REPORT 3 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-24)
Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices (D-140.951)

EXECUTIVE SUMMARY

In adopting policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to "study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership".

Increasing investments by private equity firms in health care raise ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. While not inherently unethical, private equity firms' incursion into health care warrants caution. To respond to these issues, CEJA recommends amending Opinion 11.2.3, "Contracts to Deliver Health Care Services" to more clearly encompass partnerships with private equity firms and the ethical concerns that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned hospitals.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-24

Subject:	Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices (D-140.951)
Presented by:	David A. Fleming, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

In response to Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," which instructs our American Medical Association (AMA) to "study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership", your Council on Ethical and Judicial Affairs (CEJA) presented Report 02-A-23, which offered recommendations on amending *Code* Opinion 11.2.3, "Contracts to Deliver Health Care Services." Testimony at the 2023 Annual Meeting of the House of Delegates was predominantly in opposition to the report; concerns were raised regarding the profit motives of private equity and the ethical implications of such businesses' involvement in health care. Overall, testimony expressed a desire that a stronger stance be taken against private equity's involvement in health care, and the report was referred back to CEJA.

BACKGROUND

The past several decades have seen an increase in the corporatization, financialization, and commercialization of health care [1,2]. Since 2018, more physicians now work as employees of hospitals or health care systems rather than serving in private practice [3,4]. Our AMA reports that this trend is continuing: "[e]mployed physicians were 50.2% of all patient care physicians in 2020, up from 47.4% in 2018 and 41.8% in 2012. In contrast, self-employed physicians were 44% of all patient care physicians in 2020, down from 45.9% in 2018 and 53.2% in 2012" [4]. A major factor in these trends has been the incursion of private equity into health care. It is estimated that private equity capital investment between 2000 and 2018 grew from $5 billion to $100 billion [1]. Between 2016 and 2017 alone, the global value of private equity deals in health care increased 17%, with health care deals compromising 18% of all private equity deals in 2017 [5].

Private equity firms use capital from institutional investors to purchase private practices, typically utilizing a leveraged buy-out model that finances the majority of the purchase through loans for which the physician practice serves as security, with the goal of selling the investment within 3 to 7 years and yielding a return of 20-30% [1,5,6]. However, private equity investment broadly encompasses many types of investors and strategies, including venture capital firms that primarily invest in early-stage companies for a minority ownership, growth equity firms that tend to partner

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with promising later-stage ventures, and traditional private equity firms that borrow money through a leveraged buyout to take a controlling stake of mature companies [7].

When ownership shifts from physicians to private equity firms, the firms typically seek to invest resources to expand market share, increase revenue, and decrease costs to make the practice more profitable before selling it to a large health care system, insurance company, another private equity firm (as a secondary buyout), or the public via an initial public offering (IPO) [8]. To expand market share, private equity typically employs a "platform and add-on" or "roll-up" approach in which smaller add-ons are acquired after the initial purchase of a large, established practice, allowing private equity firms to gain market power in a specific health care segment or sub-segment [1,9]. These practices by private equity appear to be driving mergers and acquisitions within health care, significantly contributing to the consolidation of the health care industry that has dramatically increased over the past decade [9].

Proponents of private equity investments in health care claim that private equity provides access to capital infusions, which may facilitate practice innovation and aid in the adoption of new technological infrastructure [6,8]. Proponents also advocate that private equity can bring "valuable managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase healthcare access by synergistically aligning profit incentives with high quality care provision" [10].

Critics argue that private equity's focus on generating large, short-term profits likely establishes an emphasis on profitability over patient care, which creates dual loyalties for physicians working as employees at private equity-owned practices [5,6]. Critics further assert that prioritizing profits likely jeopardizes patient outcomes, overburdens health care companies with debt, leads to an over-emphasis on profitable services, limits access to care for certain patient populations (such as uninsured individuals or individuals with lower rates of reimbursement such as Medicaid or Medicare patients), and fundamentally limits physician control over the practice and clinical decision making [5,8,10].

Despite strong opinions regarding private equity's incursion into medicine, empirical research on the effects of private equity investments in health care, and the impacts on patient outcomes, is currently limited [8]. Zhu and Polsky explain that this lack of research is primarily because "[p]rivate equity firms aren't required to publicly disclose acquisitions or sales, and the widespread use of nondisclosure agreements further contributes to opacity about practice ownership and the nature of transactions" [6]. Private equity firms are emerging to be major employers of physicians. Currently, it is estimated that 8% of all private hospitals in the U.S. and 22% of all proprietary for-profit hospitals are owned by private equity firms [11].

Ethical Issue

Private equity firms' commitment to ensuring high returns on their investments creates a potential ethical dilemma when investing in health care. Whether or not it may be ethically permissible for physicians to sell their practices to private equity firms or for physicians to work as employees for such acquisitions largely depends on how private equity investments impact patient care and outcomes. This report will examine how private equity investments in health care may be ethical, the circumstance and factors to be weighed, as well as how physicians may ethically navigate private equity buyouts and employment.

Relevant Practical Matters for Clinical Practice

A major concern of physicians regarding private equity investments in health care is the potential loss of autonomy, which physicians worry could translate into hospital policies designed for profitability and that limit physicians' decision-making and their ability to care for patients [9]. Loss of autonomy is also associated with increased physician burnout [12]. There are also valid concerns that private equity ownership leads to increased patient volumes and more expensive and potentially unnecessary procedures [9].

Review of Relevant Literature

Empirical Evidence in Medical Literature

More research is needed on the effects of private equity investments in the health care sector, as little empirical evidence exists on how private equity impacts utilization, spending, or patient outcomes. There is widespread concern among physicians that private equity-controlled practices result in worse patient outcomes.

The best evidence that private equity acquisition of hospitals harms patients is a recent difference-in differences study by Kannan et al of hospital-acquired adverse events and hospitalization outcomes associated with private equity acquisitions of U.S. hospitals [13]. Data from 100% Medicare Part A claims at 51 private equity-acquired hospitals were compared with data from 259 matched control hospitals (not acquired by private equity) for hospital stays between 2009 and 2019. While there was no differential change in mortality 30 days after hospital discharge, the researchers did find that after private equity acquisition, Medicare beneficiaries admitted to private equity-owned hospitals experienced a 25.4% increase in hospital-acquired conditions compared with those treated at control hospitals. This increase in hospital-acquired conditions, which are established measures of inpatient quality and are considered preventable, was largely driven by a 27.3% increase in falls and a 37.7% increase in central line-associated bloodstream infections at private equity-acquired hospitals [13]. The increase in central-line associated infections after private equity acquisition occurred even as these hospitals saw a 16% reduction in percutaneous central line placement. Kannan et al hypothesize that such increases in hospital-acquired infections could result from decreases in staffing, as such adverse events have been shown to be correlated with staffing ratios among nurses and that private equity often will reduce staffing and change the clinician labor mix at acquired hospitals as a cost-cutting strategy [13].

In another difference-in-differences study of 578 private equity-acquired practices in dermatology, gastroenterology, and ophthalmology matched with a control group of 2,874 non-private equity-acquired practices, Singh et al found a mean increase of 20.2% in charges per claim and a consistent increase in patient utilization over the first eight quarters after acquisition, with the increase in patient utilization primarily driven by a 37.9% increase in visits by new patients [14]. Overall, the researchers found that "private equity acquisition was associated with increases in health care spending and several measures of utilization, and some evidence of greater intensity of care" [14]. They also found increased coding intensity, and posit that this finding could be due to either changes in coding and billing practices that have more efficient charge capture or, conversely, could reflect upcoding to increase revenues [14]. The motivating factors behind this impact on coding deserves further study.

In a systematic review of 55 studies evaluating trends in private equity ownership in health care and the impacts on outcomes, costs, and quality, Borsa et al found that private equity ownership was associated with an increase in cost to patients or payers, primarily from increased charges and

rates for services as well as inconclusive, mixed results on how private equity impacts quality of care [10]. The majority of the studies (n=47) evaluated private equity ownership of health care operations in the US, but represented a range of settings, the most common of which were nursing homes (n=17), hospitals (n=9), dermatology (n=9), and ophthalmology (n=7). Only eight studies included health outcomes, with two finding beneficial impacts, three findings harmful impacts, and three finding neutral impacts; the three that found harmful impacts were all studies of nursing homes [10]. These results suggest that private equity may impact segments of the health care industry differently.

In their analysis of 281 private equity acquisitions involving 610 unique target hospitals, Gao et al found that over an eight-year window, acquisitions were associated with increased profitability, no change in the rate of closures, no statistically significant changes in mortality or readmission rates, and that the percentage of Medicare and Medicaid patients stayed relatively the same [15]. Over the eight year window, private equity-acquired hospitals increased their operating income by 7.4%. Compared to their matched control groups, private equity-acquired hospitals were equally or more likely to survive, contrary to the prevailing narrative. Private equity-acquired hospitals initially experienced a 14% decrease in the number of core workers (medical workers that include physicians, nurses, and pharmacists) over the first four years but over the next four years this difference dissipates to only 2% and is not statistically significant. In contrast, the decline in administrative workers is significant and persistent, with a reduction of 18% within the first four years of acquisition and a 22% reduction by the end of eight years. This reduction in administrative workers was most profound at nonprofit hospitals. Core workers' wages were not found to change, while administrative workers' wages declined by 7%. No changes to patient mortality rates or readmission were found, except for a 0.9% increase in readmission following pneumonia. In looking at rates of stroke, complications and infections during hospitalization as measure of patient outcomes, no statistically significant differences were found between private equity-acquired hospitals, the control group, or non-private equity acquired hospitals. Private equity-acquired hospitals appear to treat a higher number of resource-intensive patients and decrease their outpatient ratio. Gao et al conclude: "[o]verall, our evidence suggests that PE acquirers improve the operating efficiency of target hospitals without a compromise in healthcare quality" [15].

Normative and Substantive Views in Ethics and Medical Literature

The debate over private equity's incursion into health care often regards private equity acquisitions through a lens of exceptionalism—either negatively or positively. However, although private equity owned hospitals are different in their ownership structure and oversight compared to other traditional health care investors, private equity-acquired hospitals may not be substantively different from other for profit and non-profit hospitals in terms of their stated goals of both solvency and patient care. Zhu and Polsky argue that private equity is not inherently unethical and that there are likely good and bad actors as is the case in many sectors [6]. They add: "physicians should be aware that private equity's growth is emblematic of broader disruptions in the physician-practice ecosystem and is a symptom of medicine's transformation into a corporate enterprise" [6].

The corporatization of medicine is not without ethical and professional risks, of course. In their ethical analysis of orthopaedic surgery practices owned by non-physicians, Moses et al note that the incentives and goals of surgeons might be misaligned with those of the investors, pitting patient care against profits; profit maximization might also lead to wasteful overtreatment as well as a loss of physician autonomy within the practice as well as patient autonomy if physicians are encouraged to be more paternalistic to achieve financial goals [3].

Veatch notes that business ethics and medical ethics are not inherently at odds but admits that differences do exist [16]. Veatch highlights that physicians are uncomfortable with any removal of professional control that may accompany the increasing commercialization of the physician's role. Veatch points out that paradoxically, despite being open to the profit motive in the practice of medicine, the practice as a whole has shown strong resistance to the commercialization of medical practice. For Veatch, the crux of the issue is whether people perceive health care as a fundamental right or a commodity like any other, adding that the notion of health care as a right jeopardizes any profit motive in health care including traditional private practitioner fee-for-service models [16].

Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human good that society has an obligation to provide in some measure to all citizens [17]. Pellegrino argues that health care is substantively different from traditional market goods—it is not fungible, cannot be proprietary because medical knowledge is possible only due to collective achievements, is realized in part through the patient's own body, and requires an intensely personal relationship—and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine turns any interaction between the patient and physician into a commercial transaction subject to the laws and ethics of business rather than to medical and professional ethics. "In this view," Pellegrino writes, "inequities are unfortunate but not unjust […]. In this view of health care, physicians and patients become commodities too" [17]. Rather than claiming that health care is a fundamental right, Pellegrino takes a position of distributive justice to argue that health care is a collective good. Because a good society is one in which each citizen is enabled to flourish, and good health is a condition of human flourishing, society has a moral responsibility to provide health care to all citizens. In this light, health care is both an individual and a social good. Pellegrino also refers to this view as one of "beneficent justice" and explains, "[t]reating health care as a common good implies a notion of solidarity of humanity, i.e., the linkage of humans to each other as social beings" [17]. Pellegrino concludes:

> Understanding health care to be a commodity takes one down one arm of a bifurcating pathway to the ethic of the marketplace and instrumental resolution of injustices. Taking health care as a human good takes us down a divergent pathway to the resolution of injustice through a moral ordering of societal and individual priorities [17].

Whether health care is understood as a commodity or a human good is of course not always so clear in policy and in practice. What is evident, however, is that as health care has become increasingly commodified, the ethical risks to patients and physicians are being realized as physicians find themselves increasingly working as employees and worrying about the impact that commercial enterprises—such as private equity investments—may be having on patients.

Private equity represents the latest and most extreme form of health care commercialization that has escalated over the past few decades. This is the very reason why private equity firms became interested in health care in the first place—they recognized that health care as a market was already ripe for investment and future profitability. Private equity firms use the same investment models in health care that they do in other industries—invest in fragmented markets, acquire the most promising targets as a platform, expand through add-on acquisitions, and exit the market once a significant consolidation of market share can secure a sale, secondary buyout, or IPO [9]. Each individual acquisition is typically too small to require review by anti-trust regulators at the Federal Trade Commission (FTC); at the same time, however, this practice is driving the trend of mergers and acquisitions in the health care sector [9].

Fuse Brown and Hall explain, "[private equity] functions as a divining rod for finding market failures—where PE has penetrated, there is likely a profit motive ripe for exploitation" [1]. They continue that private equity investments pose three primary risks:

> First, PE investment spurs health care consolidation, which increases prices and potentially reduces quality and access. Second, the pressure from PE investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending. Third, physicians acquired by PE companies may be subject to onerous employment terms and lose autonomy over clinical decisions [1].

While the profit motive of private equity firms may drive them to take part in less than scrupulous practices, such as private equity's exploitation of out-of-network surprise billing, there is also potential for private equity to play a more positive role in transforming health care practices [1,18]. Powers et al write:

> Ultimately, private equity—a financing mechanism—is not inherently good or bad. Instead, it acts to amplify the response to extant financial incentives. Within a fee-for-service construct, this is intrinsically problematic. But value-based payment models can serve as an important guardrail, helping to ensure that financial return to private equity investors are appropriately aligned with system goals of access, quality, equity, and affordability [18].

Private equity firms could help accelerate changes in health care payment and delivery towards value-based models. With such models, where financial performance is tied to quality and value, private equity may be incentivized to invest in changes that support better health and lower costs [18].

While more research is needed on the impacts of private equity investments in health care, private equity firms' involvement in health care does not appear to be exceptional within the current corporate transformation of the profession and thus is inherently no more or less ethical than this current trend that has penetrated health care and the practice of medicine far beyond interactions with private equity. As Fuse Brown and Hall point out, "PE investment in health care is just the latest manifestation of the long trend of increasing commercialization of medicine. And so long as the U.S. treats health care as a market commodity, profit-seeking will persist" [1].

Ikrum et al provide a balanced view of the situation and offer some recommendations for partnering with private equity in health care:

> While PE involvement in health care delivery invokes inherent concerns, it has provided much-needed capital for many primary care practices to mitigate the effects of the pandemic and to potentially undertake care delivery innovations such as population health management under value-based payment models. To make partnerships with private investors work, providers need to select the right investors, establish strategies upfront to address misaligned objectives, and define a successful partnership by setting goals for and transparently reporting on indicators that reflect both financial and clinical performance. Safeguards and regulations on sales may also protect patients and providers [7].

Relevant Laws

Fuse Brown and Hall write that despite the market consolidation that results from private equity acquisitions within health care, these acquisitions generally go unreported and unreviewed since they do not exceed the mandatory reporting threshold under the Hart-Scott-Rodino (HSR) Act and that there are currently no legal guidelines for assessing the collective market effects of add-on acquisitions. However, they do note:

> Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade Commission (FTC) and the Department of Justice (DOJ)—can sue to block mergers and acquisitions where the effect of the transaction may be "substantially to lessen competition, or to tend to create a monopoly." To determine whether a transaction may threaten competition, antitrust agencies analyze whether the transaction will enhance the market power of the transacting parties in a given geographic and product market. […] Typically, the FTC oversees health care acquisitions (other than insurance) [1].

To protect patients from harmful billing practices, the federal government has passed the No Surprise Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most states have similar laws, such as those barring fee-splitting and self-referral, and several states have passed laws regulating or restricting the use of gag clauses in physician contracts. The FTC has also recently proposed a rule banning noncompete clauses in all employment contracts [1].

The federal Emergency Medical Treatment and Labor Act (EMTALA) ensures that hospitals with an emergency department provide all patients access to emergency services regardless of their ability to pay. Similarly, federal law requires nonprofit hospitals, which account for 58% of community hospitals, provide some level of charity care as a condition for their tax-exempt status, which the Internal Revenue Service (IRS) defines as "free or discounted health services provided to persons who meet the organization's eligibility criteria for financial assistance and are unable to pay for all or a portion of the services" [19].

Relevant AMA Policy Provisions

Council on Medical Service Report 11-A-10 reviewed the scope and impact of private equity and venture capital investment in health care, and its recommendations were adopted as Policy H-160.891, "Corporate Investors." This policy delineates 11 factors that physicians should consider before entering into partnership with corporate investors, including alignment of mission, vision, and goals; the degree to which corporate partners may require physicians to cede control over practice decision making; process for staff representation on the board of directors and medical leadership selection; and retaining medical authority in patient care and supervision of nonphysician practitioners.

Our AMA further developed and published materials to assist physicians contemplating partnering with private equity and venture capital firms:

- Venture Capital and Private Equity: How to Evaluate Contractual Agreements
- Model Checklist: Venture Capital and Private Equity Investments
- Snapshot: Venture Capital and Private Equity Investments

Policy H-310.901, "The Impact of Private Equity on Medical Training," encourages GME training institutions and programs to "demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition" and asserts that our AMA will "[s]upport publicly funded independent research on the impact that private equity has on graduate medical education."

Relevant *Code* Provisions

The AMA *Code of Medical Ethics* Opinion 11.2.1, "Professionalism in Health Care Systems," acknowledges that "[p]ayment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians" and offers recommendations for physicians within leadership positions regarding the ethical use of payment models that influence where and by whom care is delivered. Key elements include the need for transparency, fairness, a primary commitment to patient care, and avoiding overreliance on financial incentives that may undermine physician professionalism.

Opinion 11.2.2, "Conflicts of Interest in Patient Care," clearly states: "[t]he primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. […] When the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority."

Opinion 11.2.3, "Contracts to Deliver Health Care Services," stipulates that physicians' fundamental ethical obligation to patient welfare requires physicians to carefully consider any contract to deliver health care services they may enter into to ensure they do not create untenable conflicts of interest. The opinion states that physicians should negotiate or remove "any terms that unduly compromise physicians' ability to uphold ethical standards." However, it should be acknowledged that physicians have little leverage in changing entire payment structures or reimbursement mechanisms when negotiating their contracts with hospitals. Similarly, physicians in private practice often feel that they have little leverage in negotiating the sale of their practice; they simply receive an offer and are told they can take it or leave it.

Opinion 11.2.3.1, "Restrictive Covenants," states: "[c]ovenants-not-to-compete restrict competition, can disrupt patient care, and may limit access to care" and that physicians should not enter into covenants that "[u]nreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship". However, many hospitals and hospital systems today now routinely include noncompete clauses as part of their physician contracts. These clauses put physicians at risk of violation of professional obligations and their widespread use has the potential to undermine the integrity of the profession as a whole.

Ethical Analysis

The ethical concerns raised by private equity investments in health care are not unique but instead represent ethical dilemmas that exist due to the very nature of treating health care as a commodity. While private equity firms may choose to pursue financial incentives that are counter to the physicians' ethical and professional responsibilities, private equity's investment in health care is not inherently unethical. However, caution is warranted so it is crucial that policy guidelines be developed to ensure that private equity-acquired hospitals, hospital systems, and physician practices continue to function in an ethical manner that prioritizes patients and patient care over profits. Policies that require greater transparency and disclosure of data on private equity ownership, greater state regulatory control over private equity acquisitions, closing payment and billing loopholes, rules requiring an independent clinical director on the Board of private equity

firms engaged in health care, and means for physicians to help set goals and measure outcomes to ensure the alignment of corporate and clinical values should be considered [7].

Though the current literature is conflicting, there are valid concerns that private equity investment in health care might negatively impact patient outcomes. Since serious potential risks and conflicts of interest do exist, it is essential for physicians considering entering into partnership with private equity firms to evaluate their contracts and require that the agreements are consistent with the norms of medical ethics. Likewise, physicians considering entering into a contractual relation as an employee of a private equity-owned hospital should ensure that their contract does not place them in an untenable conflict of interest or compromise their ability to fulfill their ethical and professional obligations to patients [8].

It is the conclusion of the Council on Ethical and Judicial Affairs (CEJA) that new ethics guidance specifically addressing private equity investment in health care is not needed. There already exists rich House policy and AMA published materials addressing private equity investments in health care. Furthermore, the ethical issues that private equity involvement raise are not limited to that specific sphere of health care investment. In light of the fact that private equity is not unique in the ethical concerns it raises, the Council finds that existing guidance in Opinion 11.2.2, "Conflicts of Interest in Patient Care," and Opinion 11.2.3, "Contracts to Deliver Health Care Services," are sufficient at the present time to address the concerns raised by the increasing investment by private equity in health care; however, it may be appropriate to amend current guidance to more clearly encompass partnerships with private equity firms and the ethical concerns that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned hospitals.

RECOMMENDATIONS

In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended by addition and deletion as follows and the remainder of this report be filed:

> Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.
>
> Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.
>
> As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other

arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy.

When ~~contracting~~ partnering with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement:

(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;

(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;

(iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;

(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;

(v) is transparent and permits disclosure to patients.

(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians must:

(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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