No. B338625

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

ART CENTER HOLDINGS, INC. et al.

Plaintiffs and Respondents,

v.

WCE CA ART, LLC, *et al.*

Defendants and Appellants.

Appeal from the Superior Court of California, County of Los Angeles Case No. 24SMCV01185; Hon. Mark Young

AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF NO PARTY

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

Pursuant to California Rules of Court, rule 8.208, the undersigned, counsel for the California Medical Association, certifies that there are no disclosures to be made.

Dated: April 13, 2026

/s/ Long X. Do
LONG X. DO

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I
INTRODUCTION AND SUMMARY

For nearly 170 years, the California Medical Association ("CMA") has advocated against incursions on the ability of physicians to effectively and without undue interference provide the highest levels of medical care to their patients. Central to such efforts is a century-old California law restricting the corporate practice of medicine ("CPOM"). This appeal has potential to become a watershed moment in the development of CPOM law. It presents an issue of first impression for CPOM enforcement, focusing on an important feature of the friendly PC structure that is prevalent in today's healthcare industry.

For many decades, physicians have aligned with hospitals and other non-physician healthcare providers to coordinate care and improve efficiencies for the betterment of patients. Since as early as the 1960s, the economic and administrative realities of American medicine have made it prudent for physicians to also align their medical practices with third-party professional managers and private investors, including private equity ("PE") investors. Outside parties can help to sustain and grow medical practices by expanding the practice's platform, making capital and other financial resources available, and offering managerial expertise. While CPOM condones such alignments, the courts and regulators have rightfully taken a cautionary approach to scrutinize alignment arrangements that result in improper control over medical practices.

The friendly PC structure has fueled a lot of the activities around physician alignments, but it has not been a key focus of CPOM enforcement. Rather than shift control of the clinical aspects of a medical practice, which CPOM prohibits, the friendly PC structure tethers the PC

ownership interests to the lay entities involved in the alignment arrangement. That tether ultimately manifests in a contractual right for the outside interests to replace the physician owner of the friendly PC if certain conditions arise that would jeopardize the sustainability of the alignment. This appeal poses the difficult and untested questions when and how such a power of removal may run afoul of CPOM.

By this amicus curiae brief, CMA presents the tools to help the Court resolve the CPOM questions before it. In the Background section below, CMA summarizes CPOM's historical evolution and adaptation with advancements in the healthcare industry. It becomes clear that CPOM's effectiveness over the past century is rooted in its fidelity to the core tenet of guarding against undue lay control or interference at both the operational and the structural levels of a medical practice. In the Discussion section, CMA explains how and why friendly PC structures have become common in today's healthcare industry, with attention also given to the positive and negative consequences of its uses. CMA then proposes a principled, fact-dependent approach (rather than a categorical prohibition) to applying CPOM to friendly PC structures.

CMA takes no position on the outcome of this appeal, which springs from an order creating a receivership to oversee a medical practice that is subject to the parties' disputes. But the basis for the receivership is a finding by the trial court that the friendly PC structure in this case resulted in lay managers improperly controlling a clinical aspect of a medical practice. The trial court's conclusion was correct, but CMA emphasizes that how to get to that conclusion is more important than the conclusion itself. CPOM must be applied with precision to avoid unintended consequences in the industry.

II

INTERESTS OF THE AMICUS CURIAE

CMA is a non-profit, incorporated professional physician association of over 50,000 members, most of whom practice medicine in all modes and specialties throughout California. CMA's primary purposes are "to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, safe, and cost-effective healthcare.

CMA is the leading voice advocating for robust enforcement of CPOM by private and government actors. CMA consistently engages in legislative advocacy concerning CPOM doctrine by supporting measures that reinforce its protections, opposing efforts that erode or eliminate it, and evaluating proposed exceptions with careful attention to their impact on physician autonomy and the integrity of patient care. CMA also regularly files amicus briefs in federal and state courts on issues impacting the practice of medicine. The CPOM questions raised by this appeal directly bear upon the interests and work of CMA.

III

BACKGROUND

A. CPOM's Core Tenet to Protect Physicians' Independence and Medical Decision-Making Has Abided Over a Century.

The law governing the corporate practice of medicine in California does not appear to have a singular origin but has been traced to varying sources, including early 20th century statutes and caselaw regulating physician licensure and insulating the medical profession from price

competition; state regulations and laws establishing the need for medical care for workers in dangerous industries and remote areas; and the changing roles of hospitals in medical care. *See* Kim, A., *The Corporate Practice of Medicine Doctrine*, CAL. RESEARCH BUREAU (Oct. 2007).[1] Today, CPOM is widely recognized to spring directly from the Medical Practice Act, which is primarily enforced by the Medical Board of California ("Medical Board"), and provides that (1) practicing medicine without a valid license is unlawful (Bus. & Prof. Code §2052), and (2) "[c]orporations and other artificial entities shall have no professional rights, privileges, or powers." *Id.* at §2400. These statutes are interpreted as a ban on corporations practicing medicine because such artificial entities cannot be granted personal licenses or possess professional rights, privileges, and powers. While varying interpretations of CPOM have arisen in varying contexts, this core purpose has remained central. CPOM at its heart has always been and continues to be intended to preserve the independence and exclusive authority of physicians to make medical decisions for the best interests of patients.

California courts first began recognizing CPOM's core purpose in the early 20th century. In *People ex rel. State Bd. of Med. Examiners v. Pacific Health Corp.* (1938) 12 Cal. 2d 156, 160, the Supreme Court observed that "the principal evils attendant upon corporate practice of medicine spring from the conflict between the professional standards and obligations of the doctors and the profit motive of the corporation employer." The Court earlier had explained that "the underlying theory . . . is that the state's

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[1] Online at https://www.compcom.co.za/wp-content/uploads/2015/05/Mediclinic-Annexure-20-CRB-Paper-dated-October-2007.pdf.

licensee shall possess consciousness, learning, skill and good moral character, all of which are individual characteristics, and none of which is an attribute of an artificial entity." *Parker v. Board of Dental Examiners* (1932) 216 Cal. 285, 295.

By 1954, courts expanded the reach of CPOM's purpose to "consistently condemn[]" schemes involving lay individuals "intervening as a 'middleman' for profit in establishing the professional relationships between a [medical] group … and members of the public." *Complete Serv. Bureau v. San Diego Med. Soc.* (1954) 43 Cal. 2d 201, 218 (Spence, J., dissenting). Courts applying CPOM today in varying contexts continue to rely on its core tenet – that CPOM "turns on whether the non-licensee exercises or has retained the right to exercise control or discretion over the physician's practice." *Epic Medical Mgmt., LLC v. Paquette* (2015) 244 Cal. App. 4th 504, 517.

The California Attorney General ("AG") also enforces CPOM and has found its core purpose to derive from regulatory licensing schemes aimed at protecting the public:

> [F]irst, that the presence of a corporate entity is incongruous in the workings of a professional regulatory licensing scheme which is based on personal qualification, responsibility and sanction, and second that the interposition of a lay commercial entity between the professional and his/her patients would give rise to divided loyalties on the part of the professional and would destroy the professional relationship into which it was cast.

65 Ops. Cal. Atty. Gen. 223, 225 (1982) (emphasis added).[2]

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[2] "Opinions of the Attorney General, while not binding, are entitled to great weight. In the absence of controlling authority, these opinions are persuasive." *California Assn. of Psychology Providers v. Rank* (1990) 51 Cal. 3d 1, 17. Indeed, the courts regularly rely on AG opinions to interpret

CPOM case precedents are legion, spanning almost a century to uniformly establish CPOM to be robust and broad, touching upon virtually all aspects of the modern practice of medicine to prohibit practices, schemes, and arrangements that directly or indirectly affect how physicians care for their patients. *See, e.g.*, *People ex rel. Allstate Ins. Co. v. Discovery Radiology Physicians, P.C.* (2023) 94 Cal. App. 5th 521, 533-34 ("Historically, the Medical Practice Act prohibited physicians from practicing through for-profit corporations or artificial legal entities of any kind"); *California Physicians' Service v. Aoki Diabetes Research Institute* (2008) 163 Cal. App. 4th 1506, 1516 ("While the principal evils of the corporate practice of medicine may arise from the stress the profit motive places on physicians, the courts have also noted the danger of lay control"); *Conrad v. Medical Bd.* (1996) 48 Cal. App. 4th 1038, 1041 (recognizing "[t]he 'principal evils' thought to spring from the corporate practice of medicine are 'the conflict between the professional standards and obligations of the doctors and the profit motive of the corporation employer,' and applying CPOM against healthcare district hospitals); *California Association of Dispensing Opticians v. Pearle Vision Center, Inc.* (1983) 143 Cal. App. 3d 419, 434 (CPOM prohibits technical agreements affecting the manner in which professionals practice because it "requires the professional's undivided responsibility and freedom from commercial exploitation"); *Blank v. Palo-Alto-Stanford Hospital Center* (1965) 234 Cal. App. 2d 377, 390 (non-profit hospital may employ radiologists only if the hospital does not interfere with the radiologists' practice of medicine);

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and enforce CPOM. *See, e.g.*, *People ex rel. Allstate Ins. Co. v. Discovery Radiology Physicians, P.C.* (2023) 94 Cal. App. 5th 521, 535-39.

Pacific Employers Ins. Co. v. Carpenter (1935) 10 Cal. App. 2d 592, 594-96 (for-profit corporation may not provide medical services because "professions are not open to commercial exploitation as it is said to be against public policy to permit a 'middle-man' to intervene for a profit in establishing a professional relationship between members of said professions and the members of the public").

B. CPOM Has Evolved to Address Modern Healthcare Delivery Structures and Relationships.

As modern medicine became more widely available, it also became more decentralized and commercialized. The 1970s saw the beginning of substantial growth of for-profit hospitals and nursing homes, followed by a subsequent shift to a business-minded approach to healthcare among all providers. *See* Hoy, E. & Gray, B., *Trends in the Growth of the Major Investor-Owned Hospital Companies*, FOR-PROFIT ENTERPRISE IN HEALTH CARE at 250 (Nat'l Academy Press 1986). The physician practice management industry rose in the 1990s, withdrew, and then was resurrected with the boom in PE investment in the healthcare sector in the 2010s to date. *See* Zeitouni, J., *Is Pursuing Profit Commensurable with Providing Good Health?*, 27 AMA J. ETHICS 305, 305 (May 2025); Reinhardt, U.E., *The rise and fall of the physician practice management industry,* 19 HEALTH AFFAIRS 42, 44 (Jan./Feb. 2000).

It is common nowadays for lay managers and other professional administrators to have prominent roles in the business side of the delivery of medical care. Many physician practices look to outside third parties to provide such services. CPOM has evolved to focus not only on whether there is actual interference with the practice of medicine (the original, classic form of CPOM enforcement), but also on the modern day conditions

in which physicians practice to root out environmental forms of influence and control. Early CPOM cases had laid the seed for such a structural approach. *See, e.g.*, *Pacific Health Corp.*, 12 Cal. 2d at 158 (CPOM cannot be "circumvented by technical distinctions in the manner in which the doctors are engaged, designated or compensated by the corporation"). Courts now readily recognize that CPOM targets operational interference as much as structural interference. *See People v. Cole* (2006) 38 Cal. 4th 964, 970 (CPOM "restricts the relationships that [doctors] may have with corporations") (emphasis added).

Under this modern strain of CPOM enforcement at the structural level, the AG has determined that lay entities cannot employ or contract with physicians to provide medical care. *See* 11 Ops. Cal. Att. Gen. 236, 237 (1948). This is so even where there is no actual interference or control over the practice of medicine. *See id.* at 238-39. The AG explains that the employment of physicians creates "a tendency to debase the profession" and an unacceptable risk that the lay employer or contractor would be able to directly and indirectly influence or control the physician's independence and medical decision-making. *Id.* at 239. Other relationships have been found to be prohibited due to structural control or influence. *See* 54 Ops. Cal. Atty. Gen. 126 (1971) (nonprofit hospital may not employ physicians to provide professional services); 55 Ops. Cal. Atty. Gen. 103 (1972) (CPOM prohibits lay entities from having an economic interest in the net profits of a medical practice); 65 Ops. Cal. Atty. Gen. 223 (1982) (general business corporation may not lawfully engage licensed physicians to treat employees even though physicians act as independent contractors).

Courts too have found CPOM violations where a lay entity has gained undue influence or control over the conditions in which physicians

practice. In *Marik v. Superior Court* (1987) 191 Cal. App. 3d 1136, 1140, the court recognized that it is difficult if not impossible to isolate "purely business" decisions from those affecting the quality of care. Notably, in holding that a provisional director of a medical corporation was required either to be a physician or other qualified licensed person, the *Marik* court recognized the interrelated nature of these concerns and observed:

> For example, the prospective purchase of a piece of radiological equipment could be implicated by business considerations (cost, gross billings to be generated, space and employee needs), medical considerations (type of equipment needed, scope of practice, skill levels required by operators of the equipment, medical ethics) or by an amalgam of factors emanating from both business and medical areas. The interfacing of these variables may also require medical training, experience, and judgment.

Id. at 1140 n.4. Along the same line, in *People v. Superior Court (Cardillo)* (2013) 218 Cal. App. 4th 492, 498, lay owners and operators of medical marijuana clinics were held to criminally violate CPOM where they controlled the operations of the clinics by employing licensed physicians to issue recommendations for medical marijuana, setting the physicians' hours, soliciting and scheduling patients, collecting fees from the patients, and paying the physicians a percentage of those fees.

The Medical Board has issued guidance confirming the vitality of a structural approach to CPOM enforcement. *See* Medical Board, Guidance on Corporate Practice of Medicine.[3] The guidance identifies areas and activities surrounding the practice of medicine that the Medical Board believes are rife for undue control or influence:

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[3] Available online at https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information.

- Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a California-licensed physician;
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants;
- Setting the parameters under which the physician will enter into contractual relationships with third-party payors;
- Decisions regarding coding and billing procedures for patient care services; and
- Approving of the selection of medical equipment and medical supplies for the medical practice.

See also 83 Ops. Cal. Atty. Gen. 170 (2000) ("The selection of a radiology site with appropriate equipment and operational personnel . . ., as well as the selection of a qualified radiologist to view and interpret the films, would involve the exercise of professional judgment").

C. The Corporatization of Healthcare Under CPOM.

The expansion of healthcare did not sputter as CPOM adapted to ensure physician independence at a structural level. Instead, two important developments in reaction to CPOM paved the way for continued corporatization of healthcare, one legislative and the other practical.

1. The Advent of the Medical Professional Corporation Expanded Medical Practices.

Prior to 1968, CPOM made no distinctions in prohibiting corporations from practicing medicine. Whether under physician ownership or otherwise, all corporations were subject to the prohibition. Conversely, only individually-licensed physicians or general partnerships

of physicians could deliver medical care. That meant physicians could not organize themselves and their medical practices as business entities to avail themselves of corporate protections, despite the commercialization of the healthcare industry. The California Legislature addressed this problem in 1968 with the enactment of the Moscone-Knox Professional Corporation Act ("Moscone-Knox"), Corporations Code §§13400 *et seq*.

A major concern for allowing general corporations to engage in the practice of medicine was that they may include lay shareholders and directors who are not bound by the same ethical standards that professional licensees are. Through the Moscone-Knox Act, a professional corporation ("PC" or "medical corporation") could deliver medical care under the ownership and control of licensed California physicians. To do so, the Legislature established a statutory exception from CPOM for "medical corporations practicing pursuant to the Moscone-Knox" Act but only "when such corporation is in compliance with the requirements" of the Act. Bus. & Prof. Code §2402.

A PC is an organization made up of individuals of the same trade or profession that is organized to "engage[] in rendering professional services." Corp. Code §13400(b). For medical corporations, one or more California-licensed physician(s) must cumulatively hold 51 percent or more of the total number of shares of the corporation. *Id.* at §13401.5. While nonprofessionals cannot be shareholders, other specified licensed professionals can hold shares of the medical corporation so long as the non-physician shareholders do not collectively hold more than 49 percent and the number of those non-physician shareholders does not exceed the number of physician shareholders. *See id.* at 13401.5(a). Other specified licensed professionals can also serve as directors and officers in the

medical corporation. Bus. & Prof. Code §2408.

Nothing in the Moscone-Knox Act prohibits a sole shareholder from forming and operating a medical corporation. Indeed, the Act explicitly provides that "a professional corporation which has only one shareholder need have only one director who shall be such shareholder and who shall also serve as the president and treasurer of the corporation." Corp. Code §13403. This is permissible only if the sole shareholder in the medical corporation is a California licensed physician. Such sole-shareholder medical corporations have become common as physicians seek corporate protections and benefits for themselves and their medical practices.

The prevalence of medical corporations has enabled medical practices to more easily enter joint ventures and other business alignments with other non-physician providers, lay entities, and investors while staying in compliance with CPOM. *See Markow v. Rosner* (2016) 3 Cal. App. 5th 1027, 1033 (CPOM "generally precludes for-profit corporations – other than licensed medical corporations – from providing medical care through either salaried employees or independent contractors") (emphasis added). Under the corporate form, with its protections and tax advantages, physicians can take on more risks entering innovative and new practice arrangements or align with other providers that cannot directly employ or contract with physicians.

Many medical corporations contract with outside experts to handle the business side of medical practice (e.g., revenue cycle management, business management, and strategic development). Lay management companies (often called management service organizations or MSOs)

became commonly involved with medical practices.[4] And they also became a focus of CPOM due to their close ties to the operations of a medical practice. One commentator asserts that "MSOs have become a vehicle for corporate entities to functionally own medical practices while complying with corporate-practice-of-medicine (CPOM) prohibitions." Zhu, J., *Regulating Corporate Control in Health Care – Oregon's Attempt to Revive the CPOM Doctrine*, 393 N. ENGL. J. MED. 1972, 1972 (Nov. 15, 2025). The Medical Board takes a more nuanced approach and cautions that, "[w]hile a physician may consult with unlicensed persons in making the 'business' or 'management' decisions . . ., the physician must retain the ultimate responsibility for, or approval of, those decisions." *See* Medical Board CPOM Guidance, *supra*.

2. PCs Became "Friendly" with Managerial and Capital Resources to Further Expand the Reach and Scale of Medical Practices.

The development of the friendly PC model expanded and quickened the pace of physician alignments by making it less risky to connect medical practices with non-physician managerial and capital resources. Non-physician supporters and investors of a medical corporation are

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[4] "An MSO is an entity that provides non-clinical services — such as billing, human resources, payer contracting, and information technology support — to physician practices and other health care providers. By outsourcing these functions to MSOs, medical groups can focus on patient care while benefiting from economies of scale, operational efficiencies, and professional management expertise." Rooke-Ley, H. *et al.*, *The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices*, THE MILBANK MEM. FUND (April 2025), <https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices/>.

incentivized to commit capital and personnel resources if they have adequate assurance that their investments are sound and stable. A hospital or pharmacy company, for instance, may support the business operations and development of a medical practice to grow or stabilize it and thereby share in the benefits of an alignment arrangement. Complying with CPOM means that the medical decision-making and clinical aspects must remain under control of the physician-side of the arrangement. To facilitate outsider commitments to a medical practice under these conditions, a contractual "glue" must be formed to hold the alignment together, subject to compliance with CPOM.

There are many tools and mechanisms to make a PC "friendly" to outside stakeholders. Stakeholders can create the PC or at least determine who holds ownership of the PC at the onset of the arrangement, thereby having some assurance that the physician owner who takes the helm of the PC is trustworthy and aligned with the arrangement. Hospitals, for instance, have created friendly PCs and slotted their chief medical officer (a hospital-employed physician administrator) to serve as the friendly PC owner. If the chief medical officer is replaced by the hospital, the new officer would become the owner of the friendly PC.

Alternatively, restrictions for existing PCs could be put in place to control how the physician maintains ownership of the PC. Through various contractual agreements – such as stock transfer restriction agreements, succession agreements, and continuity agreements – the parties can set parameters for ownership of the PC. Most often, restrictions are imposed limiting the ability of the physician owner to transfer shares of the PC to an unknown outsider. Physician owners also are often restricted from diluting or splitting their shares or taking other

actions that could undermine the mechanisms that have been put in place to restrict how they exercise ownership over the shares.

Guardrails could also be raised to ensure the physician does not use their ownership interest to divest the PC from the venture. This often takes the form of control over the identity of the friendly PC ownership. For example, when the physician owner becomes ineligible to continue owning the PC (e.g., through retirement, disability, or loss of licensure), the outside stakeholder could substitute in a replacement physician owner to minimize disruption and maintain continuity of the PC within the alignment arrangement. Different friendly PC arrangements may have different "triggering events" that vest such replacement authority in the stakeholders. In addition to replacing an ineligible physician owner, CMA has seen broadly-defined triggering events that allow the manager to exercise the replacement power if it determines the PC owner has taken actions detrimental to the viability of the medical practice (such as committing fraud or malpractice). The triggering event in this case is as broad as can be, essentially giving the manager carte blanch authority to replace the PC owner whenever and for whatever reason.

Friendly PCs often go hand-in-hand with MSO arrangements. That is, investors connect the PC to professional management and administrative services provided by the MSO (which is owned or backed by the investors), and the MSO holds the ownership replacement rights if a triggering event arises. Two recent cases illustrate the demarcation of permissible and impermissible alignments of medical practices with managers. In *Epic Medical Mgmt., LLC v. Paquette*, *supra*, the court upheld the legality of a management services agreement between a physician and MSO. The agreement delineated responsibilities, with the

MSO handling non-medical aspects of the practice, such as leasing office space, providing equipment, and managing billing, marketing, and accounting, while the physician retained full control over medical decisions. *Epic*, 244 Cal. App. 4th at 517. The court emphasized that the MSO did not exercise control or discretion over the physician's medical practice under this arrangement.

In contrast, the court in *Discovery Radiology*, *supra*, found CPOM violations by an MSO under a management arrangement with a friendly PC. The court held that "a nonlicensed individual need not examine a patient or render a medical diagnosis to engage in the unlicensed practice of medicine – to the contrary, a nonphysician unlawfully practices medicine if he or she exercises undue control over a medical practice." *Discovery Radiology*, 94 Cal. App. 5th at 539. The MSO exercised such unlawful control "by choosing physicians to provide medical services, selecting medical equipment, determining the parameters of physicians' employment, including case load and compensation, and making billing decisions." *Id.* Unlawful control was also found in how the medical professional corporation was formed. The lay owner of the MSO created the friendly PC, filed documents on the PC's behalf with the California Secretary of State and other regulatory agencies, and recruited physician owners. *Id.* at 539-40. Further, the physician owners of the professional corporation "exercised no control, supervision or management of the corporation." *Id.* at 540.

Though different results were reached in *Epic* and *Discovery Radiology*, the two cases consistently applied the core tenet of CPOM to management arrangements between MSOs and physicians. Both cases turned on whether the arrangements resulted in undue control by the lay

entities over the delivery of medical care. *See Discovery Radiology*, 94 Cal. App. 5th at 535 (recognizing that nonphysicians "may manage some nonmedical/ business aspects of a physician's practice without violating the Medical Practice Act," but "a violation of the Act occurs if a nonphysician exercises 'control or discretion' over a medical practice"); *Epic*, 244 Cal. App. 4th at 517 (CPOM violation by a manager "turns on whether the non-licensee exercises or has retained the right to exercise control or discretion over the physician's practice"). That focus should now be fixed upon the question in this appeal whether the removal power in a friendly PC arrangement held by an MSO violates CPOM.

IV

DISCUSSION

A. This Case Presents an Issue of First Impression That Can Have Widespread Impact in the Healthcare Industry.

Like *Discovery Radiology*, this case involves a friendly PC arrangement. The arrangement was integral to a PE investment plan to acquire a successful medical practice and continue it as an ongoing medical practice business, but with the aid of the PE-backed MSO providing management and administrative services. As is common, the PE investors tethered the medical practice to this alignment arrangement by creating a friendly PC subject to some ownership control by the MSO. Specifically, Dr. Surrey – the original physician owner of the medical practice – signed a Consulting Agreement that was terminable by the MSO for any reason, coupled with a Continuity Agreement that empowered the MSO to replace Dr. Surrey with another physician owner of the MSO's choosing if the Consulting Agreement were terminated. *See* App. Appendix ("AA") 3647-

49. According to the trial court, "[e]ssentially, under the contract, [the MSO] had the right to exercise sole and absolute discretion to remove Dr. Surrey from control over the clinical entity, SCRC." AA3649-50.

The CPOM violations in *Discovery Radiology* were premised on findings that the lay manager extensively exercised control over the medical practice of the PC. *See Discovery Radiology*, 94 Cal. App. 5th at 539. No such facts of direct control are present in this case. The CPOM violations here are founded upon the MSO possessing and exercising a contractual right to replace the physician owner of the friendly PC due to a disagreement with the owner over an issue of clinical importance.

Specifically, the trial court noted "there is no dispute that hiring, firing, and discipline of clinical personnel were clinical subjects reserved to [the friendly PC]. Yet, [the MSO] had the contractual ability to remove Dr. Surrey from his position [as PC owner] if they disagreed with his decisions." AA3649. "If they have such a right, then [the MSO] necessarily had undue control over the doctor-owner of [the friendly PC]." *Id.* The court found that the MSO, "in fact, exercised this right when Dr. Surrey refused to take action, and indirectly fired [a physician employee] via their control of Dr. Kuroki [who the manager used to replace Dr. Surrey as the friendly PC owner]." *Id.* Put another way, the "Court conclude[d] that the mechanisms used to accomplish the goals of [the MSO] and ensure the firing of Dr. Ghadir, namely, the Consulting Agreement and the related Continuity Agreement, violate California law by giving [the MSO] control over clinical aspects of the medical practice." *Id.*

CMA agrees with the trial court that the MSO's exercise of the right to replace the PC owner under the facts of this case violated CPOM. The MSO took such drastic action in order to impose its will to terminate an

employee physician over the objection of the physician owner. As the trial court noted, such a clinical personnel decision directly affects patient care and falls within the purview of protected medical decision-making under CPOM. The MSO effectively was acting as the employer of the physicians of a medical practice, which violates the traditional strain of CPOM enforcement to prohibit lay interference in the clinical functions of a medical practice.

The trial court went further to find a structural violation of CPOM. It reasoned that "[e]ven the presence of such agreements [giving the MSO the right to replace the PC owner] violate California's ban on the unlicensed practice of medicine because medical doctors are placed in an untenable position – comply with the demands of their corporate partners even when involving medical decisions, or be removed and stripped of your ownership shares without any recourse." AA3649 (emphasis added). The trial court appears to have reasoned that CPOM is violated merely by the removal right existing in the Continuity Agreement, regardless whether and how the right is exercised. Such a ruling falls under the more recent strain of CPOM enforcement focusing on the structures and business arrangements that create unacceptable risks of undue control.

There appears to be no AG opinion or precedential authority supporting the trial court's apparent conclusion that a structural violation of CPOM results from a mere contractual right giving a manager the power to replace a friendly PC physician owner. That does not mean that the trial court was incorrect to the extent it reached this holding. Rather, in evaluating this important issue of first impression, CMA urges the Court to fully consider the prevalence, legitimate needs, and possible abuses of a common tool used in most friendly PC arrangements – the

ability of lay stakeholders to an alignment arrangement to retain some control over the ownership of the friendly PC. Indeed, almost every friendly PC arrangement depends on such a term in some form or another, and the Court's decision in this case can have widespread impact on most if not all friendly PC arrangements involving not only PE investors but other investors and stakeholders who may align with physicians, including many nonprofit hospitals and other community groups that arrange for the delivery of medical care using friendly PCs.

B. Friendly PCs Facilitate a Wide Variety of Physician Alignment Arrangements with Many Different Types of Stakeholders.

1. Physician Alignments with Lay Entities Are Common and Can Serve Legitimate Purposes.

As explained above in section III.C, friendly PC arrangements are common and can be useful to carry out business alignment strategies between physicians and lay managers or other partners. Federal PACE programs, for instance, empower community organizations to access federal resources to provide comprehensive medical and social services to certain frail, elderly people still living in the community. *See generally* Centers for Medicare and Medicaid Services, FAQ webpage on Program of All-Inclusive Care for the Elderly (PACE).[5] Such programs are operated through nonprofit corporations that are not exempt from CPOM, and thus the delivery of medical services under a PACE program must be arranged through a friendly PC. The Ryan White HIV/AIDS Program similarly

[5] Online at https://www.cms.gov/medicare/medicaid-coordination/about/pace#:~:text=Physicians%20&%20other%20health%20professionals,Overview%20of%20the%20PACE%20program.

provides federal financial support to nonprofit organizations to serve the HIV and AIDS community, but such organizations in California can only do so in compliance with CPOM through engagement with friendly PCs. These are but two examples of how friendly PC arrangements are deployed in California to expand the reach of medical services outside of traditional healthcare providers, such as medical offices and hospitals.

Hospitals for decades have aligned with physicians to redesign care to improve quality, decrease costs, and positively impact efficiency. Operational alignment can take the form of medical directorships, joint ventures, or service line co-management agreements that allow hospitals to access physicians' clinical management and administrative expertise. Alignments can also be transformational as they reset organizational governance and structural models of practice to support broader clinical integration across a healthcare community. These include hospital-backed or -created friendly PCs that enter into professional service agreements with hospital departments.

Other reasons explain the increase in physician alignments. "There is [] a generational shift among new physician goals and values that has been a catalyst for the change from the current-state model of the physician-hospital relationship. Physicians joining the work force increasingly value maintenance of lifestyle and time for nonwork-related activities." Sowers, K. *et al.*, *Evolution of Physician-Alignment Models: A Case Study of Comanagement*, 471 CLIN. ORTHOP. RELATED RES. 1818, 1819 (March 2013). As more physicians join medium and large organizations (turning away from small or solo practice), the AMA recently reported measurable improvements in physician job satisfaction and decreases in professional burnout. *See* Berg, S., *Burnout eases for doctors*

at every career stage as support rises, AMA News Wire (July 22, 2025).[6]

Friendly PC arrangements drive these various alignment models because, as explained above, they incentivize non-physician partners to commit resources, time, and planning to medical corporations that, under CPOM, must preserve separation and independence of the clinical aspects of the business. *See, supra*, section III.C.2. Without some control over friendly PCs in these arrangements by nonphysician stakeholders and investors, the venture can become less stable and riskier and potentially drive away outside interest in aligning with medical corporations and practices. From an industry policy perspective, CPOM enforcement needs to be precise to weed out friendly PC structures that run counter to its purpose of protecting physician independence and medical decision-making without forestalling the free flow of market forces that innovate and advance alignments of the delivery of medical care for the benefit of the public and patients.

2. All Alignment Models Carry Inherent Risks of Undue Control Over Medical Practices in Violation of CPOM.

While there are plenty of examples of legitimate physician alignment arrangements that improve care and public health, the ability of lay parties to exercise some control over ownership of medical corporations in these alignments raises serious risk of abuse. Much research has been published on the deleterious healthcare impacts from physician alignment models that prioritize profit and other non-clinical motives over clinical care. *See, e.g.*, Saghafian S. et al., *The Impact of*

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[6] Online at https://www.ama-assn.org/practice-management/physician-health/burnout-eases-doctors-every-career-stage-support-rises.

Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices, NAT'L BUREAU OF ECON. RES. at 1 (Working Paper Series) (Feb. 2023) ("We also find that although integration improves operational efficiency . . ., it negatively affects quality and overall spending"); Rooke-Ley, *Corporate Backdoor to Medicine*, *supra*, at 5-6 (discussing negative impacts on pricing, quality, and utilization of care along with physician satisfaction and morale due to PE-backed MSO alignments with friendly PCs).

Though the friendly PC structure has existed for decades, its prevalence in recent physician alignment arrangements that have yielded negative impacts on patient care has drawn scrutiny. One study concluded that "the structure that presents the greatest risk of this inversion of control is the 'friendly' physician model." Rooke-Ley, *Corporate Backdoor to Medicine*, *supra*, at 6. By having the authority to control or replace the physician owner in a friendly PC, "the MSO can . . . effectively act as shadow owners of the practice while remaining CPOM compliant on paper." *Id.*; *see also* Zhu, J., *Regulating Corporate Control in Health Care*, *supra*, at 1 (identifying the friendly PC model as a "workaround" to CPOM's purpose of preventing conflicts between patient care and obligations to shareholders).

Generally, the "financialization" of healthcare has elevated lay profit motives into more central, prominent positions in physician alignment models. "The central idea is that the financial sector has increased its influence over the economy in general and that financial calculations have come to dominate the decision-making in capitalist firms. While corporations used to make money by producing or trading goods and services, increasingly their profits depend on financial activities. Financial

analysts view companies as assets to be bought and sold and as vehicles for extracting wealth through financial strategies rather than primarily through productive activities." Appelbaum, E. & Batt, R., *Financialization in Health Care: The Transformation of US Hospital Systems*, CTR. FOR ECON. & POL'Y RESEARCH (Sept. 9, 2021)[7]

Though other types of investors and perhaps even physicians themselves in some instances have driven the push towards financialization in healthcare, much attention has been paid lately to PE investors and acquisitions. PE investors spent more than $200 billion on healthcare acquisitions in 2021 and $1 trillion in the past decade. *See* Blumenthal, D., *Private Equity's Role in Health Care*, THE COMMONWEALTH FUND (Nov. 17, 2023).[8] PE firms have long been active in hospital, nursing home, and home care settings, but investments in and acquisitions of physician practices have skyrocketed over the past decade: a six-fold increase from 75 PE deals in 2012 to 484 in 2021. *Id.* PE firms have consolidated control of physician markets through such activities. One study found that in 13 percent of metropolitan areas, a single PE firm owns more than half of the physician market for certain medical specialties. Scheffler, R. *et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets*, AMER. ANTITRUST INST. at 4 (July 10, 2023).[9]

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[7] Online at https://perma.cc/UT5S-Q8RZ.

[8] Online at https://www.commonwealthfund.org/publications/explainer/2023/nov/private-equity-role-health-care.

[9] Online at https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

Researchers have widely documented and concluded that PE acquisitions of medical practices has resulted in many harms on medical care and patient access. These include price increases for medical care, especially in areas controlled by PE firms, decreases to patient access and quality of care, increases in medical practice bankruptcies, and physician job dissatisfaction. *See id.* at 4-5; Fuse Brown, E. & Hall, M., *Private Equity and the Corporatization of Health Care*, 76 Stan. L. Rev. 527, 531 (2024) ("PE financializes health care, using health care entities as a means to extract wealth for investors, thereby prioritizing quick profits at the expense of patient care"); Zeitouni, J., *Is Pursuing Profit Commensurable with Providing Good Health Care?*, *supra*, at 305 ("Every person in this country has received or will receive health care, and a deleterious actor in health care can dramatically affect the delivery, quality, and equity of health care in the United States—deleterious being the key operating word. Given increasing inequity and costs of health care services and goods, PE is poised to be a disruptive actor in health care"); Field, R., *Can Current Legal Tools Respond Adequately to Risks of Private Equity Investment in Health Care?*, 27 AMA J. ETHICS 305, 334-35 (May 2025).[10]

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[10] That is not to say that researchers are only sour about the impact of PE acquisitions. Positive effects have also been noted:

> [T]he business literature documents many instances of acquired entities benefiting from PE investment.16 Such benefits are most notable when needed capital has been infused into failing or underperforming companies or service delivery streams.17 PE funding has also helped financially stable providers expand their range of services. For example, one partnership was developed to create 67 primary care clinics focused on elderly patients with an investment of $800 million.18 Some smaller independent physician practices stand to realize benefits from PE investment by

As this case illustrates, the friendly PC structure allowed a PE-backed MSO to control clinical aspects of a medical corporation. In assessing whether CPOM violations occurred in this context, the trial court properly focused on the MSO's ability to determine who owns the friendly PC, and it was right to find a CPOM violation when the MSO exercised its contractual right to terminate the physician owner's Consulting Agreement in order to trigger its right under the Continuity Agreement to replace the owner. As explained below, CMA believes extra care should be taken in evaluating whether the trial court was also right to the extent it found a CPOM violation by the mere presence of that contractual right of removal, which is a common feature of friendly PC structures. Put another way, this Court's task is perhaps to strike new ground and advance CPOM doctrine to evaluate the removal authority found in many friendly PC structures and separate when it is permissible and when it results in unlawful control over the practice of medicine.

C. A Fact-Based, Context Driven Application of CPOM's Core Tenet, not a Categorical Rule, Should Be the Analytical Approach to Parse Out Acceptable From Unacceptable Friendly PC Structures.

There is abundant evidence that physician alignment arrangements, especially when they involve PE-acquisitions of medical practices, can result in undue and impermissible lay control over the practice of medicine. It also cannot be denied that the use of friendly PC structures in these alignment arrangements can be the enabling factor for

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> gaining resources to compete in an increasingly expensive and competitive marketplace.

Field, *supra*, at 334.

such impermissible control. CPOM is and has been the statutory tool to address this problem. But given the widespread and legitimate uses of friendly PC structures, CPOM should be applied with precision lest counterproductive consequences should result, such as major disruption or negation of a commonly used tool to accomplish successful physician alignment strategies.

There are well developed case law, AG opinions, and guidance from the Medical Board to aid in determining what aspects of a medical corporation's business fall into the rubric of clinical or medical care versus the non-clinical administrative and business side of the operation. *See*, *supra*, section III.B. The less developed area in CPOM enforcement is determining whether and how the use of friendly PC structures results in impermissible control. *Discovery Radiology* shows that CPOM can be helpful in this inquiry when, through control of friendly PCs, an MSO interferes in the clinical aspects of a medical practice. But guidance is needed to decipher whether and how an outside party's contractually-created right to replace the physician owner of a friendly PC may create impermissible control or influence over the practice of medicine.

The trial court and the AG, in its amicus brief in this appeal, believe the mere presence of such a right of removal violates CPOM. *See* AA3649; Brief of the California Attorney General as Amicus Curiae in Support of Neither Party at 28 ("Agreements that permit nonprofessional corporations to handpick the doctors that own and operate a medical practice ensure that the dangers of divided loyalties are all but certain to materialize"). Such a view may be justifiable when, as with the contractual removal mechanisms in this case, there are no limits around the power to remove a PC owner. Here, the physician's ownership of the friendly PC

was inextricably tied to a Consulting Agreement, which by its terms and under legal contract principles could be terminated at will, without cause, and at any time so long as written notice was given.[11] That means the manager's authority to replace the physician owner was absolute and unilateral. The trial court and the AG have good reason to believe that the mere presence of such removal authority can have real influence over the physician owner, but that begs the question what aspects of the medical corporation are subject to such influence. CPOM is implicated only if there is undue control or influence over the clinical aspects of a medical practice and not the purely business aspects.[12]

It is not inevitable that simply having the power to remove the owner of a PC necessarily results in impermissible control over the clinical aspects of the PC's operations. Medical corporations can have governance structures in place that insulate clinical operations from ownership control over the corporate form. For example, a medical corporation could have directors besides the shareholder owner who have fiduciary duties to the corporation and/or professional administrators (e.g., a CEO, a chief

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[11] Such an arrangement may seek to take advantage of California's policy strongly favoring freedom of contract and the ability of contracting parties to structure their relationships as they see fit, including how they exit their contracts. *See Series AGI West Linn of Appian Group Investors DE, LLC v. Eves* (2013) 217 Cal. App. 4th 156, 157. But even so, California does not permit unfettered rights to terminate contracts without cause if they violate public policy or positive law. *Id.*

[12] What is not at issue in this case is the legality, under CPOM, of other forms of removal powers that arise when, for example, a physician owner loses eligibility to own the PC. Such provisions serve legitimate needs and do not threaten improper control. What is under scrutiny is a removal power that can be triggered for any reason.

medical officer, or managers) who have independence and authority to conduct the clinical affairs of the medical practice regardless who owns the corporate shares. Physician administrators also could develop policies and protocols that remain intact through ownership changes. These layers of governance and management could deter if not prevent third parties from interfering in the clinical affairs of the medical corporation by threats or actual removal of the owner. Granted, the new owner could make managerial changes that ultimately carry out their desires at the clinical level. But CPOM compliance should not be dictated by a worst-case scenario approach, especially if categorically striking down a provision in a friendly PC structure could mean impacting all or most friendly PC structures, good and bad alike.

CMA cautions against taking a categorical approach to evaluating the removal authority in friendly PC structures for CPOM compliance. A better approach is to consider the context concerning the formation, function, and purpose of the friendly PC structure in the alignment model at hand. While an unmitigated contractual right to replace the friendly PC owner for any reason is strong, if not dispositive, indication of improper control over the ownership of a medical corporation, it does not necessarily follow that such improper control extends to the practice of medicine by the PC. There should be further consideration of whether there are extenuating circumstances or conversely whether additional facts exist to bolster a conclusion that the intent or purpose of the removal power is to wield improper control over clinical functions of the medical corporation.

For example, the court in *Discovery Radiology* focused on the fact that the MSO created the friendly PC and inserted the physician owner into the structure from the onset. That fact coupled with actual

interference by the MSO led to the CPOM violation. As the research indicates, it might also matter who the lay managers are – are they affiliated with other non-physician providers such as a nonprofit community clinic or hospital, who may be naturally aligned with the friendly PC's clinical functions or have independent interest in delivering quality and accessible medical care. Or are the managers who can wield the removal power affiliated with investors or stakeholders with a history of using friendly PC structures to churn through medical practices in pursuit of profit first. Even in such cases where investors or PE firms are involved, there could be other mechanisms that ensure the exercise of the removal power does not interfere with the practice of medicine. Parties should be allowed to create innovative solutions to strike the right balance for their particular alignment arrangements. Such contextual facts can illuminate whether a removal provision (even one as unlimited as here) results in structural control over the PC in violation of CPOM.

It may be that consideration of relevant facts may result in findings of CPOM violations in virtually all circumstances where lay parties can remove the owner of a friendly PC for any reason and at any time. That still would not justify a categorical prohibition of any friendly PC structure that includes such broad and unfettered removal authority. CPOM categorically prohibits lay entities from employing physicians to practice medicine because that sort of employment relationship involves lay control directly over the employed physician's clinical judgment and practice. Lay entities can and do employ physicians for nonclinical services, but it is only employment to deliver medical care that runs afoul of CPOM. The same rationale does not apply to removal authority over the ownership structure of a friendly PC.

CMA's main point is that a categorical prohibition of friendly PC structures that include an unfettered power to remove the physician owner may be too blunt an application of CPOM. As the decades of case law and AG opinions teach, CPOM enforcement must be context- and fact-dependent because the delivery of medical care can be varied and complex, necessitating a nuanced approach to rooting out both direct and subtle forms of improper influence or control. Innovative alignment strategies necessarily involve some control; the critical task for CPOM is to distinguish control over clinical care from other forms of control. Erecting rigid barriers in the enforcement of CPOM could have the unintended consequence of stifling innovation and the evolution of healthcare, resulting in significant disruption to many current physician alignments. Or at least, as the Medical Board's guidance on CPOM recognizes, it is inevitable that physicians work with professional managers and CPOM is only concerned when such consultations result in actual interference.

The California Legislature took this narrow approach when it recently enacted a law targeting PE acquisitions of medical practices. The Legislature enacted CMA-sponsored Senate Bill 351 ("SB 351") to clarify the application of CPOM to PE and hedge fund investments in healthcare. *See* Senate Bill no. 351, Cal. Stats. 2025, ch. 409 (2025-26 leg. sess.). Effective January 1, 2026, SB 351 added new law that affirmed and codified the aforementioned Medical Board's guidance concerning improper lay control or involvement over the practice of medicine as applied to any PE or hedge fund involvement, including as an investor, in a physician practice. *See* Health & Safety Code §1191(a). The new law further prohibits PE groups and hedge funds from entering any contract or arrangement with a physician that would enable the lay entity to

interfere with or exercise control over the professional judgment of physicians. *Id.* at §1191(c). The Legislature made clear that the new law "is intended to ensure that clinical decision-making and treatment decisions are exclusively in the hands of licensed healthcare providers and to safeguard against nonlicensed individuals or entities, such as private equity groups and hedge funds, exerting influence or control over care delivery." *Id.* at §1191(f). Notably, SB 351 does not raise categorical prohibitions on any particular contract terms in a friendly PC arrangement.

V
CONCLUSION

For many decades, CPOM has ensured that physicians can provide the best possible medical care to their patients, utilizing their professional training, skill, and expertise under the oversight of the Medical Board. Our healthcare system has evolved greatly since the advent of CPOM in the early 1900s; but CPOM's core purpose remains vital and necessary all the same. CMA respectfully urges the Court to carefully consider this amicus brief in evaluating how CPOM applies to friendly PC structures and advancing CPOM into new territory.

Dated: April 13, 2026

Respectfully submitted,

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CERTIFICATION OF WORD COUNT

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DATED: April 13, 2026

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Attorney for California Medical Association

PROOF OF SERVICE

Art Center Holdings, Inc. et al. v. WCECA ART, LLC et al., no. B338625

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