Episode: *Ethics Talk: What Should Clinicians and Patients Know About Private Equity in Health Care?*

Guests: Robert Field, PhD, JD, MPH; Yashaswini Singh, PhD, MPA
Host: Tim Hoff

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HOFF: Welcome to Ethics Talk, the American Medical Association Journal of Ethics podcast on ethics in health and health care. I'm your host, Tim Hoff.

In May 2025, the Journal launched the *AMA Journal of Ethics* Grand Rounds. This live broadcast series features experts engaging important but neglected questions and topics health care ethics and health policy and a live questions and answer segment. Like all of our Ethics Talk podcasts, *AMA Journal of Ethics* Grand Rounds are eligible for CE credit in several multimedia formats.

This is the audio version of the *AMA Journal of Ethics* Grand Rounds broadcast: "What Should Clinicians and Patients Know About Private Equity in Health Care."

HOFF: Hello and welcome to the first *AMA Journal of Ethics* Grand Rounds broadcast. I'm Tim Hoff, multimedia editor for the *AMA Journal of Ethics*. The journal's review editor, Kree Middleton, and the journal's managing editor, Dr. Christy Rentmeester, are also with us in the chat. Thanks to everyone in the audience for tuning in.

We're excited to see so many folks here. Feel free to introduce yourselves in the chat and tell us what you'd like to know about today's topic. Joining me on this broadcast are Dr. Robert Field, Professor of Law and Professor of Health Management and Policy at the Thomas R. Klein School of Law and the Dornsife School of Public Health at Drexel University, and Dr. Yashaswini Singh, Health Care Economist and Assistant Professor at Brown University School of Public Health. Dr. Field and Dr. Singh both contributed articles to the May 2025 issue of the journal, Private Equity in Health Care. Dr. Singh and Dr. Field, thank you both for being here.

DR FIELD: Thank you for inviting us.

DR SINGH: Likewise. Thank you.

HOFF: There will be opportunities for question and answers later in the broadcast, so be sure to be putting your comments and questions in the chat.

As a reminder, Continuing Education is going to be available for this broadcast. You can follow the links that Kree is providing in the chat to access that. Private equity firms might own residency slots. They might sell parts of your community hospitals or look to purchase your physicians' practices.

Today, our guests will help us understand what clinicians and patients should know about private equity investments and acquisitions in health care. Up first, we'll hear from Dr. Field,

who will give us an overview of his article in this month's issue of the journal, “Can Current Legal Tools Respond Adequately to Risks of Private Equity Investment in Health Care?”

A link to this article and other content from the journal, both this month and previous issues, will appear throughout this broadcast in the chat. Dr. Field, the floor is now yours. Go ahead.

DR FIELD: OK. Thank you, Tim, again, for the invitation to speak here and the opportunity to speak about this very important topic, which becomes more important almost by the day for clinicians, certainly, but also for more and more patients, which is to say all of the rest of us.

We have seen significant growth in private equity investment in health care over the last 10 to 15 years. There was something of a slowdown just before and during the pandemic, but it's picking up again, and it's covering more and more different areas of health care. Almost $120 billion of investment in 2019.

Dr. Singh will provide more detailed statistics during her talk. Health care is appealing to private equity for a number of reasons. One is that it generally has a steady source of income between insurance and government programs, Medicare and Medicaid. The issue of collecting is generally not one that they would face as they might in other industries.

It's a necessary service. The need for it is not going to go away. And health care entities often have very attractive assets. In particular, institutional entities have real estate that can be quite valuable. Initially, the private equity investment focus was institutional providers, hospitals and nursing homes.

But over the last five to 10 years, it's expanded to include physician practices. They generally don't have real estate, but they all have other very attractive features. To be fair to private equity on the positive side, they can and often do inject needed capital into under-resourced facilities and practices.

They can also streamline governance. They certainly have experience in streamlined governments. And they can act more nimbly in making major decisions. On the other hand, the deleterious effects are widely noted. Higher prices from reducing competition in their markets. Financial stress that can lead to bankruptcies.

Enclosures of acquired entities. Lapses in quality. Increases in incidents of billing fraud. And techniques of interfering with clinical practice. Imposing requirements on clinicians. And encouraging them or even requiring them to refer patients within the business structure. There are also incidents of surprise bills where their providers, particularly in emergency rooms, are not part of networks.

And patients had thought that their insurance would cover the visit and it did not. Again, Dr. Singh will discuss some of these in more detail. Regulators have responded, but their toolbox could use an upgrade. The issues arise because of the distinctive business model of private equity. It is not like typical for-profit investment in health care.

If you look at the traditional acquisition of hospitals, it's usually by a larger chain. They seek wide investment from as many sources as possible. And they bring expertise in the field. They have a business plan. They're not simply looking for quick profits. Because of the size of many of those acquisitions, they trigger reporting requirements under federal and often state laws, including to agencies like the SEC, the FTC, and sometimes the antitrust division of the Department of Justice.

In contrast, private equity funds tend to be small. They would prefer a small, select group of investors, both wealthy individuals and institutions, who generally have little or no prior knowledge of health care or really interest in it. They're looking for industries where they can generate short-term profits.

Four business practices stand out for private equity to promote their agenda, practices that are not generally seen with traditional for-profit investors. The first is the complex corporate structure that they develop, intended in most cases to be opaque to outsiders and difficult to understand.

Loading debt from the acquisition onto the acquired entity rather than a central corporate parent. The entity itself might be used as collateral for the debt in what's known as a leveraged buyout. Transferring the acquired entity's assets, in particular the real estate to related owned businesses, which now have seen an influx of value, and forcing the entity to obtain ancillary services from a related entity, services like management, real estate, payroll, and so forth.

The benefits for the PE firm are the opaque transactions shield investors and the fund itself from lawsuits, claims of creditors, and the scrutiny of regulators. It can make it difficult for regulators to determine which entity is responsible for which behaviors, and importantly, which have assets for paying claims of creditors and penalties from regulators.

Loading debt, as I said, onto the acquired entities to shield the fund from liability for repaying it. The small size of the transactions, if it's a physician practice or a single hospital or nursing home, avoids regulatory filings, which reduces the chance of public scrutiny. The transfer of the real estate requires the provider entity to make lease payments that may increase over time, adding to its financial stress, and the intertwined corporate structure may require the provider to pay for management services, as I said before, billing, purchasing, payroll, and even to make payments to the fund's general partner for its oversight.

In addition to leading to quality concerns and higher prices, it often results in the bankruptcy of required entities. Private equity-owned health care facilities enter bankruptcy at a significantly higher rate than those under traditional for-profit ownership. According to one study in 2023, 21% of health care companies filing for bankruptcy were owned by private equity firms.

In another, looking at private equity leveraged backouts,

the probability of bankruptcy was found to be 18% higher than for nonacquired firms. The private equity funds generally don't care because they look to exit the business in as little as three to seven years and recoup their prices without concern about long-term sustainability.

The defenders of private equity are quick to point out that there are success stories, one in which an established health system was able to establish 67 new primary care clinics with an investment of about $800 million.

However, this is an example of a partnership in which a stable entity continued in business and was not acquired and subsumed into something else. The main areas of legal focus to date have been antitrust enforcement, enforcement of safety standards, and enforcement of billing standards, particularly Medicare and Medicaid billing fraud.

However, the regulators can still be stymied by the complexity and the opacity of the corporate structures. So I see four reforms as needed to increase the regulatory toolbox to meet the challenge. Under present political circumstances, I think they're more likely to occur at the state level than the federal level.

One would be lower reporting thresholds. For transactions, this would cover reporting to federal agencies as well as state regulators. Scrutinizing Medicaid reimbursement, particularly claimed costs, so that only legitimate clinical costs are reimbursed and not ancillary costs that go to related entities that the provider is now forced to obtain services from.

Increased oversight of the quality of care, more frequent inspections, larger fines, and more vigilant oversight of medical practice changes by state medical boards. There are also about 10 other states that have given the state attorney general the power to review and to reject private equity acquisitions. And I know there's three states are looking at them.

I think this would be an important improvement in regulatory oversight. To summarize, I don't think that private equity investment in health care needs to be prohibited entirely. There are success stories, and there are plenty of instances where the funds have helped inject resources and management expertise into needy providers.

However, given the frequency of abuses and the consequences in terms of health and life for so many people, closer oversight is certainly needed. Thank you. -

HOFF: Thank you, Dr. Field. In case you missed it in the audience, Dr. Field was also the featured guest on this month's episode of the *AMA Journal of Ethics* podcast, "Ethics Talk."

You can find that episode on our site, journalofethics.org, or on all of your favorite streaming platforms -- Spotify, iTunes, all of those. Continuing education credit is also available for that and for many other of our journal-based and multimedia content. Kree will be providing links to all of that in the chat.

We'll open the floor now to some questions from the audience. Dr. Field, I'll start you off with one. What's the most important ethics point that clinicians and patients might be taking from your article this month? -

DR FIELD: The ethical obligation of providers doesn't change, or at least it shouldn't change with the corporate structure.

There's still a fiduciary responsibility to look after the patient first. Now, having said that, it's easier to say than to enforce when your paycheck comes from a private equity fund or other corporate owner that's placing demands on you. But the ethical obligation remains the same, and I think that just reinforces the need for greater surveillance and for an increasing range of regulatory tools to make sure that that ethical obligation remains first and foremost.

HOFF: -And can you give some examples of anti-competitive effects of private equity firms' acquisitions of health care entities? -

DR FIELD: We see market consolidation leading to vertical and horizontal integration that reduces competition and therefore leads to higher prices. We've seen this in particular with some physician specialties.

Steering of patients, which is a serious ethical lapse as well as a legal lapse, since payments for referrals or forced referrals are a felony, are clearly against the law, in some cases even requiring referrals within the private equity network. Surprise bills when a private equity-owned provider has an exclusive contract, say, for services within an emergency room.

They do not enter contracts with various private insurers, leaving patients with no coverage, no means to avoid the service if it's an emergency, and a large financial hit. They also have exerted power over labor markets, reducing wages in some areas, particularly rural areas. And the quick exit, the strategy of leaving the field in three to seven years once their profits have been realized greatly reduces the incentive for long-term investment, even though one of the justifications for private equity investment is to increase the resources of the entities.

HOFF: Thank you.

We have another question here from the chat. Do physicians have any approaches that we can use to evaluate these entities before entering into an agreement with them?

DR FIELD: I think Dr. Singh will also speak to that. Do your homework speak with state regulators? The problem is their own strategy of keeping transactions opaque, of keeping corporate structure opaque.

It's not like looking at a national for-profit hospital chain where they have regulatory filings that are public and accessible, or even their websites will describe their corporate structure. So I think in those states, those 10 or so states that have enacted oversight by the attorney general, that would be the place that I would start.

In the other states, it's going to be harder.

HOFF: Great. Thank you again, Dr. Field, for sharing your expertise with us. Dr. Field will answer more questions at the end of the event, so keep them coming in the chat. We'll hear now from Dr. Yashaswini Singh. Dr. Singh wrote an article for this month's *AMA Journal of Ethics*, "How Should We Stop Private Equity Firms From Exploiting Public Health Insurance?"

More Q&A to follow, so please put questions for Dr. Singh in the chat as well. Dr. Singh, go ahead.

DR SINGH: Good afternoon, everybody. My name is Yashaswini Singh. I'm an assistant professor of health services, policy, and practice at the School of Public Health at Brown University. I wanted to start out by emphasizing sort of these trends that we're seeing with growing financialization and private equity investors, acquiring physician practices.

This is a broader trend that's been affecting the practice of medicine, and so I wanted to start out here because I think it's important to contextualize our discussion. PE is sort of one symptom of a broader trend that we've been seeing unfold. If we look at the graph on the left, we see that in the last five years, about 8 in 10 physicians are now employees of hospitals, health systems, or corporate owners, including private equity-backed companies.

And then if you look at the figure on the right, we see that if we look at all of the mergers and acquisitions that have happened within the physician practice ecosystem in the last five years, about two-thirds of all of these have been led by PE firms. So although PE is one symptom of a broader trend in corporate consolidation of physician practices, it is by far the most dominant trend in the last five years.

And so if we have a special issue on the theme of private equity in health care, perhaps that attention and interest is warranted. I also wanted to start out first by sharing the classic model of a PE investment or acquisition, if you will, in the case of physician practices, before getting into a discussion about what the effects of these investments are and what policy levers are at our disposal.

So as Dr. Field mentioned, PE firms generally raise capital from a whole variety of limited partners, pension funds, university endowments, and so on. The important thing to remember is that PE firms often use the vehicle of debt to make majority stake investments. So the capital raised by institutional investors is often combined with 60 to 90 percent of debt or borrowed money to make a majority stake investment in a physician practice.

Now, importantly, the use of debt or the loan is placed on the balance sheet of the acquired entity and not the PE firm making the investment, which can create sort of financial pressures as entities now have interest payments and obligations to complete. This investment vehicle is then used to make a majority stake investment in a platform practice.

A platform practice could be a physician practice that perhaps enjoys good brand recognition, a loyal stream of patients, and so on. Now, depending on the state that the investment is happening in, PE firms can also use the form of a management services organization or an MSO to facilitate the investment.

The key thing to remember about PE investments and physician practices is that this is a strategy of consolidation. So what starts out as an initial investment in one platform practice is often followed by a subsequent series of roll-up acquisitions of smaller physician practices in the same market.

And so in this illustrative example on the slide, we see that what starts out as a platform practice acquisition of three physicians is followed by a roll-up of practice A with two physicians, a roll-up of practice B with a single physician, and a roll-up of practice C with four physicians. Together, these series of roll-up acquisitions give the PE firm the ability to command higher market share in the market for physician services, negotiate higher prices from commercial insurers, and perhaps more importantly, sell the practice for a higher valuation upon the time of exit.

Now, what does exit look like? PE firms often exit their investments over very short time periods, as Dr. Field highlighted. Theoretically, exit can take the form of an IPO, where the practice is listed on the public stock exchange for the first time. An exit might also take the form of a sale to another PE firm, or the exit can take the form of a sale of the practice to a strategic buyer that's not a PE firm, which in health care can look like a hospital affiliate or a health insurer affiliate.

With this overview, I wanted to share a little bit about the empirical research on private equity investments in physician practices. We see that investments have spanned every clinical area. Dermatology was the initial practice specialty that attracted PE investments starting in 2012. Over 2015, 2016 onwards, a lot of the specialties that have attracted investments have been procedural in nature, gastroenterology, urology, and ophthalmology.

And since the onset of the COVID-19 pandemic, we've seen investments shift towards value-based specialties, such as primary care, cardiology, and oncology. Now, if we look at the geographic presence of these acquisitions, it's apparent from the map on the left that these acquisitions do not happen at random.

Investments reflect the strategic selection of investment opportunities in select geographic areas. The areas that are most affected by these trends seem to be pockets in the Northeast, but also in the Southeast, in Florida, Texas, and pockets of Arizona. Some of my research has shown that when private equity firms invest in physician practices, perhaps it's of no surprise given the model of consolidation deployed here.

We find that negotiated prices increase by about 11%. There are increases in charge master or list prices by 20%. Physicians are also made to see a greater number of patients as the patient volume increases by 26%, driven largely by the influx of new patients that increase by 38%. On the Medicare side, we've also done some research that shows that private equity investments change the practice patterns of physicians by incentivizing them to prescribe more expensive drugs that are favorable from a reimbursement standpoint.

So in this particular study, we looked at the prescription or prescribing patterns for anti-vegiff agents, and we found that even when generic cheaper alternatives exist, following acquisition by a PE firm, physicians increase the use of higher-cost anti-vegiff agents by about 20%. On the flip side, if you look towards what happens to services that might be critical for the patient, but perhaps unprofitable from the perspective of the investor, we've also done some work that shows that following investment, PE firms discourage the provision of services for which the reimbursement might not be at par with the cost.

In this particular study, we looked at the context of retinal detachment surgeries for which cost can often exceed reimbursement, and we found that following investment, the provision of these critical surgeries that can prevent irreversible blindness decreases by about 20%. From the physician perspective, a lot changes in the practice once it gets bought out by PE firms, so it's perhaps of no surprise again that we see a higher incidence of physician turnover following physician practices becoming acquired by PE firms.

So in this study, we looked at the share of positions that were exiting their practice or separating from their practice year after year after the practice got bought out by PE firms, and we found that while baseline physician turnover rates were around 5%, this increased to over 20% in the three years following acquisition.

And finally, I wanted to highlight that we've also done some work to uncover what the future of these trends looks like for the physician practice ecosystem, what does private equity exit look like, and we've seen that looking at about 550 acquisitions that have happened between 2016 and 2019, we've uncovered a couple of key facts.

First, exit happens in a relatively short time period within three years after investment. Second, exit takes the form of a sale for practice to a secondary PE firm, which essentially restarts the cycle of buying to sell. And third, we see about 8% of practices end up closing operations after their initial purchase by a PE firm.

So the key takeaways from the empirical research so far show that 1] PE, again, is a part of a broader trend or a symptom of the growing presence of financial actors in the American health care system. When we look at physician practices in particular, there's a growing and consistent evidence that these investments spur a series of consolidation which has the effect of increasing health care prices and increasing the billing of profitable services.

I must highlight that the effects on quality are a little bit more ambiguous. We've seen in other contexts such as hospitals and nursing homes, PE investments can be very harmful for patients, but in the physician practice setting, the evidence is still lacking, and so I wanted to highlight that part.

From the workforce implications, though, we've seen consistent evidence that a lot of disruptive changes happen to the practices that get bought out by PE firms. There's an increased reliance and staffing of advanced practice providers and also an increase in physician turnover. So the key policy question then is how can we, as a society, leverage public policy tools to design a system where the incentives of PE firms are aligned with the incentives of physicians and then also ultimately patients and taxpayers.

The key policy challenge, of course, is to create an environment where private capital is encouraged and incentivized, but at the same time, the rights and sort of responsibilities of PE firms are in check to safeguard patients and health care workers. In the last couple of minutes, I wanted to highlight some policy actions taking place both in the federal and state domain, and so here, this slide summarizes action at the federal level.

About two years ago, the Federal Trade Commission filed the first of its nature antitrust lawsuit against a private equity firm and its anesthesia platform. This case was the first of its

kind because it targeted the specific role of mechanism that I've highlighted a couple of slides prior.

At the same time, in January of this year, there was a bipartisan Senate report on sort of all of the harmful effects of PE investments in hospitals. That's the report highlighted in the middle of the slide. There was again the first of its kind collaboration between the Federal Trade Commission, Department of Justice, and Department of Health and Human Services to have a public request for inquiry towards the different sorts of strategies that PE firms might deploy to drive profitability in ways that can harm patients and health care workers.

Now, of course, as Dr. Field mentioned, this is an area where we've seen a spree of state-based activities as well, and I predict we'll see more state enforcement actions being proposed and debated in the months and years to come. This slide here highlights a couple of these. Massachusetts in January of this year became the first state to essentially outlaw some of the practices that involve real estate leasebacks that have led to hospital bankruptcies and closures in several states at this time.

And I'll leave this here for follow-up for our future Q&A. Finally, I'll wrap up here by highlighting a model legislation developed by one of my colleagues at Brown, Professor Erin Fusay Brown, who worked with the National Academy for State Health Policy to develop model legislation to counter some of the harms that we've seen result from private equity investments in health care practices.

I must emphasize that any policy approach here must be very specific about the policy concern it is addressing. And so if the antitrust tools traditionally are not up to the task of regulating private equity investments, then the policy approach lies in increasing health care transaction authority for the state attorney general or an independent health care markets commission.

If the policy concerns are more around the professional autonomy and the exercise of sort of financial judgment or clinical judgment, then the policy tools and the policy reform lies in the domain of strengthening the corporate practice of medicine doctrines, ensuring that restricted contract clauses such as non-competes and non-disclosure agreements are not unduly restricted.

And then finally, underpinning all of this is a desire for greater transparency and accountability. Again, I must emphasize that there are no reporting or systematic disclosure requirements at present for private equity firms, which makes it very difficult for researchers, policymakers, patients, and physicians to know who the ultimate owner of a practice is.

Having greater ownership transparency can help remedy some of this. I'll pause there with my remarks and look forward to your questions.

HOFF: Thank you, Dr. Singh. You can find Dr. Singh's article as well as the rest of the May 2025 issue on private equity in health care at our site, Journal of Ethics.org. The journal is completely free to access, so while you're there, you can check out all of our previously published issues, podcasts, artwork, yes, we have artwork in our ethics journal, and more.

In addition to continuing education credit being available for this event, readers can earn credit from engaging hundreds of our previously published articles and podcasts as well. We'll turn now to some questions from the chat for Dr. Singh. Dr. Singh, do you think private equity agreements could be voided in part for violating public policy if they do force physicians to breach their ethical duties?

DR SINGH: I might phone a friend and ask Dr. Field to help me here because I don't have legal training, and so, you know, I don't know about contract law as well. But I think that question highlights sort of this inherent ethical dilemma with PE investments and physician practices. We like to see the physician as sort of the traditional agent of the patient.

You know, you take the oath to do no harm, you, the physician, are essentially acting as your patient's agent. What happens with private equity investments, though, is that it can fuel the sort of double agent problem where the physician now is not only an agent of the patient, but also is due to contractual reasons an agent of the PE firm that is investing in the practice and is responsible for the physician's paycheck.

DR FIELD: I think public policy arguments are difficult to win.

Courts don't like to rely on them because it's hard to set limits and decide what's promoting and what's opposing public policy. I think a more fruitful legal tactic would be good old malpractice. If the physician is doing things in the interests of a corporate parent and neglecting standard of care, then that would be malpractice.

It puts the physician in a bind, but it would be a statement that clinical practice standards of care come first, regardless of what the corporate bosses say.

HOFF: Great. Thank you, Dr. Field, for weighing in. I think another question for Dr. Singh. Do any of these arrangements, particularly in primary care, become involved with value-based or capitated agreements?

DR SINGH: That's a really good question.

We have some preliminary data on this that does suggest a lot of the investments in primary care, not only by P.E. firms, but venture capital as well, are sort of fueled by and can exacerbate this trend towards value-based care contracts. The reality is that participating in these types of value-based care contracts requires extensive capital and investments in technology and so on, and so that's sort of an obvious need for capital that investors seek to build.

HOFF: Great.

Thank you. One final one. What might be done to bolster transparency by private equity firms? You touched on that briefly, but if you wouldn't mind expanding.

DR SINGH: Absolutely. And here we have some examples of things that Massachusetts has done in January of this year to require explicit reporting to the Attorney General's Office, not

only with respect to the practice that's receiving investment, but also all of the sort of opaque interrelated corporate hierarchies that are involved with investments of this nature.

And so having greater reporting and requirements can shed some light to further ownership transparency.

HOFF: Thank you. We will close out this session by opening up the Q&A to both of our guests. So audience, please put your questions in the chat if you have any at the moment. A question for Dr. Field. One observation that drives our inquiry here and did in the episode of the podcast this month as well is that private equity acquisitions in health care get a lot more public scrutiny than other kinds of business practices.

Can you give a brief response to why that increased scrutiny might be justified from a legal standpoint?

DR FIELD: They are what used to be very unconventional arrangements. I mentioned the various ways that they differ from traditional for-profit acquisition of health care entities, the opaque nature of the transactions of the corporate structure, the leveraged nature of some of the buyouts, placing debt on the acquired entity, using the acquired entity itself as collateral, and the research that has shown negative consequences, some involving quality, certainly involving market structure and prices, and at the very least inconvenience, certainly cost to patients when there are surprise bills or required referrals within the network.

So I think that this is a new beast or relatively new beast that risks both financial and quality of care decrements, and it needs to be scrutinized and enforced differently.

Great. Thank you.

HOFF: A follow-up question, I believe, to your reference to good old malpractice. Could malpractice be aimed at the private equity firm rather than the physician who is under pressure, or does it have to be aimed at a physician specifically?

DR FIELD: The physician is the one who has the legal responsibility for taking care of the patient.

There are other legal tools. Dr. Singh mentioned the corporate practice of medicine, which is sort of ironic. It's an archaic doctrine that was instituted in the early 20th century in most states to prevent corporate interference with medical practice. There was then a lot of backtracking starting in the 1970s because that's what HMOs do, and there was a policy initiative to promote HMOs, and now it looks like policymakers have backed off too far and allowed more corporate influence than we thought would be necessary.

But trying to reactivate that doctrine against the corporate owners would be one route, and then the relationships with the doctors, the financial incentives, incentives for referrals is clearly illegal. So while I don't think malpractice would fit, there are other legal avenues that can accomplish something similar.

HOFF: Great. Thank you. Dr. Singh, I know you've published recently on this topic, and your slides touched on it briefly, but if you wouldn't mind expanding on what the data suggests about what happens to local health care workforces when physicians' practices are acquired by private equity companies.

DR SINGH: Sure. Thank you for that question.

The workforce angle is very interesting because if we think about the incentives firms have to drive profitability, you can either do that by increasing your revenues or by cutting down on costs, and in health care, oftentimes the largest cost that practices face has to do with hiring and retaining talented workers, and so that's sort of an obvious area where we see the effects of PE investments in two distinct forms.

One, we've done some work that has shown that when PE firms acquire physician practices, and dermatology, gastroenterology, and ophthalmology, there is a shift towards a greater reliance on advanced practice providers. At the same time, a sort of related study in the same journal, Health Affairs, published in March of this year showed that this also has implications for the physician workforce, where we've seen physician turnover increase by about 200% after PE firms invest in physician practices.

I want to be mindful that turnover can be explained by a variety of reasons, right, and so changes in practice patterns that come about from financial investors is one reason, but the other reasons could range from, you know, early retirement decisions that are facilitated by, you know, some physician partner owners receiving a large financial payout at the time of sale and so on.

The other finding from the study was that when you look at the physicians who end up leaving PE acquired practices, they often have to move great distances in search of alternate employment. In the study, we found that physicians move on average about 100 miles in search of alternate PE employment, and so this kind of highlights the other sort of hidden aspect of the role of consolidation, because in many markets across the country, the only viable employment option physicians have is to partner with PE firms, given that PE firms have already acquired and consolidated a large share of specialty practices in distinct geographic markets.

HOFF: Great, thank you.

Dr. Field, a question for you, I believe. Legally, does interest in patient well-being and/or health supersede the fiduciary duty to the private equity firm?

DR FIELD: I wouldn't call the duty to the private equity firm fiduciary. Fiduciary means a position of trust. A physician has a fiduciary duty to a patient because the patient places trust in him or her.

That duty ethically would supersede everything else, and really the point of the ethical recognition of that duty is that it should supersede financial interests, personal interests,

whatever. So I would say on an ethical level, absolutely, the duty to the patient would overcome the duty to the private equity acquirer.

The duty to the private equity acquirer would be more prosaic. It would be based on contractual relationships, which are legally complex and raise a lot of questions given corporate practice and other legal doctrines, which restrict interference with the practice of medicine.

HOFF: Wonderful, thank you. Dr. Singh, what are ways in which private equity acquisition of health care entities has made ethics in clinical practice more fraught?

DR SINGH: So this has been a long-standing tension, certainly in the American health care system, where the presence of for-profit actors certainly is not a new phenomenon, and it highlights this sort of inherent tension between the practice of medicine and the business of health care.

And so the key ethical concern is, you know, if you have a physician, those obligations might not always be consistent with whatever obligations corporations might have to shareholders. And that inherent ethical sort of tension is what is now being amplified when you see a growing presence of private equity firms with their emphasis on short investment turnaround times.

HOFF: Great, thanks.

Final question for you both. Are there any legal or other updates, public policy updates, to private equity governance or regulation that we should know about since the publications of your article?

DR FIELD: I would say an additional set of bankruptcies and financial stress for acquired entities.

And we've seen a growing number of states, Massachusetts, possibly Pennsylvania, and some others step in to give their attorneys general new powers to create new reporting obligations. So I think those are the biggest two changes I've been aware of. Great.

HOFF: Dr. Singh?

DR SINGH: I'll just echo what Dr. Fields said. I think to end on an optimistic note, this is an area where a lot of states are paying attention.

And I personally expect to see a lot more activity in the months to come. You know, this can range from having greater reporting requirements to the Office of the Attorney General or setting up an independent health care market oversight committee like we have in Oregon or making non-competes unenforceable.

And so there are a range of activities here that states are taking the lead on that I think will have implications for the future of PE and health care.

HOFF: Great. Thank you both. That's all the time we have for today. Thank you to Drs. Singh and Field for joining us for the first *AMA Journal of Ethics* Grand Rounds.

And thank you to everyone in the audience for tuning in and for your questions. As a reminder, CE credit is available to all viewers whether you're here with us live or watching this later via the AMA EdHub. Links to all of that will be in the chat. We'll be back with the next *AMA Journal* of Ethics Grand Rounds on September 10th.

You can register at JournalOfEthics.org or at the link in the video feed **here**. Thank you very much for tuning in. We'll see you next time.