A Day at the Office

A Day at the Office: Is Private Practice Orthopaedic Surgery Dead?

Douglas W. Lundy MD, MBA

In referring to the state of the physician workforce, so-called experts have argued that private practice of medicine is on “life-support” or should even be considered an endangered species [3, 4]. It has also been argued that the increasing administrative burdens of Medicare Access and CHIP Reauthorization Act (MACRA) and the Patient Protection and Affordable Care Act (ACA) are too much for the private physician group to endure [2]. Are private practice physicians simply holding on to an

antiquated model that cannot survive in the new healthcare paradigm? Should we embrace this belief and abandon ship? Should we leave private practice for the seemingly greener pastures of hospital employment?

I believe the current landscape is far different from the perception. The American Academy of Orthopaedic Surgeons reports that 35% of the workforce is in private group practice and 15% are in solo private practice [1]. The combination of the different private practice models comprises 73.5% of the orthopaedic surgical workforce. The same census stated that 15% are employed by a hospital or medical center [1]. If hospital practice was the be-all-end-all of practice, why are only one in six orthopaedic surgeons employed by hospital systems?

Indeed, hospital employment gives the orthopaedic surgeon considerable reduction of stress in terms of the administrative burden of running a

practice. Most of us became physicians for the joy of clinical and surgical practice, so deferring the drudgeries of the administrative side of medicine is extremely appealing. The requirements of MACRA, the ACA, and other governmental mandates can be confusing, frustrating, and overwhelming. Many employed models have the built-in referrals from other physicians employed by the same system. Concerns regarding the viability of the group’s ancillary services that could require expensive capital investment now become the hospital’s problem. The potential nightmare associated with human resource issues is mitigated. It only takes one expensive Equal Employment Opportunity Commission complaint to sour an orthopaedic surgeon on wanting to be an employer. For many, a turn-key approach and promise of “just show up and see your patients” may seem like nirvana.

What are the benefits of private practice? In talking with my colleagues, the thrill of autonomy is the ultimate benefit of remaining independent. As opposed to other specialties, I have noticed that orthopaedic surgeons tend to form in groups and work well with each other regardless of the employment model.

A Note from the Editor in Chief:
We are pleased to introduce to readers of Clinical Orthopaedics and Related Research® our newest column, A Day at the Office. In this column, private practice orthopaedic surgeon Douglas W. Lundy MD, MBA, provides perspective on the pressures that orthopaedic surgeons face on a typical “day at the office,” as well as a broader viewpoint about trends in nonacademic clinical-care settings.

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We benefit from the pooling of resources, specifically in covering the different specialties as well as making ancillary services more efficient. The biggest draw to me is working with like-minded orthopaedic surgeons, controlling our own destinies within the paradigm that we work. Although we are not completely free to do what we want within the systems that we work, we can decide within our practice whether we will engage with another physician group, insurer or system and to what level.

The dilemma then becomes clear. In the face of mounting pressure to become employed by a hospital, how does an orthopaedic surgery private practice group both maintain its autonomy and appease the powers that be in the hospital employed medical group? I believe that a negotiated compromise can be achieved between these two parties such that both can get what they want.

The hospital system wants to employ orthopaedic surgeons for several reasons. As physicians, we often sabotage our position by loudly complaining about issues that no hospital can completely control. We bitterly protest having to take call without fully realizing that the hospital has a mandate to provide emergent and urgent musculoskeletal care to the

community that it serves. If we are not willing to staff this need, we can inadvertently destroy our position by forcing them to employ their own orthopaedic surgeons. In the not-too-distant past, our profession was almost faced with general surgeons expanding their scope of practice to meet the musculoskeletal conditions of patients whom we refused to treat on an emergent basis.

On the other hand, hospital administrators may believe that all of the ancillary revenue generated by orthopaedic surgeons actually belongs to the hospital system itself. The fact that we generated loyal referral patterns through years of hard work and took considerable financial risk to invest in expensive ancillary services seems irrelevant to some administrators. Many orthopaedic groups I am familiar with felt forced to open MRI, physical therapy services, and ambulatory surgery centers—often at a high cost to the group—because the hospital system had been unresponsive to the needs of their patients. The hospital administrators may believe that the patients and the referrals belong to them, so all of the revenue generated from these encounters belongs in their coffers.

In my experience, open dialogue and friendly negotiations can make

both parties happy with the arrangement that is finally forged. The hospital generally wants stability and consistency. The administrators want to hear enthusiastic reports from the patients in their system, and they would rather devote their attention to more grandiose ventures than supervising the orthopaedic workforce. I am not naïve. I know that not every conflict can be worked out amiably. But I do believe we should seek concessions on both sides to reach a satisfying compromise.

At our practice, we have a busy trauma center that performs a high volume of fracture work. The hospital leadership grew tired of inconsistent call coverage, which was a tremendous stressor, damaging the practices of the elective orthopaedic surgeons. We developed an orthopaedic trauma service that gave the hospital the consistency it needed to provide high-quality trauma coverage. Removing the burden of trauma care also enabled other orthopaedic surgeons to be more effective in developing their specialty scope, increasing the services the hospital could provide. This partnership with the hospital system was most evidently shown when the affiliated private practice orthopaedic surgeons met the system's requirements for American College of

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Surgeons trauma verification at a higher level than many of the system's employed physicians.

We also partnered with the hospital to reduce orthopaedic implant costs. By maintaining a strong united front with the hospital, it was able to negotiate lower prices. In the modern era of cost restraints and decreasing revenue, the hospital system viewed this cooperation in a positive light.

In terms of ancillary revenue, sometimes it is better to join them rather than to go to battle against them. If a private practice orthopaedic group wants to remain independent in the face of an aggressive healthcare system, collaborating in ambulatory surgery centers can more-effectively align the interests and incentives of the two parties. I understand that we

would love to maintain the solidarity of our ancillaries, but sometimes the better part of valor is to reach a compromise.

Certainly, these strategies will not always work, and sometimes, ineffective leadership may force orthopaedic surgeons into conflict. Let us be completely honest in saying that occasionally orthopaedic surgeons lack the perspective of seeing the bigger picture. Many times though, we can find a common ground if we work collaboratively. As orthopaedic surgeons, we can control the outcomes and the experiences our patients enjoy far better than anyone else can. Orthopaedic surgeons, regardless of their employer, can develop more innovative and effective mechanisms for delivering care for orthopaedic

conditions far better than anyone else. Private practice is doing just fine.

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