

HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted and the remainder of the report be filed.

REPORT 01 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)
The Impact of Private Equity on Medical Training
(Reference Committee C)

EXECUTIVE SUMMARY

Private equity (PE) refers broadly to any activity where investors buy an ownership, or equity, stake in companies or other financial assets that are not traded on public stock or bond exchanges. In recent years, the AMA Council on Medical Education and Council on Medical Service have studied related issues as demonstrated in their reports, “Graduate Medical Education and the Corporate Practice of Medicine” (CME 2-N-20), “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” (CME 3-N-20), “Corporate Investors” (CMS 11-A-19), and “Sources of Funding for Graduate Medical Education” (CME 1-I-15). Per a new directive from the House of Delegates, the AMA has been asked to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back to the House of Delegates with possible publication of their findings.

PE’s role in health care has increased in recent years, as has its influence on graduate medical education (GME). This report reviews the extent of PE in health care and provides examples of PE and for-profit ownership of GME. It also summarizes the impact of PE on the GME learning environment and trainees and offers perspectives from key stakeholders, including the AMA and its related policies.

Understanding of the impact and mitigating any potential negative consequences of PE and for-profit entities in GME will take a concerted effort on the part of the medical and academic communities. There are numerous layers of complexity in what is a rapidly evolving health care practice model, and increasing data collection to recognize trends and ultimately outcomes is warranted. As PE involvement evolves, sponsoring institutions must be open to many kinds of partnerships that can support excellent residency and fellowship programs. This includes diligent monitoring of these programs to minimize disruptions to training and ensure that continuity of excellent education is maintained. The commitment to the educational mission is not only a commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

This report proposes amendments to current AMA policy as well as new recommendations which support institutions or medical education training programs in upholding current policies and developing new policies; protect trainees and empower designated institutional officials (DIOs); encourage transparency as well as changes to the Public Student Loan Forgiveness Program (PSLF); and promote more research and public statements on PE in order to heighten awareness among the physician community.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 01-I-22

Subject: The Impact of Private Equity on Medical Training

Presented by: John Williams, MD, Chair

Referred to: Reference Committee C

1 INTRODUCTION

2

3 American Medical Association (AMA) Policy D-310.947, adopted at the June 2021 Special
4 Meeting, asks that our AMA:

5

6 Work with relevant stakeholders including specialty societies and the Accreditation Council for
7 Graduate Medical Education to study the level of financial involvement and influence private
8 equity firms have in graduate medical education training programs and report back to the
9 House of Delegates with possible publication of their findings.

10

11 This report is in response to the directive. Testimony on this item raised concern for recent
12 incidents where private equity has impacted graduate medical education (GME) funded training
13 positions, such as the Hahnemann closure in the fall of 2019. Additional testimony recognized the
14 importance of recent Council reports on similar topics.

15

16 BACKGROUND

17

18 *What is private equity?*

19

20 The American Investment Council (AIC), an advocacy and resource organization established to
21 develop and provide information about the private investment industry, describes private equity
22 (PE) such that “private equity invests capital in companies that are perceived to have growth
23 potential and then works with these companies to expand or turnaround the business. This capital is
24 contributed by large institutional investors and is organized into a fund. After three to seven years
25 of ownership and working with the company, the fund manager will seek to ‘exit’ the company by
26 taking the business public or selling it for a higher valuation than it was purchased. This exit
27 distributes profits from the sale (‘returns’) to the investors in the fund and the fund manager.”¹

28

29 The Medicare Payment Advisory Commission (MedPAC) adds to this definition: “Private equity
30 refers broadly to any activity where investors buy an ownership, or equity, stake in companies or
31 other financial assets that are not traded on public stock or bond exchanges.”²

32

33 According to the National Association of Securities Dealers Automated Quotations (NASDAQ), a
34 private equity firm is one that uses its own capital or capital raised from investors to take
35 companies private with the aim of running them better and later taking them public or selling them
36 at a profit.³

1 Simply put, PE firms invest in health systems and in health care to make a profit. Investors pool
 2 money to accumulate large sums of cash that are used to invest through the purchase of a business
 3 (e.g., physician practice or health system) with the goal of streamlining operations and cutting costs
 4 to make a short-term profit after selling the business. Sometimes, the return on the investment can
 5 be 20-30% of the original investment.

6
 7 Strategies used by PE firms to ultimately turn a profit include the merging of multiple health care
 8 practices, reducing staff, closing down portions of a hospital or health care practice's operations,
 9 focusing on growing a specific aspect of a health care practice's offerings, and renegotiating
 10 reimbursement rates with insurers.⁴ As PE is not publicly traded, there is little transparency to the
 11 public regarding the business dealings of the PE firm, and with a focus on short-term profit, there is
 12 often little regard to the downstream effects of these strategies on employees, patients, or in the
 13 present case, the residents/fellows training at the institution.

14
 15 In 2020, it was found that hospitals acquired by PE were associated with larger increases in net
 16 income, charges, charge to cost ratios, and case mix index as well as with improvement in some
 17 quality measures when compared to control.⁵ In 2018, PE hospitals were on average located in
 18 lower-income, more-rural areas and had fewer patients discharged and employees per bed.⁶

19
 20 In recent years, the AMA Council on Medical Education and Council on Medical Service have
 21 studied related issues as demonstrated in their reports, "Graduate Medical Education and the
 22 Corporate Practice of Medicine" (CME 2-N-20), "Protection of Resident and Fellow Training in
 23 the Case of Hospital or Training Program Closure" (CME 3-N-20), "Corporate Investors" (CMS
 24 11-A-19) and related issue brief, and "Sources of Funding for Graduate Medical Education" (CME
 25 1-I-15). Further, the AMA developed a guide designed to answer some of the frequently asked
 26 questions posed by trainees faced with closure of their hospital or residency program.

27 *Extent of Private Equity in Health Care*

28
 29
 30 Investments by PE firms in U.S. health care increased from \$23.1B in 2015 to \$78.9B in 2019⁷
 31 with hospitals that are owned by PE firms being a subset of investor-owned hospitals that has
 32 increased in recent years.

<u>American Hospital Association (AHA) Annual Survey</u>	<u>FY 2019⁸</u>	<u>FY 2015⁹</u>
Total Number of All U.S. Hospitals⁸	6,090	5,564
Number of U.S. Community Hospitals (i.e., all nonfederal, short-term general, and other special hospitals)	5,141	4,862
<ul style="list-style-type: none"> • Number of Nongovernment Not-for-Profit Community Hospitals 	2,946	2,845
<ul style="list-style-type: none"> • Number of Investor-Owned (For-Profit) Community Hospitals 	1,233	1,034
<ul style="list-style-type: none"> • Number of State and Local Government Community Hospitals 	962	983

Number of Federal Government Hospitals	208	212
Number of Nonfederal Psychiatric Hospitals	625	401
Other Hospitals (i.e., nonfederal long term care hospitals and hospital units within an institution such as a prison hospital or school infirmary)	116	89

1
2 While there is no clear picture of how many for-profit hospitals, or those owned by PE, have one or
3 more GME programs, the most recent results of the National GME Census of active GME
4 programs provide a glimpse. Results indicated that 7,695 programs' trainees are paid by a nonprofit
5 entity; 1,620 programs' trainees are paid by a for-profit; while 3,550 programs did not answer.¹⁰
6 When analyzing this data, it is important to note that the salary-paying entity may not always be the
7 same as the sponsoring institution or hospital.

8
9 As the number of investor-owned (for-profit) hospitals grows in GME, the greater the dependency
10 of GME programs on their stability and success. Conversely, the closure of such institutions
11 directly impacts GME programs including the residents, fellows, and physician faculty who rely on
12 them for training and employment. One such recent example was the sudden closure of
13 Hahnemann.

14 15 EXAMPLES OF PRIVATE EQUITY AND FOR-PROFIT OWNERSHIP OF GME

16 17 *Closure of Hahnemann University Hospital*

18
19 In fall 2019, Hahnemann University Hospital (HUH), a 500-bed teaching hospital and community
20 safety net in downtown Philadelphia, closed. The closure was the culmination of 20+ years of
21 financial troubles and changing ownerships. Tenet Healthcare Corporation, a for-profit health care
22 company, acquired the hospital in 1998. American Academic Health System, LLC (AAHS), an
23 affiliate of the private equity firm Paladin Healthcare Capital, LLC, purchased HUH in 2018 in
24 partnership with a Chicago-based health care real estate private equity firm, Harrison Street Real
25 Estate Capital, LLC. At the time, suspicions loomed that the purchase of the hospital was really a
26 means to acquire and develop the valuable Center City Philadelphia real estate property rather than
27 to provide patient care in service to the community. While there is a state law that a hospital cannot
28 be closed with less than 90 days' notice, AAHS filed for bankruptcy and shut down HUH's service
29 to the community in about half that time. This left 572 trainee physicians without an Accreditation
30 Council for Graduate Medical Education (ACGME)-accredited program in which to continue their
31 medical education.¹¹ This included 140 newly matched trainees and 59 individuals on J-1 visas
32 who were required to find a position with another GME program within 30 days of the hospital
33 closing or face deportation from the U.S.¹²

34
35 To improve their financial gain, AAHS attempted to sell its government-funded residency slots as
36 "assets" during bankruptcy proceedings, which was allowed by the presiding judge at the time.⁶
37 Bids included a coalition of local hospitals (\$55 million) intending to keep the residency positions
38 in the Philadelphia region, as well as a health care firm in California (\$60 million) that wanted to
39 increase the number of funded physicians in its hospitals. However, the Centers for Medicare &
40 Medicaid Services (CMS) objected to the judge's ruling, arguing that the allocation of Medicare-
41 funded slots is their sole purview and that the auction would set a dangerous precedent. As a result,
42 the auction did not go forward,¹³ and the residency positions were redistributed by CMS using their
43 existing process which prioritizes local hospitals without charge.¹⁴

1 Not only were these professionals left to endure the stress of finding new training positions
2 elsewhere throughout the country, but they were also faced with the loss of the long-tail medical
3 liability insurance coverage needed to continue practice. The [AMA](#) and other organizations took
4 action in support of the affected trainees. Specifically, the AMA joined the Pennsylvania Medical
5 Society (PAMED) and the Philadelphia County Medical Society (PCMS), as well as the
6 Educational Commission for Foreign Medical Graduates (ECFMG), Association of American
7 Medical Colleges (AAMC), and ACGME to pursue a solution for the physicians affected by the
8 closure. This advocacy included encouraging the purchasing of tail coverage by the institutions that
9 accepted HUH trainees among a host of other measures.

10
11 Ultimately, a federal bankruptcy judge approved a settlement with AAHS in early 2020 to pay for
12 the long-tail medical liability insurance coverage for the residents, fellows, and alumni of the
13 hospital's training programs.¹⁵ Since Pennsylvania required that all physicians have tail coverage
14 from previous employers, this effort was particularly important.¹⁶

15
16 Together, the AMA and AMA Foundation committed \$70,000 to assist the trainees affected. Many
17 other organizations contributed to the Hahnemann University Displaced Resident Fund including
18 the American Osteopathic Association, American Board of Medical Specialties, Council of
19 Medical Specialty Societies, National Board of Medical Examiners, PAMED, PCMS, and AAMC.
20 In addition, the ECFMG, now a member of Intealth, created a fund for trainees who had J-1 visas.¹⁷
21 The ACGME also took several steps to support these trainees such as the enactment of their
22 Extraordinary Circumstances Policy to expediently arrange for the transfer of trainees, drafting a
23 compilation of available positions, and making two separate filings with the bankruptcy court.¹⁸

24 25 *Closure of Emergency Medicine department at Summa Health Care*

26
27 Summa HealthTM is an integrated nonprofit health care delivery system in the Akron, OH area that
28 sponsors 19 GME programs, of which 15 are ACGME-accredited residency and fellowship
29 programs. While Summa's employed physician group provided most of the educational and clinical
30 services for these programs, the emergency medicine (EM) services (i.e., staffing of five
31 emergency departments; faculty for EM residency program) were provided by a contracted third-
32 party vendor owned by the private equity company U.S. Acute Care Solutions (USACS). A
33 contract dispute between Summa HealthTM and USACS in late 2016 ended in nonrenewal of the
34 longstanding contract. The EM service physicians were forced to leave the institution and program.
35 The program acquired new leadership and faculty but ultimately lost accreditation causing
36 disruption of services for patients as well as for the trainees within the EM residency program.¹⁹

37
38 The experience for the trainees who went through the change in groups and subsequent closure of
39 the program was difficult for all and devastating for some. It was particularly difficult for the
40 PGY3s given they had long-standing relationships and mentoring from their former attendings,
41 faculty, and program leadership, not to mention a familiarity and comfort from working in a stable
42 learning environment. The AMA, AMA Foundation, and others offered financial support to the
43 affected trainees in need of relocating.²⁰

44
45 This experience led to a revision of Summa's GME Disaster or Interruption in Patient Care Policy
46 as well as a comprehensive restructuring of the institutional contracting process. This overhaul
47 included clarifying the definition of a disaster to include a "catastrophic loss of faculty";
48 reinforcing the authority and responsibilities of the GME Committee (GMEC) members to call an
49 emergency GMEC meeting to discuss a potential impending disaster; making transparent the
50 disaster action steps and procedure; creating a linkage of the GME Disaster Policy to the new
51 contracting process; cataloging all clinical and education service agreements and contracts that

1 involved third-party groups; and quarterly review by the Designated Institutional Official (DIO) of
 2 the status of each agreement at a GMEC meeting to provide the committee oversight of this aspect
 3 of the learning environment. USACS continues to invest in education and has shared best practices
 4 from other institutions where they provide care and operate residencies. In September 2019,
 5 Summa's EM Program was given initial accreditation status by the ACGME effective
 6 immediately.²¹ Emergency medicine training at Summa is once again thriving.

7 *Example of extensive PE ownership of GME*

9
 10 HCA Healthcare is the nation's leading provider of GME and has 5000+ trainees working across
 11 61 hospitals in 16 states. They were responsible for 20% of the 667 new EM residency slots created
 12 in the U.S. from 2016-2019.²² In 2006, HCA was acquired by Bain Capital, Kohlberg Kravis
 13 Roberts & Co. (KKR), and Merrill Lynch and facilitated massive multi-hospital consolidation with
 14 seemingly marginal benefit for patients as well as increased cost-to-charge ratios/profits.^{23,24,25} In
 15 2011, HCA became a public company again. In the meantime, the PE investors had turned a \$956
 16 million contribution into \$3.14 billion in proceeds.²⁵ HCA bought back 3.8 million shares from
 17 Bain for about \$294 million and spent \$750 million to buy back 9.4 million of its common shares
 18 from KKR in 2016.²⁶ The potential impacts of HCA's enormous market share within GME is
 19 concerning and highlights the need for publicly funded, independent research on the impact of
 20 private equity in GME and health care delivery alike.

21 PRIVATE EQUITY AND THE GME LEARNING ENVIRONMENT

22
 23
 24 As mentioned previously, PE is fundamentally driven by the desire to generate a positive margin
 25 for investors through a variety of strategies. Ultimately, these strategies are to grow, repackage, and
 26 sell.²⁷ While it does not appear that PE invests in hospitals, health systems, or practices with the
 27 intent of eliminating or dramatically altering GME, such programs as well as their trainees can be
 28 impacted. Examples include but are not limited to:

- 30 • Erosion of educational mission: One key outcome of GME training is the intentional
 31 exploration of self-directed learning and pursuit of scholarly activity. The focus of PE is on
 32 creating a wide profit margin through operational decisions and efficiencies, and these are
 33 likely to directly or indirectly impact a trainee's ability to learn. Education and learning
 34 require time and mentoring, especially in GME, and thus it is inherently inefficient. PE
 35 firms driven toward profit are likely to eliminate or minimize key aspects of trainee
 36 professional development.
- 37 • Disruption to trainee supervision: A sudden transition of leadership can result in new
 38 faculty not familiar with ACGME common program requirements and/or institutional
 39 requirements which mandate resident supervision of trainees.
- 40 • Residents are not employees: Trainees are commonly in a unique situation in which they
 41 are able to provide significant value to a health system by caring for patients and making
 42 independent decisions that generate clinical revenue. For institutions driven by profit,
 43 however, there may be undue pressure for trainees to contribute to the positive margin
 44 either through their medical practice or being utilized as a relatively low-cost employee
 45 (e.g., shift scheduling).
- 46 • Replacing residents with non-physicians: There is concern that some for-profit institutions
 47 are driving to replace resident physicians with non-physicians in order to not be beholden
 48 to regulatory rules, reduce recruiting budgets, and pay lower cumulative salaries over the
 49 long term.

- 1 • Academic instability: The situation at Hahnemann has been described as a "...concerning
2 trend that underscores the dissonance in mission of private equity and academic
3 medicine."²⁸ This dissonance creates an unstable, if not adverse, working and learning
4 environment that unquestionably impacts trainees and their professional growth.
5

6 IMPACT ON PHYSICIANS IN TRAINING 7

8 As referenced in the above examples, trainees and faculty are significantly impacted by disruptions
9 to GME imposed by PE. The interruption to a trainee's education and experience can impact their
10 ability to finish as scheduled, which has natural implications for their future careers and leaves
11 them at financial risk. The potential loss of long-tail medical liability insurance coverage needed to
12 continue practice as well as confusion regarding the amount of funding that would travel with a
13 transferring trainee from a suddenly closed program is problematic.
14

15 Additionally, the stress of uncertainty, having to find a new GME program, needing to upend their
16 lives to move to the next location, and the cost of moving and rehoming place a heavy weight on
17 the shoulders of residents, faculty, and their families. This problem is further compounded by the
18 likely change of mentorship and planned educational trajectory for learners as they re-enter at
19 another institution.
20

21 International medical graduates (IMGs) with J-1 visas must adhere to rules set forth by their J-1
22 visa status. In the event of a sudden hospital/GME program closure, the implication for these
23 trainees is that they face deportation to their home country if they do not find a new position at
24 another GME program within 30 days of such closure. This short timeline presents significant
25 challenges to professional continuity for reasons in which the IMG has no control.
26

27 Further, the trainees may not have received clarity from all the boards on how the closure could
28 impact the number of rotations or number of procedures (especially those nearing the end of
29 training) they need to complete. The ABIM did state that "all accredited training continues to meet
30 ABIM's policies for initial certification eligibility. Additionally, should a trainee have a 'gap' in
31 training due to relocation, we are committed to working with you and the receiving
32 institutions/program directors to ensure that the maximum flexibility possible under ABIM's Leave
33 and Deficits in Required Training Time policies can be applied."²⁹
34

35 As a result of the Hahnemann closure, CMS changed its rules related to the transfer of indirect
36 medical education (IME) and direct graduate medical education (DGME) funding to accepting
37 institutions. Current Medicare policy allows a temporary cap adjustment for hospitals that accept
38 displaced residents from a hospital or program that is closing so that these hospitals can receive
39 Medicare funding for the displaced residents for the duration of their training. The definition of a
40 displaced resident was such that the resident be physically present at the hospital training on the
41 day prior to or the day of hospital or program closure; however, the revised definition now states
42 that a resident will be considered displaced from the day the hospital or training program publicly
43 announces the closure.³⁰ This rule, however, does not impact GME trainees whose salaries are not
44 paid for through Medicare funds (e.g., trainees in programs that are not accredited by the ACGME,
45 such as sub-specialties that receive approval/certification from specialty societies). Without
46 guarantees for ongoing trainees, the educational continuity of these learners is dramatically
47 impacted.
48

49 The impact on the income of trainees is another important consideration. One study found that
50 while there was significant growth of newly ACGME accredited for-profit affiliated EM residency
51 programs from 2016–2021, the for-profit affiliated programs paid lower salaries to first-year

1 trainees than the nonprofit affiliated programs (even after controlling for other factors that could
2 influence salary). It concluded that better oversight of the salary determination process is needed to
3 protect trainees from underpayment and ensure equity.³¹ While this study was specific to EM
4 programs, there could be broader implications to other specialties where PE investment is a factor.

5
6 Finally, the emotional and psychological toll on trainees working in an unfamiliar, possibly
7 unwelcoming, learning environment likely has significant implications on professional identity
8 formation. Most trainees do not understand and have not received formal education regarding the
9 corporate practice of medicine and thus may not understand or appreciate the economic forces that
10 directly or indirectly impact their education.

11 *Public Service Loan Forgiveness Program*

12
13
14 The involvement of private equity can also impact a physician's eligibility for the Public Service
15 Loan Forgiveness Program (PSLF). The PSLF Program forgives the remaining balance on an
16 individual's direct loans after making 120 qualifying monthly payments under a qualifying
17 repayment plan while working full-time for a qualifying employer. From the 2019 data presented in
18 the AHA table above, 4,116 hospitals are PSLF-eligible, or roughly about 68 percent of hospitals in
19 the U.S. Although most residency and fellowship programs are in nonprofit institutions, the for-
20 profit or nonprofit status of programs is not generally readily discernible to a medical student or
21 resident investigating training options. Additionally, residents and fellows who are training in a
22 nonprofit university-based residency or fellowship program will be excluded from the PSLF
23 Program if they are officially employees of an affiliated for-profit hospital or health system. During
24 the match process, medical students may not be aware of or have access to information about the
25 for-profit status of the entity that will pay their salary as GME often takes place within complicated
26 institutional arrangements of "sponsoring" and "participating" institutions. Even if residents and
27 fellows rotate to several nonprofit clinical sites and funds are contributed to that salary by nonprofit
28 or government institutions, the institution writing the salary check may not be a nonprofit and thus
29 not be a qualifying employer for the PSLF Program. This system can create multiple hurdles for
30 physicians hoping to enter the PSLF Program and means that students will need to be cautious
31 about choosing institutions as part of the residency matching process and physicians must do the
32 same when picking their future place of employment.

33
34 In July 2022, the Department of Education (DOE) announced [proposed rule changes](#) including
35 amendments to regulations governing PSLF in the Direct Loan program to improve the application
36 process and to clarify and expand definitions for full-time employment, qualifying employers, and
37 qualifying monthly payments. The AMA responded to the open comment period encouraging the
38 DOE to adopt the clarifying language developed by the California Medical Association and Texas
39 Medical Association following the definition of "employee" or "employed" so that CA and TX
40 physicians working full-time in private nonprofit hospitals and other organizations that meet the
41 definition of "public service organization" and satisfy all the other PSLF requirements may
42 lawfully participate in the program. The AMA letter also encouraged extension of the current PSLF
43 waiver deadline and expansion of the program so that more associations and a larger range of
44 nonprofits be considered "qualified employers." Further, the letter urged reconsideration of the
45 proposed definition of "public education service" as being too narrow and unclear, as well as
46 reconsideration of the proposal which would allow a total and permanent disability discharge
47 application to be certified by a nurse practitioner, physician's assistant, or a licensed certified
48 psychologist, in addition to an MD or DO.

49 50 PERSPECTIVES FROM STAKEHOLDERS

51

1 Medical specialties that have notably attracted the majority of PE investment include dermatology,
2 orthopaedics, radiology, cardiology, gastroenterology, urgent care/emergency medicine,
3 anesthesiology, and ophthalmology.

4
5 To illustrate, dermatology practices represent 15 percent of recent private equity acquisitions of
6 medical practices even though dermatologists account for only one percent of physicians in the
7 U.S.³² PE firms invest in dermatology management groups (DMGs) which operate multiple clinics
8 and have been known to acquire smaller, physician-owned practices. Research suggests that this
9 consolidation of dermatology practices may be associated with changes in practice management
10 and that PE firms have a financial stake in an increasing number of dermatology practices in the
11 U.S.³³ PE's interest in dermatology points to several factors including: treatment of skin cancer,
12 which is the most common cancer in the U.S.³⁴; a growing older population in need of skin care; a
13 specialty with a history of fragmentation; demand for dermatologists; and profitability of the
14 specialty as well as its specialized services such as Mohs and dermatopathology.³⁵ However, there
15 are considerations for dermatologists. As stated by AMA President Jack Resneck, Jr., MD,
16 "Practice acquisitions at inflated prices in a competitive quest to quickly consolidate fragmented
17 markets and sell practices at a profit to future investors may eventually lead to bankruptcies,
18 leaving dermatologists without practices and patients without services."³⁶ Further, the impact on
19 dermatology training programs is unclear. The American Academy of Dermatology and American
20 Board of Dermatology do not appear to have issued statements regarding private equity and its role
21 in the specialty or impact on GME.

22
23 Another example of PE growth is within ophthalmology, for reasons similar to dermatology. As of
24 2019, 30-35 PE firms were in this market.²⁷ PE's focus is on large and regionally important
25 practices as well as those with a strong ambulatory surgery center (ASC) component. It is believed
26 that such interest in ASCs will increase, as "stable ASC profits and comparatively low enterprise
27 complexity are most in keeping with a corporate environment—much more so than the massive
28 complexity and volatility of the underlying practices themselves."⁴⁶ The American Academy of
29 Ophthalmology (AAO) notes, "Purchases of private equity in the health care market have soared in
30 recent years with hospitals and larger practice acquiring smaller practices. The Academy urges
31 every physician who is considering a practice equity acquisition to perform careful due diligence
32 and seek good counsel." The [AAO](#) offers information to physicians who are considering such
33 opportunities.⁴⁷

34
35 In April 2022, the American College of Emergency Physicians (ACEP) issued a statement on
36 Private Equity and Corporate Investment in Emergency Medicine. In it, they expressed increased
37 concerns about the expanding presence of PE and corporate investment in health care, including
38 emergency medicine.⁴⁸

39
40 Prior to this, the American Academy of Emergency Medicine (AAEM) Resident and Student
41 Association issued an open letter addressing their concerns with regards to training in an
42 environment influenced by corporate entities. Specifically, they urge the profession to, "Purge our
43 specialty societies from the influence and funding from corporate entities" among other
44 recommendations.⁴⁹ Further, this letter calls for a moratorium on new EM residency training
45 programs until issues are addressed, namely concerns about program quality as well as the
46 oversupply of EM physicians.

47
48 Likewise, a 2021 position paper from the American College of Physicians (ACP) concluded,
49 "Ultimately, professionalism, medical ethics, and the patient-physician relationship must guide
50 how physicians navigate the business side of medicine. Nonprofits must act like nonprofits and
51 have a community-oriented mission, private equity firms and investor-owned organizations must

1 attend to the needs of patients and not just shareholders, and physicians should not have a financial
2 stake in an organization with which they have a referral relationship.”⁵⁰

3
4 The ACGME is actively monitoring this situation as indicated in the 2021 National Reporting of
5 Findings from their Clinical Learning Environment Review (CLER) Site Visits. This report noted,
6 “Over the past few years, U.S. health care has experienced a number of accelerated changes. There
7 has been a dramatic increase in mergers and acquisitions of hospitals and related health care
8 entities, resulting in increasingly large and complex health care organizations. There has also been
9 rapid entry of private equity in ownership of physician group practices, particularly among certain
10 specialty-based clinical practices.” By examining clinical learning environments (CLE) during this
11 rapid evolution of the U.S. health care system, the ACGME can illuminate the challenges and
12 opportunities related to how CLEs engage their trainees in planning for and implementing system
13 changes. ACGME programs continue to assist the GME community in testing and sharing new
14 approaches to improving complex challenges in the CLE. Also, the ACGME will revise its
15 institutional requirements in 2022 as part of a 10-year major revision cycle. Thus, the CLER
16 Evaluation Committee is studying the results of their current report and past reports to highlight
17 opportunities for improvement to be considered by the Institutional Review Committee.⁵¹

18
19 Despite the significant level of concern that has been expressed, not all stakeholders have
20 implemented policies designed to combat the impact of PE on GME. The associations and societies
21 that represent residents and physicians should have a vested interest in the impact that PE may have
22 on trainees who belong in the GME programs of said specialties. However, few have released
23 policy statements or positions on the subject; for those who have not, such action may be
24 considered. Further, the water gets muddied when physicians associated with PE firms are
25 outspoken in their societies or if the leadership of such societies has financial relationships with
26 PE-backed management firms.

27
28 Clearly there is concern about PE and its impact on the practice of medicine, but little is known or
29 commented about the impact of PE on GME, whether that be for an individual residency program
30 or for an institution.

31 32 CHANGES TO DATE

33
34 As a result of the Hahnemann closure, CMS implemented a rule change related to the transfer of
35 GME funding from one institution to another in the case of sudden closure of an institution or a
36 program. As described earlier, this change updated the definition of a “displaced resident” and
37 applies to residents currently training in the closing program as well as residents who are not
38 physically present because they have not started training or do not intend to return to training at the
39 closing institution.³⁰ Allowing the closing hospital to temporarily transfer the slots as soon as the
40 closing is made public allows trainees flexibility in finding new programs and allows for more
41 certainty in the continuity of training. This change was encouraged by AMA and AAMC.⁵²

42
43 The Summa example provides other changes that have occurred at an institutional or systemic level
44 that have helped to optimize training at that institution while also taking provisional steps to
45 prevent dramatic closures from recurring in the future.

46
47 While positive developments, there remains concern that the positive changes implemented to date
48 are only temporary and may not lead to lasting change or prevent dramatic closures from
49 happening again as a result of PE investment.

50
51 *Proposed federal legislation*

1 In October 2021, the Stop Wall Street Looting Act ([S. 3022](#)) was introduced to subject certain
2 private funds to joint and several liability with respect to the liabilities of firms acquired and
3 controlled by those funds. The sponsor described it as “a comprehensive bill to fundamentally
4 reform the private equity industry and level the playing field by forcing private investment firms to
5 take responsibility for the outcomes of companies they take over, empowering workers, and
6 protecting investors.”⁵³ A similar bill by the same name, [H.R. 5648](#), also was introduced. Such
7 legislation could pave the way for greater scrutiny and accountability of PE, and ultimately, more
8 protection for trainees and residency programs.

9 10 RELEVANT AMA POLICY

11
12 The AMA has extensive policy addressing the financial involvement of for-profit institutions in
13 GME and the influence of private equity firms on the practice of medicine. The most specific
14 policies related to this topic are as follows:

- 15 • [D-310.948](#), “Protection of Resident and Fellow Training in the Case of Hospital or
16 Training Program Closure,” addresses concerns related to the protection of residents and
17 fellows in the case of training program closures and specifically encourages the AMA to
18 work with other stakeholders to ensure that GME trainees can continue safely on their
19 training pathway despite needing to change institutions mid-training.
20
- 21 • [H-310.904](#), “Graduate Medical Education and the Corporate Practice of Medicine,”
22 acknowledges that the learning environment for trainees must be free of conflict between
23 fiduciary responsibilities of an institution and the educational mission.
24
- 25 • [H-310.943](#), “Closing of Residency Programs,” provides recommendations for some
26 medical education regulatory bodies to actively monitor GME programs for non-
27 educational closing and accommodate those trainees who are impacted when GME
28 programs close for this reason. In addition, it calls for federal regulation to increase
29 transparency and accountability of the training institution in the event of hospital or
30 training program closure.
31
- 32 • [H-310.929](#), “Principles for Graduate Medical Education,” identifies a list of principles for
33 GME including the institutional responsibility as it relates to supporting trainees and their
34 program as well as promoting an environment that is conducive to learning.
35
- 36 • [H-160.891](#), “Corporate Investors,” provides a list of detailed guidelines for physicians who
37 are contemplating investor partnerships.
38
- 39 • [H-215.981](#), “Corporate Practice of Medicine,” opposes federal legislation that preempts
40 state laws prohibiting the corporate practice of medicine, offers guidance to state societies,
41 and encourages continued monitoring of the corporate practice of medicine.
42

43 These policies addressing PE are listed in full detail in Appendix A.

44 45 SUMMARY AND RECOMMENDATIONS

46
47 Understanding of the impact and mitigating any potential negative consequences of PE and for-
48 profit entities in GME will take a concerted effort on the part of the medical and academic
49 communities. There are numerous layers of complexity in what is a rapidly evolving health care
50 practice model and increasing data collection to recognize trends and ultimately outcomes is

1 warranted. AMA Policy D-310.948 instructs the AMA to work with the ACGME to monitor issues
2 related to training programs run by corporate entities and the effect on medical education. Research
3 into this work should continue in concert with affected specialty societies and others.

4
5 Specialty associations and societies that represent trainees and physicians have a vested interest in
6 the impact of PE on GME training, yet few have studied the issue and released policy or statements
7 on the subject. The AMA Council on Medical Education encourages this work from the physician
8 and medical education communities.

9
10 The AMA must continue to advocate that full GME funding follows trainees of a suddenly closed
11 institution to the new location and that funding stays with the institution for the duration of the
12 displaced resident's term. For institutions and systems, tail coverage for malpractice insurance
13 should be mandated and institutional transparency increased to trainees on the closure process as
14 well as disclosure of the intent to sell or close. Benefits (such as COBRA) should be continued in
15 instances where new residency programs are not found in a timely manner. Finally, upon a
16 shutdown, all trainees should be protected from being held captive at a hospital that is not actively
17 admitting patients but hasn't officially "closed." The AMA must also continue to work with the
18 ACGME, ABMS, and ABOMS to accommodate trainees who have been displaced because of
19 program or institutional closure.

20 21 *Conclusion*

22
23 It is likely that the involvement of PE in health care systems, physician practices, and thus, GME
24 programs, is not going away. As this space evolves, sponsoring institutions must be open to many
25 kinds of partnerships that can support excellent residency and fellowship programs. This includes
26 diligent monitoring of these programs to minimize disruptions to training and ensure that continuity
27 of excellent education is maintained. The commitment to the educational mission is not only a
28 commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

29
30 The Council on Medical Education therefore recommends that the following recommendations be
31 adopted, and the remainder of this report be filed. That our AMA:

- 32
33 1. Affirm that an institution or medical education training program academic mission should
34 not be compromised by a clinical training site's fiduciary responsibilities to an external
35 corporate or for-profit entity. (New HOD Policy)
- 36
37 2. Encourage GME training institutions, programs, and relevant stakeholders to:
- 38 a. demonstrate transparency on mergers and closures, especially as it relates to
39 private equity acquisition of GME programs and institutions, and demonstrate
40 institutional accountability to their trainees by making this information available to
41 current and prospective trainees;
 - 42 b. uphold comprehensive policies which protect trainees, including those who are not
43 funded by Medicare dollars, to ensure the obligatory transfer of funds after
44 institution closure;
 - 45 c. empower designated institutional officials (DIOs) to be involved in institutional
46 decision-making to advance such transparency and accountability in protection of
47 their residents, fellows, and physician faculty;
 - 48 d. develop educational materials that can help trainees better understand the business
49 of medicine, especially at the practice, institution, and corporate levels;
 - 50 e. develop policies highlighting the procedures and responsibilities of sponsoring
51 institutions regarding the unanticipated catastrophic loss of faculty or clinical

- 1 training sites and make these policies available to current and prospective GME
2 learners. (Directive to Take Action)
3
- 4 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to
5 allow medical students and physicians to enroll in the program even if they receive some or
6 all of their training at a for-profit or governmental institution. (Directive to Take Action)
7
- 8 4. Support publicly funded independent research on the impact that private equity has on
9 graduate medical education. (New HOD Policy)
10
- 11 5. Encourage physician associations, boards, and societies to draft policy or release their own
12 issue statements on private equity to heighten awareness among the physician community.
13 (Directive to Take Action)
14
- 15 6. Encourage physicians who are contemplating corporate investor partnerships to consider
16 the ongoing education and welfare for trainee physicians who train under physicians in that
17 practice, including the financial implications of existing funding that is used to support that
18 training. (Directive to Take Action)
19
- 20 7. Amend Policy [D-310.948](#) “Protection of Resident and Fellow Training in the Case of
21 Hospital or Training Program Closure” by addition to read as follows:
22
- 23 Our AMA: (6) will continue to work with ACGME, interested specialty societies,
24 and others to monitor issues, collect data, and share information related to training
25 programs run by corporate and nonprofit entities and their effect on medical
26 education. (Modify HOD Policy)
27
- 28 8. Reaffirm the following policies:
29
 - [H-310.904](#) “Graduate Medical Education and the Corporate Practice of Medicine”
 - [H-310.943](#) “Closing of Residency Programs”
 - [H-310.929](#) “Principles for Graduate Medical Education”
 - [H-215.981](#) “Corporate Practice of Medicine” (Reaffirm HOD policy)
33
- 34 9. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind
35 HOD policy)
36
37
- 38 Fiscal note: \$1,000

APPENDIX A: RELEVANT AMA POLICY

Corporate Investors H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
 - a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
 - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
 - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
 - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
 - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
 - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
 - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
 - h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
 - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

Graduate Medical Education and the Corporate Practice of Medicine H-310.904

Our AMA: (1) recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources; and (3) will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care, and other relevant issues.

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948

Our AMA:

1. will ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. will encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. will encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. will work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. will encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. will continue to work with ACGME to monitor issues related to training programs run by corporate entities and the effect on medical education.

Closing of Residency Programs H-310.943

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for “years of continuous training” to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

- A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
 - B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
 - C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
 - D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
- A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
 - B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
 - C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

1) **PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care.

Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.**

Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and

professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form house staff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome

management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

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