of production or extending shared services to more businesses invested in by the PE firm).[6,18,19,20] However, many physicians and policy makers fear that the core incentives of PE could risk eroding physician satisfaction and autonomy and impede physicians' ability to provide high-quality care. Within the United States, there is less satisfaction and autonomy among PE-employed physicians, and there is concern that PE-employed physicians are co-opted or unduly incentivized to prioritize profit over patient care.[21,22,23]

Private Equity and Outpatient Care

Studies on the impact of PE investment in health care have increased in the last decade, with the preponderance of data suggesting that PE acquisitions are associated with reduced staffing levels and on-hand medical supplies.[24] A 2023 systematic review concluded that PE ownership was associated with increased costs to payers and patients,[25] largely driven by increases in payments per claim, amounts charged per claim, and amounts paid per visit.[26,27,28] Prices at PE-acquired practices have also been found to significantly outstrip those of matched controls across multiple specialties, especially in areas where a PE firm controls a significant share of the local market.[4] Indeed, reduction of market competition through consolidation may be the mechanism by which large PE firms increase service costs. Changes in procedure volume, use of ancillary testing, or use of higher-priced medications could also be contributing to the increased per-patient cost.[27,29,30]

Several studies have also noted increases in practice visits and patient volume following PE acquisition,[26,27] which could be a lever that PE firms use to increase revenue. Although this strategy likely increases access for patients requiring a doctor's care, it may decrease the quality of care provided. In a recent survey, nearly half of physicians at PE-owned practices reported that ownership changes worsened their relationships with patients, largely due to decreased time and communication with patients.[31] Appointment availability appears to vary by payer, with some secret shopper studies demonstrating decreased access for Medicaid patients and stable-to-increased access among Medicare and privately insured patients in PE-owned relative to non PE-owned clinics and practices.[32,33] Moreover, visits are more likely to be with non-physician clinicians at PE-owned practices, which could be due to increased physician turnover and increased employment of advanced practice practitioners.[32,34] In some specialties, such as dermatology, this workforce shift among PE-owned practices has raised concerns regarding the volume of procedures performed that are not clinically indicated or are performed by advanced practice practitioners without sufficient supervision.[35]

In addition to the cost and volume of care, quality of care could also be impacted by PE acquisitions in medicine. In a recent survey by the Physicians Advocacy Institute, many physicians in PE-owned practices reported that ownership changes had a negative impact on quality of patient care due to decreased autonomy and increased focus on financial incentives.[31]

Notably, potential benefits include access to capital for technology and facilities, as PE firms might be able to purchase new equipment or space; economies of scale through consolidation, as PE firms controlling several offices or groups may be able to negotiate better prices from suppliers; and relieving clinicians of the burden of administrative and financial aspects of practice. However, the objective impact of PE ownership on quality and outcomes of outpatient care remains unclear due to limited evidence.[25] More research will be needed to quantify the changes associated with PE investment in health care, but progress continues to be challenging due to a lack of comprehensive, publicly available data.[19]

What to Think About Prior to Selling

As highlighted above, the incentives of PE firms—both in the abstract and in documented cases—can conflict with the priorities of physicians and patients. As the practice's current owner, Dr W has both the power and the obligation to determine the manner of its disposition, thereby influencing how it could deliver care to patients in the future. It is important to note that national trends in decreased physician ownership of independent practices suggest that Dr W could face difficulty in finding a noncorporate purchaser,[18,36] but if there are other alternatives like selling to a large physician-owned medical group or an academic medical center, these should also be considered alongside the current offer. In the absence of other willing buyers, Dr W could also consider closing the practice upon retirement. While doing so could allow Dr W to avoid a potential ethical quandary about the practice's future ownership, the loss of the practice could itself harm patients by reducing the availability of care. As a result, closure is also not without ethical consequence.

From a legal perspective, state corporate practice of medicine (CPOM) laws must also be considered in the sale of a medical practice to a non-physician. These laws were largely drafted in the early 19th century to limit the influence of corporate interests on physicians' clinical decisions and professional autonomy, such as through ownership and control of medical practices.[15,37] However, the scope and enforcement of CPOM laws vary widely by state, and critics have argued that they are outdated and easily circumvented by corporations through the use of intermediaries such as management services organizations, which can then assume de facto control over physician practices.[38] Federal- and state-level antitrust laws also need to be taken into consideration, depending on the transaction size, but it is estimated that over 90% of PE acquisitions in health care do not meet the current Hart-Scott-Rodino Antitrust Improvements Act threshold for reporting ($119.5 million in 2024) and thus largely operate outside the public and regulatory radar.[4,21,39,40]

Obligations to Patients

If Dr W proceeds with the sale of their practice to the PE company after weighing these considerations, one of the most pressing risks to Dr W's patients is the maintenance of physician integrity and autonomy. Despite regulations to restrict nonphysician influence on clinical decision-making, violations have been reported and prosecuted in multiple specialties[41,42,43] and continue to remain a significant concern for clinicians in PE-owned practices.[24,44,45] During sale negotiations, there are opportunities for Dr W to codify protections for remaining physicians with regard to clinical decision-making and other critical areas of the practice.[46] Ways to codify protections could range from covenants in purchase and sale documents to brokering investment positions for physicians in the practice sufficient to secure some degree of direct operational control even after the PE

buyout. Dr W could also leverage the current offer to generate alternative offers from entities with potentially better-aligned incentives or deal terms.

After sale of the practice, Dr W has a legal and moral responsibility to notify their patients regarding the upcoming change in practice ownership, their retirement from the practice, and how patients can access or transfer their medical records. In addition to the federal Health Insurance Portability and Accountability Act, some states also require explicit patient consent for the transfer of their medical records to a new clinician.[47] Although not all states legally require patient notification of a change in practice ownership, Dr W should proactively disclose information regarding the new ownership, including the names of the individual or corporation assuming ownership, out of respect for patient autonomy. With this information, patients can be empowered to make informed choices when seeking care.

After the relinquishment of the practice is complete, Dr W will no longer have a duty to steward their prior patients' health interests. If there are other physicians remaining in the practice or joining it, their priority should continue to be putting their professional responsibility to care for patients above any self-interest or legally permissible contractual relationship.[15,48,49] Specifically, physicians should continue to make decisions for patients based on their individual needs, resisting pressures to over- or under-provide care to reach financial milestones or operational goals.

Regardless of practice ownership model, it is also important for practicing physicians to understand federal and state legislation regarding fraud, kickbacks, and non-physician influence on clinical decision-making.[50] Some have argued that methods commonly used by PE firms to achieve growth in profitability (such as dictating referral patterns for ancillary services, increasing procedure volume, or billing for higher levels of service) could carry increased risks of violating fraud and abuse laws such as the Physician Self-Referral (Stark) Law and Anti-Kickback Statute.[51,52,53] If such concerns were to arise, there are well-established mechanisms for reporting to the US Department of Health and Human Services (HHS),[54] as well as protections for whistleblowers.[55]

Finally, although Dr W would no longer be directly caring for patients after retirement, they could still advocate for patients to be safeguarded against potential exploitation by PE interests. This topic has been the focus of multiple physician advocacy groups[56,57,58] and has been gaining traction on a federal level in recent years. In 2023, a bill, HR 3262, was introduced to the US House of Representatives that would require certain health care entities (including PE-owned physician practices) to report mergers, acquisitions, and changes in ownership to HHS for public disclosure.[59] In March 2024, the US Federal Trade Commission, Department of Justice, and HHS held a public workshop to examine the role of PE investment in health care markets and published a request for public comment.[60] The following month, the US Senate Committee on Health, Education, Labor, and Pensions held a subcommittee field hearing titled "When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk."[61] During the hearing, Senator Edward Markey of Massachusetts announced a draft bill titled the Health Over Wealth Act, which seeks to require greater transparency and accountability regarding for-profit investment in health care.[62]

Prioritizing Health

PE investment in health care has grown dramatically in recent years, developing into an area of significant interest for patients, physicians, and legislators. Although PE purports

to offer benefits to health care practices—including capital, business expertise, and operational efficiency—evidence from outpatient physician practices has shown that PE acquisition decreases market competition and raises costs for payers and patients. Furthermore, although studies on outcomes and quality in this setting are still limited, available evidence suggests that practice patterns change for the worse with PE acquisition due to increased pressure for profit. Ultimately, the primary responsibility of PE is to investors rather than to patients, and while rigorous research and federal regulations are critical for addressing the impact of PE investment on health care, the core of medicine will always be the care of patients. As such, the moral and legal duty of physicians remains as it always has been: to prioritize the health and well-being of their patients, a responsibility that takes precedence above all else.[63]

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