The Private Equity Takeover of Medicine

Critical Corporate Theory Collection

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About the Critical Corporate Theory Collection

The Critical Corporate Theory Collection is part of the *Systemic Justice Journal*, published by the Systemic Justice Project at Harvard Law School. The Collection is comprised of papers that analyze the role of corporate law in systemic injustices. The authors are Harvard Law students who were enrolled in Professor Jon Hanson's Corporations course in the spring of 2021.

The Collection addresses the premise that corporate law is a core underlying cause of most systemic injustices and social problems we face today. Each article explores how corporate law facilitates the creation and maintenance of institutions with tremendous wealth and power and provides those institutions a shared, single interest in capturing institutions, policies, lawmakers, and norms, which in turn further enhance that power and legitimates its unjust effects in producing systems of oppression and exploitation.

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ABSTRACT

Private equity is a decidedly corrupting influence in health care. Wealthy investors and elite institutions use money and power to undermine the traditional practice of medicine and turn a profit from the sickest and most fragile members of society. When treating the sick, healing the injured, and caring for those who cannot care for themselves become a means to an end, and that end is profit, the system has gone seriously awry. If the corporate domination of medicine is to be squared with the moral imperative to deliver quality care and to do so ethically, equitably, and humanely, there must be a legal duty that requires corporate entities to take into account the interests of patients in business decisions. Creating a new fiduciary duty on the part of corporate entities engaged in the practice of medicine to act in the interests of patients as a collective is an incremental — albeit fundamental — step forward, and it will provide an important stepping stone on the path to healing America's ailing healthcare system.

The Private Equity Takeover of Medicine

I. PROBLEM DESCRIPTION

> There can be little doubt that today's health care system has become thoroughly saturated with market ideology. . . . I am puzzled that the consequences of this sort of commercial transformation of medical care have so far generated relatively little concern among health policy experts. A few authors have written about this change, but virtually no connections have been made between it and the current problems of our health care system. Health policy articles often consider whether we should rely largely on market forces or on government regulation to control health care costs . . . . But there is little discussion of the social and health effects of the growth of investor ownership and the transformation of health care into a gigantic profit-oriented business.[1]
>
> Dr. Arnold S. Relman, former editor-in-chief of the *New England Journal of Medicine*, in *A Second Opinion: Rescuing America's Health Care*

Each and every entity in the web of interconnected healthcare providers seeks to turn a profit from the care of patients. This is as true of not-for-profit hospitals as it is of for-profit hospitals.[2] It is as true of doctors, clinics, and physician groups as it is of urgent care centers, dialysis centers,[3] and long-term care facilities.[4] The drive for profits has

produced a system that fails the very patients whom it is intended to serve. Despite the fact that the United States spends twice as much per person as does the average, comparably wealthy industrialized nation,[5] U.S. health care produces substandard outcomes that include the lowest life expectancy among peer nations and the highest chronic disease burden.[6] The single-minded pursuit of profit by providers of healthcare goods and services has left American patients suffering, in the literal sense, with poor heath while struggling to navigate a system that remains dysfunctional, inequitable, costly, and wasteful.

Superimposed on a sick system is a new illness: private equity. In recent years, private equity has rapidly and inconspicuously infiltrated the healthcare sector in the United States,[7] and it is effectuating deleterious changes on the practice of medicine. In the nearly two decades from 2000 to 2019, private equity investment in health care increased twenty-fold, from less than $5 billion to more than $100 billion.[8] There were more than 850 private equity deals in health care in 2018 alone.[9] The COVID-19 pandemic has accelerated the trend toward private equity takeover of medical practices, nursing homes, hospitals, and other providers of health care as they face sustained declines in revenue.[10] In March of this year, the *New England Journal of Medicine* (*NEJM*), one of the nation's leading medical journals,

published an article spotlighting the concerning trend toward private equity ownership of physician practices.[11] Also in March of this year, the Subcommittee on Oversight of the House Committee on Ways and Means held a hearing regarding private equity in health care that highlighted private equity as a driver and accelerator of healthcare disparities in minority communities.[12] Testimony emphasized the lack of reporting and transparency surrounding private equity-controlled nursing homes, the site of a high percentage of COVID-19 deaths.[13]

Private equity's infiltration of health care is a microcosm of a larger problem: the corporatization of medicine and the incentive-skewing effects of profit motive in health care. This Note uses a discussion of private equity as a springboard to address these deeper and more fundamental problems, and it ends by proposing a comprehensive solution.

Private equity is a technical term used to describe collective financial organization for purposes of investing. It is by no means limited to health care; chains including Dunkin' Donuts,[14] Payless,[15] and Toys "R" Us[16] have been the recent targets of private equity investment, sometimes with disastrous results for acquired companies and for their creditors.[17] Using funds from a mix of individual and institutional investors, private equity firms buy target companies in highly leveraged

transactions. Typically, a private equity firm will put up only a fraction of the purchase price, using a strategy called a *leveraged buyout*, and finance the rest of the acquisition cost with debt. It is not uncommon for a private equity buyout to have a ratio of debt to equity as high as 7:1.[18] A physician-seller may be given some equity ownership of the resulting company, but the private equity firm will usually retain a majority ownership.[19]

The life cycle of private equity is fairly uniform: identification and acquisition of a target company; restructuring, which often includes mergers with other similar companies; and exit through sale of the restructured company several years later for a profit. In the context of health care, the aim of the private equity firm is not to retain ownership of acquired practices for the long haul, as physician-owners might do. Instead, the goal is to restructure acquired practices and sell them, with a positive return on investment, in roughly three to seven years.[20] Private equity firms' general partners take a sizeable cut from investors' returns in management and performance fees.[21]

Wealthy, powerful private equity firms, such as Boston-based Bain Capital, take advantage of business opportunities that the solitary investor cannot feasibly undertake due to a lack of financial resources and know-how, such as the merger of 100+ medical practices or clinics

in a region under common ownership.[22] High-volume merger and acquisition (M&A) in a specific sector is commonly referred to as a "roll-up,"[23] often centered around a "platform" company, such as a large, well-managed medical practice.[24]

The ruthless and single-minded pursuit of profit at the heart of private equity investing makes it the ideal case study to examine the implications and effects of profit-seeking in health care, writ large. Private equity is thus important in itself — as a disturbing contemporary trend within health care that warrants intervention — and as an illustration of the larger, forerunning problem of profit-oriented forces, undergirded by corporate law, that effectuate harm on the delivery of care and the practice of medicine.

II. CURRENT DOMINANT NARRATIVE

Private equity firms "capture value"[25] by rapidly improving a business's profit-making performance and savagely cutting costs. Senator Elizabeth Warren, who has proposed federal legislation to rein in private equity's excesses,[26] aptly described the phenomenon: private equity firms "slash costs, fire workers, and gut long-term investments to free up more money to pay themselves."[27] In the context of health care, private equity firms achieve target returns (usually 20% per year[28]) by increasing provision of both non-essential healthcare services and

services that are most highly reimbursed. They put pressure on doctors to see more patients and thus to decrease the amount of time spent per visit. They also dictate management practices, such as whether an office will accept uninsured patients and patients with Medicare and Medicaid. These changes usually go unnoticed, and patients are not informed when practice ownership changes hands: "subtle changes in operations or unfamiliar fees may be the only clues that anything has happened."[29]

Due to cost pressures imposed by management, practices may switch over to cheaper equipment,[30] hire lower cost providers such as nurse practitioners and physician assistants rather than more expensive MDs and DOs,[31] foist surprise medical bills on unsuspecting patients,[32] and then use vulture-like tactics such as "aggressively suing poor patients" unable to pay astronomical bills.[33] Other common mechanisms to boost profitability include performing more out-of-pocket procedures, increasing surgical volumes, and conducting unnecessary testing.[34] That's right, you read correctly: *unnecessary testing*.

The goal of private equity, again,

is to maximize profit —

not to do what is best for patients.

The False Promise of Efficiency

The infusion of capital from private equity may seem beneficial for a practice struggling to stay afloat financially. But the allure is a false one. Private equity undermines the quality of health care, and it epitomizes the worst of corporate influence on the medical profession. Doctors and investors alike buy into the legitimating narrative that private equity will enable practices to achieve an otherwise unattainable degree of efficiency. It will help standardize medical practice, eliminate waste, and reduce variability, they claim. It will enable medical practices, clinics, and hospitals to expand, innovate, integrate, and implement new models of health care delivery,[35] they argue. Private equity's promise of cost-cutting and efficiency is portrayed as a panacea to the problem of excessive health care spending. The ruthless pursuit of efficiency may finally help the United States deliver cost-effective care, precisely what is needed when we spend twice as much per capita on health care as do other, comparably wealthy nations.

But the efficiency-based narrative just articulated, which I will refer to as *the efficiency micro script*, is a convenient smokescreen. Private equity investment does not make health care provision more efficient. Instead, it erodes quality, ignores critical countervailing interests such as patient safety, and undermines the patient-physician

relationship. A growing body of research provides support for the harmful effects of private equity on health care outcomes. For example, private equity-backed hospitals, when compared with matched counterparts, had lower measures of patient experience and fewer full-time employees per occupied bed.[36] Private equity ownership of nursing homes has been associated with higher mortality for nursing home residents,[37] and according to recent research, an estimated 20,150 lives were lost due to private equity ownership of nursing homes over a twelve-year period studied.[38] In addition to taking a human toll, private equity roll-ups reduce competition and drive up prices because acquired entities use their size and scale to exact higher rates from insurers.[39]

Private equity effectively drives a wedge between the interests of patients and the incentives of the providers and the healthcare systems that care for them.[40] In so doing, private equity hides behind a veneer of efficiency while contributing to the very problems it claims to solve. The money and power private equity firms wield allow them to imbue their own role with an unjustified righteousness; as private equity firms and investors solicit buy-in from key stakeholders within health care, they shape the ideologies that surround health care value creation in a way that bolsters their own survival.

The Health Care Value-Creation Paradox

Lurking behind the efficiency micro script is a larger meta script that pervades health policy discussions: markets will bring about the most efficient and desirable outcomes, whereas regulation will stifle innovation and hinder the path to progress. Health care markets, however, are beset by information asymmetries, the principal-agent problem, and moral hazard attendant with insurance that, in totality, make health care markets poorly suited to bring about the desirable outcomes proponents promise. The market ideology behind private equity parallels that of larger health policy schemas and frameworks. The famed Harvard Business School professor Michael Porter declared in a *NEJM* article in 2010 that "[a]chieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent."[41] Yet, there is something inherently perverse about defining value in health care with a denominator that includes a dollar sign. Good health is invaluable. It is not a commodity to be bought or sold. Much like personhood, friendship, and autonomy, the value of good health remains unmeasured because it is immeasurable.

But how can that be, many would ask, if the system so easily places a price tag on the surgery to remove a cancerous growth, the drug

that saves a person's life, or the intensive care unit stay that sustains it? We have become so accustomed to the commodification of health care that we take it for granted. We no longer see its inherent perverseness or object to its exploitation for profit maximization. In his article, aptly entitled *What Is Value in Health Care?*, Porter continued:

> Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge. Nor is value measured by the process of care used; process measurement and improvement are important tactics but are no substitutes for measuring outcomes and costs.[42]

Take a close look at Porter's language: In modern medicine, the patient is the equivalent of a customer. The other actors in the system await rewards based on the value they can create for those customers. According to Porter, rewards should depend on "results, not inputs" — that is, "outcomes and costs." But where is the rhetoric of health? The extension of life? The healing of illness? Where is the American Medical Association (AMA) Code of Ethics' exhortation about the moral "imperative to care for patients and to alleviate suffering"?[43] It is nowhere to be found in Porter's description of "Value in Health Care," an article that has been cited more than 2,400 times and which draws on many of the same principles as private equity's legitimating narrative of efficiency. Paradoxically, the value of health has become

conflated with monetary value creation through provision of health care. Worse yet, the ultimate accrual of value is not to patients, but to providers, to investors, and to the corporate entities of which they are a part.

The Physician's Duty of Care and the Corporate Form

The tension between profit motive and the ethical duty to act in the best interest of patients has generated a latent and longstanding unease that spans the gamut of healthcare providers, from the individual physician to the corporate form.[44] This tension is often viewed as most problematic at the level of the individual physician. As learned intermediaries, physicians have the power diagnose and treat. They function as gatekeepers to utilization of drugs, diagnostic tests, devices, and procedures. As members of a profession that aims to treat, cure, and heal the ill, physicians have the most palpable and direct ethical duty *to act in the interest of the patient*. The AMA Code of Ethics reflects on the patient-physician relationship, characterizing patient care as "fundamentally a moral activity"[45] and one that is based on trust between a patient and a healthcare provider:

> The practice of medicine . . . is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility

> to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for . . . patients' welfare.[46]

Despite the ethical duty that a health care provider owes to "place patients' welfare above the physician's own self-interest or obligations to others,"[47] the reality of medical practice often departs from this ethical aspiration. Tempted by personal gain, some physicians compromise their ethical and legal duties toward patients, conducting themselves and their practices in ways that do not place patients' interests first. Notwithstanding the financial conflict of interest at the heart of medicine, the corporate form increasingly influences how physicians deliver care, what care is delivered, and to whom. The corporate form, not the individual physician, is increasingly at the helm, dictating the hours a clinic operates, the number of patients on the clinic or operating room schedule, the choice to accept or decline new patients, and the precise amounts charged for services.

The role of health care providers and the physician lobby in the private equity takeover of medicine is a complex one. On the one hand, many physicians express serious reservations regarding private equity, and their concerns are consistently tied to fears of erosion of physician autonomy.[48] (Yet, absolute physician autonomy is itself illusory due to the financial conflicts of interest inherent in the practice of medicine that distort providers' incentives, even when they have the best of

intentions.) Other physicians myopically rationalize and legitimate private equity based on appeals to situational factors, such as the increased cost of new technology or reduced practice volumes during the pandemic.[49] But this situationist defense is a bald denial their own agency in the process. Private equity firms, in turn, opportunistically exploit situational factors such as high healthcare costs and low practice acquisition costs during times of economic downturn to validate their own existence and their "contribution" to the healthcare sector. Most concerning is that physician groups have lobbied *against* regulation of private equity in medicine,[50] acting on an instinct for self-preservation and selfishly assuring doctors the opportunity to "cash out" when the time comes. The direct and indirect support that private equity has received from organized medicine,[51] a powerful lobbying force in the United States, represents a form of *deep capture* that is as alarming as it is pervasive.

III. ANALYSIS OF THE ROLE OF CORPORATE POWER IN CREATING HARM

Traditionally, the law has taken steps to combat the perverse financial incentives associated with the practice of medicine. In particular, an old doctrine called the corporate practice of medicine doctrine forbade all but licensed physicians and other licensed

healthcare providers from provision of medical services.[52] Corporations could not obtain medical licenses, nor could they see patients, and so they were prohibited from "practicing medicine," and in effect, from hiring physicians, or owning and controlling physician practices.[53] This doctrine, which has been described by some as obsolete, remains in existence in only a few states,[54] and even in those states, it is not uniformly enforced.[55] Where it exists, loopholes, exceptions, and workarounds[56] have permitted the "corporate practice of medicine" to arise, proliferate, and become the dominant mode of healthcare provision in the United States.

Hospitals are typically deemed exempt from the corporate practice of medicine doctrine, such that, in most states, hospitals can employ physicians. But some states, such as Illinois, prevent the hospital employer from "unreasonably exercis[ing] control, direct[ing], or interfer[ing] with the employed physician's exercise of his or her professional judgment."[57] In other words, a hospital can employ physicians, but it can't interfere with a physician's decisionmaking. California has one of the most robust versions of the corporate practice of medicine doctrine, effectively partitioning business management from medical management of physicians' practices.[58] The corporate practice of medicine doctrine has been criticized as a hindrance to healthcare

innovation, efficiency, and integration.[59] But, as with private equity investment, the efficiency micro script is an illusion — nothing more than an indefensible legitimation of the corporate influence in medicine that drives up costs while squeezing more and more money out of the provision of health care.

Corporate law claims to take seriously the fiduciary duties of its managers and directors toward shareholders and the corporation itself. First, there is a *duty of care*, which requires directors and officers to have a reasonable basis for their decisions[60] and to exercise the level of care an ordinarily prudent person would exercise under similar circumstances.[61] Second, there is a *duty of loyalty*, which requires a director or officer to act in good faith to promote the corporation's interests.[62] Medicine, similarly, claims to take seriously the provider's duty to meet the standard of care — that is, the legal duty on the part of a physician to exercise reasonable care and diligence that the average doctor, skilled in the practice of medicine, would provide to a patient under similar circumstances.[63]

Both the standard of care and the fiduciary duties of care and loyalty are duties that the law, in its respective domains, purportedly applies and upholds in earnest. But, when corporate law and medicine merge, what result? A doctor's legal duty toward the patient she serves

does not extend to the corporate entity's relationship to the collective of patients it serves. An exercise of logic gone wrong, the law as it currently operates finds no legal duty on the part of a corporation that provides medical services to act in the interest of patients. In the bliss of this logical disjunctive, corporations have free rein to operate within a system based exclusively on *shareholder primacy*, with no consideration for the key stakeholder in health care: patients.

Toward Adoption of a New Fiduciary Duty

Many now call for new reporting requirements and transparency of private equity ownership within health care.[64,i] The recent uptick in private equity roll-ups has attracted the attention of the Federal Trade Commission (FTC). Although many private equity roll-ups have anticompetitive effects on the market by increasing prices and reducing competition, they often fall below reporting thresholds. The FTC seems poised to act on this critical issue by bringing more M&A deals within the agency's oversight.[65]

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[i] For example, a federal bill introduced in the House of Representatives last term — H.R. 5825, the Transparency in Health Care Investments Act — would have required annual IRS filings on income, assets, and debt of private equity firms with a controlling interest in health care providers. H.R. 5825, 116th Cong. (2020).

Transparency is undoubtedly a critical starting point, but more can and should be done. The burgeoning of private equity epitomizes the power and influence that money and wealth exert on our most sacred and fundamental institutions. At no point does a private equity–backed group need to account for the patient experience, patient safety, health outcomes, or values woefully deficient in the current framework for healthcare delivery, such as distributional health equity. These factors are, at best, relegated to a secondary status. Patients are but a means to an end, and that end is profit.

As discussed earlier, corporate managers and directors owe duties to shareholders that the law recognizes, including a duty of care and a duty of loyalty. The problem is that limiting the parties to whom these duties extend to shareholders only creates a self-aggrandizing system that leaves out the primary constituency in health care. The lack of corporate accountability to patients creates a system that thrives on profit and fuels greed, while American patients become and remain sicker than citizens in other comparably wealthy, industrialized nations. Pawns in a game of profit maximization, patients have been given a back seat on a runaway train whose primary goal is maximizing shareholder profits. Before the train derails, it is time create a new fiduciary duty on the part of corporate entities that serve patients, one

that inures to the benefit of consumers of healthcare services: corporations engaged in the provision of medical services should be made legally obligated to make business decisions in the interests of patients. Without this important extension of fiduciary duty in the healthcare context, patients are destined to suffer poor health outcomes, while providers continue to maximize profit at their expense.

A new fiduciary duty for corporate entities involved in health care provision to act in the interests of patients is a common-sense and desperately needed fundamental change to corporate law vis-à-vis medicine. Many facets of corporate law, from generous tax structures[66] and lax oversight frameworks to fiduciary duties that only consider shareholders' interests and ignore other stakeholders, create a system in which corporate power breeds more of its kind. Corporate law and the corporate power that undergirds it force other parties, such as physicians, hospitals, and ultimately patients, to accept as inevitable the existence of corporate influence within health care and the harm that it produces. But, make no mistake: the corporatization of health care is neither natural nor inevitable, and the dynamics that it produces are indisputably causing harm.

CONCLUSION

We exist in a moment of malleability with respect to private

equity. Although private equity investment in health care continues to escalate, the efficiency micro script that legitimates private equity is beginning to crumble, as policymakers and members of the public come to recognize the insidious influence of private equity not only on health care prices but also on important metrics of health and health care delivery. Congress and agencies such as the FTC appear poised for change. But, proposals put forth to rein in private equity within health care may ultimately fail precisely because of the power that corporations wield within Congress and other branches of government to shape policies and regulations in a manner favorable to their singular and exclusive prosperity.[67] When the health and prosperity of the American people hang in the balance, no expense should be spared to restrain corporate entities from reinforcing their own wealth and power on the backs of our nation's sickest and most vulnerable.

FURTHER READING

For further reading on the influence of corporate money and power in U.S. health care, see:

STEVEN BRILL, AMERICA'S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM (2015).

ROBIN FELDMAN, DRUGS, MONEY, AND SECRET HANDSHAKES: THE UNSTOPPABLE GROWTH OF PRESCRIPTION DRUG PRICES (2019).

MARTY MAKARY, THE PRICE WE PAY: WHAT BROKE AMERICAN HEALTH CARE — AND HOW TO FIX IT (2019).

ENDNOTES

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[11] Jane M. Zhu & Daniel Polsky, *Private Equity and Physician Medical Practices – Navigating a Changing Ecosystem*, 384 NEW ENG. J. MED. 981, 981 (2021).

[12] *Examining Private Equity's Expanded Role in the U.S. Health Care System: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means*, 117th Cong. (2021), https://waysandmeans.house.gov/legislation/hearings/oversight-subcommittee-hearing-examining-private-equity-s-expanded-role-us [hereinafter *Hearing, Private Equity's Expanded Role*].

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[30] *Id.*

[31] *See* Gretchen Morgenson & Emmanuelle Saliba, *Private Equity Firms Now Control Many Hospitals, ERs, and Nursing Homes. Is It Good for Health Care?*, NBC NEWS (May 13, 2020, 5:55 AM), https://www.nbcnews.com/health/health-care/private-equity-firms-now-control-many-hospitals-ers-nursing-homes-n1203161.

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[33] Morgenson & Saliba, *supra* note 31.

[34] Shriji N. Patel, Sylvia Groth & Paul Sternberg Jr., *The Emergence of Private Equity in Ophthalmology*, 137 JAMA OPHTHALMOLOGY 601, 602 (2019).

[35] *See* Sachin H. Jain, *Practicing Medicine in the Era of Private Equity, Venture Capital and Public Markets*, FORBES (July 27, 2020, 3:00 PM), https://www.forbes.com/sites/sachinjain/2020/07/27/practicing-medicine-in-the-era-of-private-equity-venture-capital-and-public-markets/?sh=d5627a751ac3.

[36] Joseph Bruch, Dan Zeltzer & Zirui Song, Letter, *Characteristics of Private-Equity Owned Hospitals in 2018*, 174 ANNALS INTERNAL MED. 277, 279 (2021).

[37] Atul Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* 26 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2021).

[38] *Id.* at 20.

[39] Casalino et al., *supra* note 28; Zhu & Polsky, *supra* note 11, at 982.

[40] Casalino et al., *supra* note 28; Patel, Groth & Sternberg, *supra* note 34.

[41] Michael E. Porter, Perspective, *What Is Value in Health Care?*, 363 NEW ENG. J. MED. 2477, 2477 (2010).

[42] *Id.*

[43] AM. MED. ASS'N, CODE OF MEDICAL ETHICS SECTION 1.1.1, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf.

[44] For an in-depth discussion of the financial interests in medicine and the conflicts of interest they pose, see MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST (1993).

[45] AM. MED. ASS'N, CODE OF MEDICAL ETHICS, *supra* note 43.

[46] *Id.*

[47] *Id.*

[48] *See, e.g.*, Zhu & Polsky, *supra* note 11, at 982.

[49] *See id.*

[50] *See, e.g.*, Chris Cumming, *California Bill to Rein in Private-Equity Health-Care Buyouts Dies*, WALL ST. J. (Sept. 4, 2020, 4:07 PM), https://www.wsj.com/articles/california-bill-to-rein-in-private-equity-health-care-buyouts-dies-11599250052 (noting that the California Medical Association lobbied against a state bill that would have given the state attorney general power to review acquisitions of health care providers and facilities, including acquisitions by private equity firms).

[51] *See, e.g.*, AM. MED. ASS'N, REPORT 11 OF THE COUNCIL ON MEDICAL SERVICE (A-19) 2–6 (2019), https://www.ama-assn.org/system/files/2019-07/a19-cms-report-11.pdf (reaffirming AMA policy endorsing physicians' "right to enter into whatever contractual arrangements they deem desirable and necessary," *id.* at 7).

[52] Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 110 (Ill. 1997).

[53] *Id.*

[54] *See generally* AM. HEALTH L. ASS'N, CORPORATE PRACTICE OF MEDICINE: A FIFTY STATE SURVEY (Andrew G. Jack et al. eds., 2019).

[55] BARRY R. FURROW ET AL., HEALTH LAW 547–54 (3d ed. 1995).

[56] *Id.* at 552–53.

[57] 210 ILL. COMP. STAT. ANN. 85/10.8 (West 2018).

[58] Paul Giancola, *Navigating the California Corporate Practice of Medicine "CPM" Prohibition*, SNELL & WILMER (Feb. 17, 2017), https://www.swlaw.com/blog/health-law-checkup/2017/02/17/navigating-the-california-corporate-practice-of-medicine-cpm-prohibition/.

[59] *See, e.g.*, James Flannery, *Time to Rethink the Illinois Corporate Practice of Medicine Doctrine in the PPACA Healthcare Market Era*, 24 ANNALS HEALTH L. ADVANCE DIRECTIVE 64, 70–75 (2015).

[60] JAMES D. COX, THOMAS LEE HAZEN & F. HODGE O'NEAL, CORPORATIONS 179–80 (1997).

[61] WILLIAM ALLEN & REINIER KRAAKMAN, INTRODUCTION TO THE LAW OF ENTERPRISE (2002).

[62] COX, HAZEN & O'NEAL, *supra* note 60.

[63] ALFRED W. GANS, CHARLES F. KRAUSE & STUART M. SPEISER, 4 AM. L. OF TORTS, § 15:20.

[64] *See* Patel, Groth & Sternberg, *supra* note 34; *see also Hearing, Private Equity's Expanded Role*, *supra* note 12.

[65] *See* Statement of Commissioner Chopra, *supra* note 23; Fed. Trade Comm'n, Statement of Commissioner Christine S. Wilson, Joined by Commissioner Rohit Chopra, Concerning Non-Reportable Hart-Scott-Rodino Act Filing 6(b) Orders (Feb. 11, 2020), https://www.ftc.gov/system/files/documents/reports/6b-orders-file-special-reports-technology-platform-companies/statement_by_commissioners_wilson_and_chopra_re_hsr_6b_0.pdf.

[66] *See* Andrew Ross Sorkin et al., *Private Equity's Favorite Tax Break May Be in Danger*, N.Y. TIMES (Apr. 23, 2021, 7:50 AM), https://www.nytimes.com/2021/04/23/business/dealbook/carried-interest-biden.html.

[67] *See* Brian Schwartz, *Investment Firms, Private Equity Advocacy Group Hire Lobbyists as Lawmakers Target Tax Loopholes*, CNBC (Mar. 8, 2021, 5:17 PM), https://www.cnbc.com/2021/03/08/investment-firms-hire-lobbyists-as-lawmakers-target-tax-loopholes.html.