DISCLAIMER

This Hospital Employment of Orthopaedic Surgeons Primer is intended to provide general, authoritative information, available at the time of publication, in regard to the subject matter covered. It is offered with the understanding that the publisher and the contributors are not rendering formal legal, accounting or information systems consulting advice. Nothing contained herein is intended to serve as a substitute for obtaining such advice.

The American Association of Orthopaedic Surgeons and the American Academy of Orthopaedic Surgeons do not endorse, support or accept the applicability of this data to any reader’s particular practice setting. Each practice has its own particular needs, patient populations, revenues, volume and mix of services, and professional goals and objectives.

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Hospital Employment of Orthopaedic Surgeons
A Primer for Orthopaedic Surgeons

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Dear Colleague:

The AAOS Health Care Systems Committee (HCSC), with input from the Practice Management Committee (PMC), has developed this Primer to help educate AAOS members on issues related to hospital employment of orthopaedic surgeons. The HCSC is a Committee that reports to the Council on Advocacy, and has been tasked with addressing hospital-physician relationships. The PMC is charged with providing orthopaedic surgeons with practical information in the area of Practice Management. To this end, the PMC develops and produces a Primer every year on a subject of importance to the membership. This year, the HCSC teamed up with the PMC to develop this Primer. Previous Primers covered Human Resources, Electronic Medical Records and Picture Archiving and Communication Systems (PACS).

The subject of this year’s Primer is hospital employment of orthopaedic surgeons. The content of the Primer relates primarily to orthopaedic surgeons who are considering hospital-based employment. However, much of the information applies to already-employed orthopaedists, or orthopaedic surgeons in any practice setting who are in competition with a hospital-based physician group. The Primer consists of the following nine major sections plus a list of additional resources.

• Reasons physicians are seeking employment
• Reasons hospitals are seeking to employ orthopaedic surgeons
• Types of hospital employment
• Potential drawbacks
• Feasibility and appropriateness
• Legal considerations
• Tips for ensuring long-term success
• Using consultants and advisors
• Implications of increased employment of physicians by healthcare institutions

AAOS members can download a PDF copy of this Primer from the on-line Practice Management Center (www.aaos.org/pracman). The Practice Management Center contains additional hospital employment-related information.

A cautionary note: a Primer is “a book or booklet that covers the basic elements of a subject.” This Primer is not designed to make you a hospital employment expert, but it will give you important tools to improve your knowledge of hospital-based employment as well as prepare you for potential hospital employment.

Members of the 2009-2010 Health Care Systems Committee and Practice Management Committee, whose names are listed on the inside front cover, helped develop this Primer. Specifically, input was provided by HCSC members Kevin Bozic, MD, MBA; John Cherf, MD, MBA, MPH; Ranjan Sachdev, MD, MPH; and PMC member Steven Makk, MD, MBA. The HCSC and PMC wishes to acknowledge the contributions of AAOS members Samuel Agnew, MD and J. Melvin Deese, MD; and legal expert Todd Rodriguez, Esq.

Additional contributions came from AAOS PMC and HCSC staff liaisons: Steven Fisher and Jacqueline Buschmann. This Primer could not have been written without them.

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Hospital Employment
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HOSPITAL EMPLOYMENT OF ORTHOPAEDIC SURGEONS

INTRODUCTION
Hospital employment of physicians has gone through periods of intense activity and decline over the past several decades. In the early 1990’s, hospitals began purchasing primary care physician practices with the goal of increasing market share in markets dominated by managed care plans. However, due in part to poor planning and a lack of shared goals and accountability, many of these relationships were not successful, and most were divested in the late 1990’s and early 2000’s. Recently, there has been a trend toward increasing employment of specialist physicians by hospitals. Many factors, not all unique to orthopaedics, are driving this trend. Health care policy and reimbursement trends favor provider alignment. It is worth examining the factors underlying this trend, the pros and cons of hospital employment, the impact of this trend on our profession, and on our ability to deliver high quality, efficient care before deciding to take an employment position with a hospital.

Economic forces and factors driving the employed model for orthopaedic surgeons
Hospital employment of orthopaedic surgeons is a relatively new component of the orthopaedic workforce, and the long-term effects of the strategy are yet to be determined, but the short-term effects are measurable indeed:

• Compensation stability for the surgeon
• Market stabilization or growth for the hospital
• Call schedule reconciliation

Economic forces
The economic pressures that set into motion the rapid expansion of the hospital employment model start with the very basic level of orthopaedic business: emergency room call and the opportunity cost produced from the act of being on-call. The initiation of call pay, though valid in its concept, has proven to be a major force in prompting a facility to seek direct surgeon employment once that stipend has reached a critical amount specific to each region and market. An attempt to create fair and equitable call stipend guidelines and fair market analyses has not proven to slow the number of hospitals seeking to employ their own orthopaedic practitioners. While call pay may be viewed in some regions as the sentinel event initiating the employment model, it is the income guarantee that drives this business model. A review of the present orthopaedic job postings reveals the overwhelming majority to be hospital employment offers with not only income guarantees, but also signing bonuses. (Cjeka & Assoc Merritt-Hawkins, Pacific.com, Curare Comp)

Income guarantees sometimes 200% of those from the private practices in the region produce a competitive recruiting advantage in favor of hospitals. Ironically, those institutions have built their reputation on the work and services provided by private orthopaedic practices and are now competing against them for new surgeons. This societal effect has yet to be completely measured, but the changes in the regional medical center and the hospital-medical staff relationship produces, among other effects, the further development of orthopaedic ambulatory surgical centers (ASCs) in the region. The social fabric of the hospital is vulnerable to degradation if changes are not crafted properly to include a careful education and implementation plan for all stakeholders.

Trends
Hospital employment positions are also growing for reasons beyond that of the need to produce call coverage solutions. Of the approximately 5000 accredited hospitals providing a full spectrum of surgical services, approximately 500 have initiated bona fide orthopaedic employment programs, and industry estimates are that another 200 will be initiated in the next two years (Orthopaedic Call Coverage and the impact on the Employed Surgeon Model, Orthopaedic Trauma Practice Consultants, LLC).

Alternatives
Income guarantees should be replaced by mutually agreed-upon performance goals over time for this model to truly benefit the hospitals and patients in need of care and the surgeons whose careers are dedicated to providing that care.

On-call coverage needs for the hospital and the associated call-pay obligations have driven the creation of the employed physician model and the specific expectations therein. Employment models need to be patient-centric and physician-centric to be sustainable. It is the intent of this primer to provide guidelines that can enable the surgeon to create a career-sensitive and successful alignment with the hospital.
REASONS PHYSICIANS ARE SEEKING HOSPITAL EMPLOYMENT

Income stability
In many instances, orthopaedic surgeons consider selling their practices to hospitals because of the economic uncertainty of the current environment. Many practices have seen their income fall over the last five years because of decreasing professional reimbursement in the face of fixed or rising costs. Solo and small practices that cannot supplement revenues by ancillary services are particularly affected by this trend and are more prone to consider sale to a hospital. Larger practices initially driven by concern that congressional action might adversely impact their revenues from ancillaries are also starting to consider this option. Hospitals initially usually guarantee income, and in most cases this income is higher than the surgeon’s income from a struggling private practice.

Transferring financial risk
A hospital-employed physician is no longer responsible for covering monthly shortfalls that may occur between practice income and expenses. Also, the physician does not have to personally guarantee any loans or lines of credit for equipment or working capital, which improves his or her borrowing ability for personal needs.

Eliminating practice management problems
Many orthopaedic surgeons believe that by becoming employees they will not have to deal with as many practice management issues. Although this may be true for billing and collections, physicians still must be involved with the daily administrative tasks of their practices. Also, instead of dealing with practice partners, a hospital-employed physician must meet with hospital administration and other department staff, which can be just as time consuming.

Unloading human resource issues
Hospital employment frees a surgeon from the responsibility of handling day-to-day employee problems. However, this freedom does come with the loss of responsibility to terminate a problem employee, which has to be done in accordance with hospital human resource policies.

Better contracting leverage with payers
Hospitals generally have negotiating expertise and relationships with payers that allow them to negotiate better contracts than can most physicians. Orthopaedists often find this allows them to earn more for their services.

Access to capital
Hospital employment potentially allows better access to capital, although this does involve getting hospital administration to support the expenditure, which can take time and effort. It does afford the opportunity to modernize and adopt newer technologies such as electronic medical records (EMR) and digital radiography without any capital outlay on the part of the physician.

Increased referrals
Most employed orthopaedic surgeons are supported by employed family practitioners, internists, and emergency physicians. Also, hospitals have marketing and public relations staff that can help employed orthopaedists market their services to patients and referring doctors.

More acceptable working hours
Many orthopaedic residents and young orthopaedic surgeons entering practice place greater emphasis on quality of life than on autonomy and ownership. Most students entering medical school have never been a wage earning employee. Also, almost all orthopaedic residents and young orthopaedic surgeons entering practice have had duty-hour restrictions throughout their training.

Dealing with regulatory issues
Hospitals usually have compliance departments to help employed physicians deal with risks involved in complying with Health Insurance Portability and Accountability Act (HIPAA), Occupational Safety and Health Administration (OSHA), Evaluation and Management (E/M) coding, and other regulatory areas. As Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), and Healthcare Fraud Prevention and Enforcement Action Team (HEAT) become more prevalent, more orthopaedists may seek refuge in a hospital environment.

REASONS HOSPITALS ARE SEEKING TO EMPLOY ORTHOPAEDIC SURGEONS

Build market share and revenues
Hospitals want to employ orthopaedic surgeons to build market share and revenues. It is estimated that a busy orthopaedic surgeon can contribute as much as $3.3M annually to hospital revenues with $2.2M coming from surgery and ancillary services (Sg2 report). This income stream is a powerful motivator and often results in hospitals paying an orthopaedic surgeon more than private practice groups in the area would or could pay.

Preserving market share
Hospitals often buy orthopaedic practices and employ physicians to preserve their market share. Loss of market share to a competitor in the area can have significant negative impact on their revenues, so hospitals will look at employment as a defensive strategy.

Stabilizing the medical staff
Hospitals find it difficult to get reliable emergency room (ER) coverage especially if the hospital serves a large indigent population. Physicians who are struggling to cover their rising overhead costs in the face of flat or declining
reimbursement may have limited means to provide this indigent care. Physician employment solves this issue by providing coverage for the ER and indigent care.

**Staffing charity clinics and providing care to uninsured**
Hospitals often have to provide care to uninsured and find it more cost effective to staff free clinics with their employed physicians rather than pay for repeated visits to and care in the ER.

**Better negotiating position with vendors**
Case rate (e.g., Diagnosis Related Groups [DRGs]) payments for major inpatient orthopaedic procedures have forced hospitals to manage their costs more carefully. Hospitals are realizing that a significant portion of their costs are implant-related, and cutting implant costs is crucial to profitability. Employed orthopaedic surgeons are more likely to help in negotiating better implant prices with vendors and to participate and support cost-control strategies such as standardization and demand matching.

**Implementing quality initiatives**
Hospitals have a growing need to implement quality improvement and patient satisfaction initiatives, especially as these initiatives are tied to payments. Employing physicians enables hospitals to focus on these initiatives.

**Bundled payments and other payment initiatives**
Public and private payers are encouraging alignment of physician and hospital incentives to improve coordination of care and increase the value of healthcare. Bundled payments are being tested by both public and private payers in several regions across the U.S., and CMS has already aligned Part A and B under one fiscal intermediary to better monitor hospital and physician payments.

**TYPES OF HOSPITAL EMPLOYMENT**
Hospitals employing orthopaedists vary in size, location and mission. It is important to understand the differences and the implications of employment by different types of hospitals. The main types are as follows:

**Large trauma centers**
These are busy level-1 and -2 trauma centers that need on-site coverage. These positions are best suited for orthopaedists with an interest and training in trauma.

**Hospitals looking for orthopaedic hospitalists**
In this situation, coverage is often provided for a specific time period (e.g., 1 week out of 3), with the remaining time being free time with no call. Orthopaedists provide inpatient consultation, ER coverage and run clinics in the hospital. Private companies are stepping in and working as intermediaries to supply orthopaedists to these hospitals.

Orthopaedists looking to supplement their income often find these opportunities attractive.

**Not-for-profit community hospitals**
These hospitals are looking to develop a dominant position in orthopaedics in their market and value special expertise that can draw patients to their institutions. For example, a hospital looking to develop an integrated joint replacement service will pay more for a joint reconstruction specialist than for a general orthopaedist.

**Hospitals in urban areas looking to develop a niche**
The decision to specialize in orthopaedic care has paid off for hospitals, with many showing a marked increase in revenues and profitability. This trend is very recent and is likely to be followed by others. Hospitals that specialize will be looking for physician-partners to help them in this effort and will offer opportunity for employed physicians to display leadership skills.

**Rural hospitals**
Rural hospitals are having a difficult time recruiting orthopaedic surgeons because they are in remote locations that are often perceived as less desirable places to live. These jobs are mostly filled by foreign medical graduates or physicians who want a more leisurely work schedule and lifestyle. Rural hospitals are financially vulnerable to economic downturn, which can often lead to termination of contracts caused by closure of service from lack of resources. Lack of coverage and support is an issue employed physicians often have to deal with. It is not unusual to have no anesthesiologist, cardiologist, or urologist available in this setting so that orthopaedists may be limited in treating patients with complex health problems.

**PHYSICIAN EMPLOYMENT BY HOSPITALS: POTENTIAL DRAWBACKS**
Physicians are increasingly aligning with hospital systems through various arrangements, including employment. Although many underlying circumstances are driving this trend, physicians should consider both the positive and negative consequences to themselves, their patients, their practice, and the healthcare system before entering into an employment agreement with a hospital.

**Decreased competition**
Patients may have limited healthcare choices when the full array of providers and services is not available.

**Higher cost and less efficient site of service**
Ancillary services (e.g., imaging, physical therapy) and ambulatory surgical procedures may be moved from a more efficient outpatient setting to a less efficient, more costly hospital setting.
Illegality
Physician employment is illegal in some states, such as Texas and California, except in some academic and government settings (hospitals maneuver around these laws through hospital contracts with physician services through foundations that employ the physicians). The issue is not about legality per se, but that laws exist largely because of concerns that physician objectivity and incentives could be conflicted.

Outside competition limited
Hospitals are often effectively monopolistic (or oligopolistic) in communities. They may terminate non-employed physicians’ privileges to push the hired arrangement.

Limited control of employees
Hospitals cut costs to maximize profits. The hospital may not hire high quality, experienced employees, and the orthopaedist may have little or no input over this decision. In addition, the hospital may terminate loyal, skilled employees who followed the orthopaedist into the new employment arrangement because of their higher compensation and benefits, which may exceed hospital pay standards.

Lack of participation in negotiation process
Hospitals will negotiate with insurers on behalf of their physicians. They may accept insurance policies that could prove troublesome for the physicians and their patients. They may also negotiate down the level of professional reimbursement (what the orthopaedist get credited for in production) and negotiate up the facility component (what the hospital receives), especially once the initial contract (often RVU-based) is renegotiated (often collections based).

Driving down private practitioners’ negotiation power
The “community standard” for physician remuneration may be lowered through hospital negotiations on behalf of their employed physicians.

Loss of surgeon choice
The hospital may dictate supply and implant choice based on pricing and negotiations.

Loss of autonomy
Many orthopaedists enter private practice because they value entrepreneurship and independence. Employed physicians’ incentives become aligned with those of the hospital employer. In theory, this could compromise clinical judgment if the physician allows the hospital’s priorities to intrude into the doctor-patient relationship.

Non-compete clauses
Orthopaedists should expect some form of non-compete language in the contract. This clause may prove ominous, as it could limit contacting patients because they are essentially the hospital’s patients now. In addition, the physician may be prevented from being employed by competing hospitals, which may require an orthopaedist either to stay with the current hospital or move out of town.

Contract renegotiation
Contract renegotiation generally occurs three to five years after the initial employment contract. The administrator with whom an orthopaedist initially negotiated the arrangement may no longer work at the hospital. Hospital administrators change jobs every 5.5 years on average, 14-18% attrition per year (The Impact of CEO Turnover in U.S. Hospitals, ACHE). In addition, the productivity formula has probably changed from RVUs (insulate doctor from reimbursement drops as long as workload maintained) to collections. It may be very difficult to re-enter private practice after employment because of the high capital outlays that are typically required (EMR, employees, office).

Limiting ancillary income choices
Hospital salaries are often initially supported at a level above market rates because they capture revenue streams from physician ancillary services (such as surgery center, magnetic resonance imaging [MRI], physical therapy [PT], occupational therapy [OT], durable medical equipment [DME]) that are often higher for hospitals than for physicians. Newly hired physicians from practices that did not enjoy these passive revenue streams often get effective “raises” when they are hired. Ancillaries may disappear in the current political/regulatory environment, but once employed, the physician lacks control of these services.

You can be fired
Depending on the contract, if an orthopaedist becomes less productive, he/she could be terminated. This can happen without cause. Re-entering practice becomes exceedingly difficult and expensive.

Passive real estate investment
Office ownership can be an attractive investment opportunity providing passive income with a favorable “buy-out” at the end of one’s career. Hospital employment may negate this ancillary opportunity. If an orthopaedist owns his/her office and then decides to become employed, he/she should consider negotiating for the hospital to pay rent for this office.

Fragmentation of the profession
Recent survey data suggest that hospital-employed physicians are less likely to participate in professional medical societies (e.g., AAOS, state orthopaedic societies), and less likely to contribute to the orthopaedic Political Action Committee.
CONSIDERATIONS IN DETERMINING FEASIBILITY AND APPROPRIATENESS OF BECOMING A HOSPITAL EMPLOYEE (W-2 EMPLOYEE):

The AAOS™ Practice Management Directory of resources should be sought for assistance and direction in performing this exercise.

Outside sources to produce-perform

• Undertake Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of current practice if applicable and assess the model to be created.
• Practice Valuation
  • Assess value of your current practice
  • Assess global (Net-Halo) value of your alignment model
• Assess hospital-centric objectives
• Create business plan that is commensurate with career plan

Feasibility and Appropriateness Evaluation: a Protocol

Table 1: Steps you should take when considering hospital employment

<table>
<thead>
<tr>
<th>Analyze background information</th>
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</thead>
<tbody>
<tr>
<td>• Why is the hospital organization or hospital itself seeking to employ an orthopaedic surgeon?</td>
</tr>
<tr>
<td>• What was the genesis of this business venture?</td>
</tr>
<tr>
<td>• For yourself as practitioner?</td>
</tr>
<tr>
<td>• For the institution?</td>
</tr>
<tr>
<td>• Are they compatible missions?</td>
</tr>
<tr>
<td>• What practices will be immediately affected by this alignment?</td>
</tr>
<tr>
<td>• Are the surrounding practices in support of this venture?</td>
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<table>
<thead>
<tr>
<th>Consider options that will achieve the same objectives for your career</th>
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<tbody>
<tr>
<td>• Independent contractor status</td>
</tr>
<tr>
<td>• Third-party management of your business operations, and career aspirations</td>
</tr>
<tr>
<td>• Maintaining present (private practice) status with realignment of duties and responsibilities within the institution and organization.</td>
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</tbody>
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<tr>
<th>Analyze each option for</th>
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<tr>
<td>• Impact on the timely delivery of care</td>
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<tr>
<td>• Impact on people: your referral base, your family, and your career</td>
</tr>
<tr>
<td>• Your leverage in each process</td>
</tr>
<tr>
<td>• Compensation methodology, targets, and transparency</td>
</tr>
<tr>
<td>• Ability to produce a concise and timely implementation plan. The manner and exact methodology of the implementation should be well drawn out and available for review.</td>
</tr>
</tbody>
</table>

Assess the pros, cons, risks, and returns for each option.

The decision to undertake hospital-based employment is certainly complex when one acknowledges all of the variables that impact a successful alliance. Oftentimes, the agreement, or alliance process appears to be quite simple: one party is in need of certain services, and another party is in a position to deliver said services; efforts are then put forth in assuring compliance from a regulatory standpoint (hospital) and maximizing the compensation guarantee (surgeon). Unfortunately, often very little time is spent identifying the needs that this relationship is trying to address, or what benefits the alliance will produce for the institution or surgeon. Hospital employment contracts frequently stem from a particular event or critical need: surgeons aging or opting off the call schedule, clinical niches or markets not being available or accessible (spine, total joint arthroplasty, sports medicine, etc.). The type of employment model is almost forgotten when one speaks to the physician recruiter, or physician search firm; careful inquiry may be needed as to the reason for the employment offer. If the institution is embroiled in some issue with the existing orthopaedic surgeons in the community (e.g., call-coverage, competition with a physician-owned ambulatory surgery center), it is imperative that this issue be fully explained and reconciled prior to signing an employment target, as no compensation target could or should entice one to become involved in such an issue.

Hospitals by and large are not seeking to become practice developers, and therefore the impetus for the employment offer is to fill specific needs that must be delivered to the community it serves. There may be suitable alternatives to hospital employment that yield the same personal freedoms and compensation targets the surgeon is seeking. If the orthopaedist’s service is particularly unique and specialized, then perhaps an independent contractor relationship based on mutual performance metrics may achieve his/her goals and objectives.

Third-party management, although very much in its infancy within orthopaedic surgery, may be an option that yields the same clinical and personal satisfaction while allowing the surgeon to avoid the rigors of day-to-day operational issues and to maintain some degree of personal autonomy within the framework of the hospital structure. Finally, crafting individualized co-management arrangements within the service line of the hospital may prove to be the best alternative.
for some (if not many) surgeons in the latter stages of their career. In these arrangements, the surgeon is compensated for administrative duties and programmatic successes within the institution in addition to clinical practice.

Presently, few, if any, hospital-surgeon employment agreements represent the needs of the surgeon either short- or long-term other than to provide income. The agreements may be replete with duties and responsibilities of the surgeon, with very little attention paid to what the institution is to do for the surgeon beyond compensation and benefits. They also specify various conditions under which the surgeon’s compensation can be reduced if certain actions are not dutifully performed (eg, timely dictation, little time off, and adherence to a rigorous call schedule to name a few).

If the hospital needs to employ surgeons due to inefficiencies in operations that forced the production-based surgeon cohort out of the hospital in the first place, then the hospital should be contractually obligated to meet certain performance standards. If the surgeon who is seeking the income guarantee as the end-point cannot perform effectively in an inefficient environment, then any leverage has been forfeited, as the surgeon often needs the hospital’s help in creating an environment that will effect achievement of the production targets on which the income guarantee is based.

**Assessment process: feasibility and appropriateness questionnaire**

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Are you suited for a surgeon W-2 type position?</td>
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<tr>
<td>Are you willing to surrender certain day-to-day authority?</td>
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<tr>
<td>Have you been a successful, content, and productive W-2-based employee before?</td>
</tr>
<tr>
<td>Are you compatible with the HR rules, corporate ethos, and the hospital’s day-to-day business practices?</td>
</tr>
<tr>
<td>Are you able to function within the proscribed number of support staff (#FTE staff/MD)?</td>
</tr>
<tr>
<td>Are you comfortable with a staff not working for you personally, but employed and governed by the hospital?</td>
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<tr>
<td>Are you suited to the time and freedom restrictions imposed by a W-2 position?</td>
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<tr>
<td>Are you able to design the specifics of your practice to include a particular anatomic content area and to exclude others (back pain, dysvascular limbs, infection, pediatrics, etc.)?</td>
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<tr>
<td>What are the mechanics for term-renewal or restrictions to your practice should you leave employ of the hospital?</td>
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<tr>
<td>Can you produce a three-year and five-year career and business plan to meet specific goals?</td>
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<tr>
<th>Table 3: Questions to be asked to determine if the hospital is suited to physician employment</th>
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<tr>
<td>Is there a professional facility in which to see patients?</td>
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<td>• Is it available or in the planning stage?</td>
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<tr>
<td>• Did physicians help to design and consult on workflow?</td>
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<tr>
<td>• Does the organization presently run any practice efficiently and profitably?</td>
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<tr>
<td>• What are the estimated capabilities of the orthopaedic facility and personnel (patients per day estimates)</td>
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<td>• What are the documented triggers for adding on-site technology (MRI, DR)?</td>
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<td>What is the methodology of charge capture?</td>
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<td>• What is the ratio of data entry personnel to providers?</td>
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<tr>
<td>• What is the ratio of Master coders in orthopaedics to orthopaedic providers?</td>
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<tr>
<td>• What is the denial rate for surgical codes?</td>
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<td>• What are the current managed care contracts and their term?</td>
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<td>• Do physicians have input into orthopaedic fee schedule?</td>
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<tr>
<td>• If a wRVU-based compensation formula is used, what constitutes a compensation-valid wRVU?</td>
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<tr>
<td>• Is the practice a service line of the hospital or a separate s-corp., or c-corp.?</td>
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<tr>
<td>• Will radiograph readings be applied to your clinical (wRVU) formula, or will the radiology department retain all?</td>
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<td>• What access to ancillary income is available?</td>
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<tr>
<td>• What is the formula/plan for reconciling honoraria, expert witness fees, consulting fees, and intellectual properties on your behalf?</td>
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<tr>
<td>What is the responsibility related to the hospital primary care network?</td>
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<td>Was a Pro forma generated in creating this position?</td>
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<td>• What was the result of internal analysis or external analysis?</td>
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<tr>
<td>• What are the methodologies for growth in your business/clinical sector?</td>
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<tr>
<td>Does the institution have clear patient-centric and physician-centric goals and objectives for the practice model?</td>
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<tr>
<td>What are the expectations of the surgical service?</td>
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<tr>
<td>• Clinical expectations?</td>
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<tr>
<td>• Call coverage?</td>
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<tr>
<td>• Business expectations?</td>
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LEGAL CONSIDERATIONS IN HOSPITAL EMPLOYMENT

Private medical practice is not for every physician. Many physicians want to practice medicine without owning and running a business, with its attendant headaches. For these physicians, hospital employment can make a great deal of sense. After all, most hospitals already have management teams and sophisticated clinical and business technology in place, and generally hospitals can more easily afford the financial demands of a volatile and competitive health care market than can many smaller private medical practices. If you are considering hospital employment as an alternative to private practice, here are some important issues to keep in mind when negotiating your employment agreement.

Term of Employment

When considering hospital employment, bear in mind that the contract term will be time-limited – typically between one and three years initially. Many physician employment agreements will automatically renew from year to year at the end of the initial term (this is called an “evergreen” provision) but some will expire, which means unless a new agreement is entered into, the arrangement simply ends. Moreover, even contracts with longer initial terms can be terminated in a variety of ways before the end of the term (termination is discussed below). Given the potentially short-term nature of a hospital employment arrangement, you must know its term and how and when it can be terminated.

Sample Term Provision with Evergreen Renewal

The term of this Agreement shall be for a period of one (1) year (the “Initial Term”) beginning on ______________, 20__ or sooner as mutually agreed by Employer and Employee (the “Commencement Date”). At the conclusion of the Initial Term this Agreement shall automatically renew for successive twelve (12) month periods (“Successor Terms”) unless and until terminated as set forth herein.

Termination of Employment

Starting off an employment relationship by focusing on how it can be terminated seems counter-intuitive and counter-productive, but it is important that both parties understand the limits of the relationship. For this reason, you should be sure that your employment agreement clearly defines whether it can be terminated for “cause” and/or without cause. Termination rights should generally be reciprocal (i.e., both the employer and the employee have the right to terminate with or without cause). The Agreement should also clearly identify the grounds for termination with cause, and ideally those grounds should be objective. For example, termination for loss of a medical license is an appropriate cause for termination, but termination “for any cause determined by the Employer” leaves too much to discretion.

Sample Termination Provision

a. Either party may at any time terminate this Agreement, without cause, upon not less than ninety (90) days advance written notice.

b. Either party may terminate this Agreement by written notice immediately upon material breach by the other party provided that the breaching party shall have fifteen (15) days to cure any such breach.

c. Employer may terminate this Agreement for cause upon the occurrence of any one of the following events:

   (i) Failure to obtain, or suspension or loss of Employee’s license to practice medicine in the Commonwealth of Pennsylvania or any other jurisdiction, or suspension or loss of Employee’s right to dispense or prescribe narcotic drugs;

   (ii) Employee’s felony conviction;

   (iii) Employee becomes a “sanctioned individual” within the meaning of §1128(b) of the Social Security Act or is otherwise sanctioned, suspended or excluded from Medicare, Medicaid or any government sponsored health care payment program, or any third party payment program with which Employer contracts;

   (iv) Employee becomes ineligible for professional liability insurance in at least statutory minimum amounts;

   (v) Employee’s intoxication while on duty or Employee’s illegal use or possession of drugs or intoxicants.

Compensation

More and more frequently, hospitals are compensating employed physicians based, at least in part, on the physician’s performance. Performance criteria may include productivity (based on charges, collections, or relative value units, for example), patient satisfaction, or quality scores. Whatever the criteria, they should be clearly delineated in the agreement and they should be objective, measurable and reasonably achievable. In addition, if a physician’s compensation will be reduced by any direct or indirect expenses allocable to the physician, the agreement should clearly identify each of these expense categories and how they are calculated. Furthermore, a mutually agreed-upon budget should be established for these expenses.
Sample Practice Budget Provision
Employee shall operate pursuant to an annual expense budget ("Budget"), which Budget shall initially be determined by Employer. Thereafter, the Budget shall be reviewed and, if appropriate, adjusted from time to time at least once prior to the beginning of each calendar year commencing with 2009, and more frequently if necessary. Final determination of any such adjustments to the Budget (other than those that are (i) subject to a standard schedule generally applied by Employer, (ii) subject to a third-party schedule not controlled by Employer or Employee, or (iii) otherwise self-determinative), shall be determined by Employer and reviewed with Employee.

Restrictive Covenants
Most hospital employers will expect their employed physicians to agree to certain non-competition and patient non-solicitation restrictions. Be sure these provisions are as narrowly tailored as possible. For example, a non-competition restriction should not prohibit an orthopaedist from practicing medicine in general, but rather should be limited to your practice of orthopedic medicine/surgery. Similarly, geographic restrictions should generally be limited to the area from which the hospital draws its patients. Finally, the duration of these covenants following termination of employment should be limited (typically two and no more than three years). Hospitals may also be willing to include various carve-outs in the covenants. For example, a hospital may be willing to permit a physician to go into private practice in the hospital’s service area (in hopes that the physician will continue to support the hospital) or to waive the covenant if the agreement is terminated within the first six months.

Sample Restrictive Covenant Provision
Physician agrees that during the term of this Agreement and any renewal term and for two (2) years after its termination for any reason, Physician shall not enter into or engage in the practice of orthopedic medicine or surgery, directly or indirectly, at or within _______ (___) miles of Hospital, any Hospital outpatient facility, office site or any other office or facility owned Hospital where Physician regularly provided services during Physician’s employment; nor shall Physician directly or indirectly, in any capacity, solicit any patient, employee or referral source or contractual arrangement of Hospital or any employee of Hospital for Physician’s own behalf or on behalf of any other party.

Dispute Resolution
Even when both parties to an employment arrangement are generally satisfied, disputes may arise. They may be related to method of calculating compensation, on-call scheduling, assignment of support personnel, or the purchase of medical equipment or supplies. It is, therefore, a good idea to include some form of informal dispute resolution process in the employment agreement. Informal processes may call for disputes to be resolved by a small committee made up of “disinterested” representatives from the hospital and the medical staff or from the local business community. More formal processes may involve referral to an independent arbitration service.

Sample Dispute Resolution Provision
The parties agree to attempt in good faith to resolve any disputes arising hereunder in an informal manner. To that end, either party hereto may, by written request, require that any dispute between the parties relating to or arising out of Physician’s employment be referred to an informal arbitration panel for resolution. The arbitration panel shall consist of one vice-president level Hospital employee whose principal responsibility is outside of Physician’s department (as selected by Hospital), one physician on the active medical staff (as selected by Physician), and a third party selected by mutual agreement of the Physician and Hospital representatives. Decisions of the arbitration panel shall be in writing and shall be binding on both Hospital and Physician, and all arbitration costs (other than personal legal fees) shall be equally borne by Physician and Hospital.

TIPS FOR ENSURING LONG-TERM SUCCESS
The Contract is the tool for achieving success, not merely an agreement about compensation. It should:
• Create a system capable of delivering care to an increasing number of patients without a significant increase in time or resource allocation
• Define expectations and deliverables, and the timeline therein
• Define authorities:
  • Throughput
  • Cost-containment
  • Operational
  • Process-Improvement
• Align Financial Interests:
  • Sustainable performance-based model capable of producing yearly improvements in both surgeon lifestyle as well as contribution margin to facility
  • Contain ‘reward’ metrics tied to successful delivery of performance or cost containment initiatives
    • Market share acquisition
    • Market share dominance
    • Re-investment program based on global net (Halo) effect.
• Growth objectives:
  • Anatomic
  • Geographic markets

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Long-term success within a hospital-employment model is certainly a relative term specific to each practitioner. As hospital management and ownership can change during the life span of an agreement, the key component to a sustainable relationship is growth in market share, financial reward, and reputation. As these are all inherently measurable, the important factor is to identify your impact on these sectors and report to the institution the impact your practice has on these metrics. If the genesis of the employment model was a call crisis, for example, then over time that may be forgotten, and the rationale for some of the deliverables may lack documentation. For example, if a newly hired neurosurgeon contests orthopaedic operating room (OR) allocation, and there is no justification in the records of the utilization committee or in the by-laws for such allocation, without administrative purview and tangible data that depicts the financial impact you have had, you are vulnerable.

Hospitals have the potential to be a successful partner in your career. The critical first step to creating a sustainable relationship is to be the right surgeon at the right facility. The right agreement-contract is the sine qua non for this successful relationship.

**USING CONSULTANTS AND ADVISORS EFFECTIVELY**

The trend toward hospital employment is relatively new, so orthopaedists often do not recognize there are many resources available to help them make an informed decision about whether or not to change their practice setting. The following can provide advice and counsel.

- **AAOS** During the past seven years, the American Academy of Orthopaedic Surgeons has increasingly become the “go to” place for information on all aspects of practice management.
  - The Academy offers educational courses and symposia that include segments devoted to the issues of hospital employment.
  - In addition, articles can be found in *AAOS Now* and in the online Practice Management Center (www.aaos.org/pracman).
  - The Academy has also developed a service that members can access free of charge: the Practice Management Resource Directory or PMRD (www.aaos.org/pmr). Companies listed in the PMRD offer products and services (including consulting advice); to be listed, a company must submit recommendations from three orthopaedic practices.
  - Finally, AAOS Practice Management Group staff have experience as practice executives, management consultants, or both; these individuals are eager to assist members with their practice management-related issues and questions. Just contact: Steven Fisher.
  - **Financial Advisor** A qualified certified public accountant (CPA) can review a practice’s financial statements and ascertain that financial transactions are being recorded correctly. The CPA can also review a hospital’s finances to determine the institution’s financial stability. A certified financial planner will be able to compare the hospital’s proposal for practice purchase and/or salary and benefits with the current and anticipated future bottom line under the status quo. A business or commercial real estate appraisal firm can help physicians develop a sense of the value of their practice, including bricks and mortar, accounts receivable and goodwill. Although it may be generally true that goodwill is a concept of the past, it pays for the doctor to verify practice value early in the employment discussion process to avoid creation of unrealistic expectations.
  - **“Been-there-done-that” colleagues** Perhaps the best source of information is that obtained from the trenches; that is to say, from people who have considered becoming hospital employees or actually done so. For some of these individuals, the move has been successful; for others, it was a disaster. Although it is true that each situation is unique, posing the right questions can help a physician considering hospital employment decide whether one case study or another one might be analogous. AAOS is developing a list of members who have agreed to support their colleagues by talking about their experiences as hospital employees. The Academy is also developing a series of questions to ask these individuals.
  - **Legal counsel** When an orthopaedist in private or academic practice begins to think about becoming a hospital employee, involving legal counsel from the outset is of paramount importance. At a minimum, the individual should be experienced in negotiating employment agreements in the healthcare field, as was discussed previously in this Primer. Depending on the physician’s specific personal circumstances, he or she may also want to involve an attorney who is expert in federal and state laws relating to employment. These laws were listed in the 2009 Primer on Human Resources Management. These regulations include, but are not limited to:
    - The Americans with Disabilities Act
    - The Civil Rights Act
    - The Health Insurance Portability and Accountability Act
    - The Occupational Safety and Health Act.

No one should negotiate with a healthcare institution without having retained competent counsel.

- **Family and friends** There are great advantages to seeking input from spouse/significant other, children and close friends when a major decision is being made. Despite our best efforts, we do not always approach decision-making with respect to our own lives in a rational manner.
example, if an individual has to make a choice between two attractive alternatives and then begins to lean toward one of them, it often becomes increasingly more attractive and the second one becomes less and less attractive. However, if both options are unattractive and the individual initially leans toward one, then the alternative not being considered becomes more attractive by comparison, and the person may “toggle” back and forth. Family and friends certainly have a stake in the physician’s decision but they are, typically at least, somewhat more dispassionate regarding what the possible consequences of an action might be.

• **Outside professional support** As an adjunct to soliciting input from family and friends, some physicians might want to consider taking a personality test, such as the Myers-Briggs Type Indicator (MBTI). These kinds of assessments can, among other things, measure the degree to which an individual wants to be in control. The greater the individual’s need for control, the less likely he or she is to enjoy working for someone else. Physicians may also want to consider engaging the services of a life coach; these individuals can be very useful in helping make informed decisions regarding strategies for moving forward.

• **Professional liability insurance agent/agency** Finally, any physician considering moving from private or academic practice should consult his/her professional liability insurance agent or agency. In most cases, working for a hospital means being covered by the hospital’s policy, and hospitals are often at least partially self-insured. The physician must understand the implications of canceling an existing policy in terms of lawsuits filed after the date of transition for work performed before the date of transition. If tail coverage is required, then the cost of the tail is something that should be negotiated by the attorney as part of the compensation package with the hospital.

### IMPLICATIONS OF INCREASED EMPLOYMENT OF PHYSICIANS BY HEALTH CARE INSTITUTIONS

There is increasing interest in having health care providers form more integrated delivery systems. This transformation is being driven by both government and commercial payers and includes both clinical and financial components. Several studies have shown that the quality of care can be improved with better provider alignment. Hospital employment of physicians and physician ownership of hospitals are examples of the most integrated provider systems.

Hospital employment of physicians has existed in the United States for years. Some employment models have proven to be quite successful and others have failed to leverage their provider alignment. There is concern that hospital employment of physicians may alter the inherent checks and balances that currently exist in our health care system as well as increase cost of care. Independent physicians who are not employed by hospitals have the freedom to direct their patients to facilities they desire. This freedom of facility referral choice has a significant influence on hospitals and other provider facilities. An orthopedic surgeon can direct admissions as well as outpatient procedures and studies to facilities that best meet the needs of the surgeon and patient. Both quality of care and cost may be significant drivers of where physicians elect to treat their patients. Most hospitals recognize this market dynamic and are more competitive in meeting their physicians’ and patients’ needs. Eliminating the freedom of choice removes an important balance in our current market. Hospital-employed physicians typically do not have the flexibility to treat patients outside of the facilities in which they are employed. This limitation is independent of the quality and cost of care that may exist within a market. This potential lack of responsiveness by hospitals to free market behavior may compromise the ability of a physician to drive positive change in an institution. This lack of choice may also play a larger role as the health care system becomes more consumer-driven. Patients will likely be driven to higher quality and lower cost facilities in their search for value. Physician providers who have less direct control over these variables may lose a competitive advantage in the marketplace.

The site of care will likely change as a result of hospital employment of physicians. Orthopaedics has seen a significant shift of musculoskeletal services from inpatient to outpatient facilities over the past two decades. More patients are receiving their orthopaedic care in outpatient facilities than inpatient facilities. Care has also moved away from the hospital setting to less acute care facilities. Non hospital-based facilities that typically treat orthopedic patients include ambulatory surgery centers (ASC), independent imaging centers, outpatient rehabilitation centers and physician offices. The cost of care in these non-hospital based facilities is significantly less than the cost of care when performed in a hospital or hospital outpatient department. Additionally, numerous studies have found improved quality of care and patient satisfaction in these outpatient facilities, which tend to be more consumer-oriented than most hospitals. The ability of these non hospital-based facilities to compete and survive may be limited by the increase in hospital employment of physicians. This may result in increased costs and erosion of care.

The orthopaedic profession and role of the AAOS may also change with the progression of hospital employment of physicians. Our current autonomy offers an unbiased voice for our profession. This voice has been particularly important when discussing major changes to the health care system. The AAOS continues to work on behalf of its members and their patients to ensure that high quality musculoskeletal care can be delivered efficiently and effectively in different
types of practice settings. Our recent comments and opinions that have been made at both the state and federal level are often not consistent with those of the AHA and other health care stakeholders. There is concern that with hospital employment physician allegiance may shift from our professional base to that of the employer (the hospital) over the long term. This could erode orthopaedist independence and minimize another check and balance in the orthopaedic health care system.

Moving to a more integrated health care delivery system has many benefits for patients and providers. However, we need to be cognizant of the short- and long-term implications of this trend and how it may affect our patients and profession.

**ADDITIONAL RESOURCES**

American Association of Orthopaedic Surgeons: www.aaos.org/pracman and www.aaos.org/pmrd

American College of Healthcare Executives: The Impact of Hospital CEO Turnover In U.S. Hospitals
http://www.ache.org/PUBS/research/pdf/hospital_ceo_turnover_06.pdf

American Medical Association: Annotated Model Physician Employment Agreement


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