— PRACTICE & CAREER GUIDE

The Three Orthopedic Practice Models

A working comparison for residents, fellows, and surgeons considering a move.

COMPANION GUIDE TO SUNDAY PRACTICE ROUNDS, EP. 1

THE CORE TRADEOFF

Every practice model is a trade between three things: **stability**, **control**, and **upside**. No model gives you all three. Understanding which one you're optimizing for at your current stage matters more than picking the “best” model — and most surgeons move between models at least once in a career.

AT A GLANCE

	Hospital Employed	PSA	Fully Independent
Income stability	Highest	Moderate–High	Variable
Clinical autonomy	Lowest	Moderate	Highest
Operational control	Minimal	Moderate	Full
Ownership upside	Rare	Limited	Highest
Business burden	None	Moderate	Full
Startup risk	None	Low	Moderate–High
Typical fit	Early career	Mid career	Mid–late career

MODEL 1

Hospital Employment

The structure: You are a W-2 employee of the hospital or health system. They own the practice; you provide the clinical services.

HOW YOU'RE PAID

Base salary, often guaranteed for the first one to two years, plus a work RVU productivity bonus above a stated threshold. Occasionally quality or citizenship metrics are layered on top. After the guarantee expires, compensation typically resets against a productivity target.

WHAT THE HOSPITAL HANDLES

Billing and collections, malpractice coverage, EMR, front desk and clinical staffing, credentialing, payer contracting, marketing, real estate, payroll.

WHAT YOU GIVE UP

Clinic template (patient volume per day, slot length), OR block time allocation, hiring and staffing of your surgical team, contractually defined call obligations, and ownership of ancillaries and the equity value of the practice you build.

WHO IT FITS

Surgeons coming out of training who want to build case volume and technical skill without simultaneously learning to run a business. Anyone entering a market dominated by a large system where independent options are limited. Anyone who genuinely does not want operational responsibility — a legitimate preference, not a weakness.

WHERE IT FRUSTRATES PEOPLE

Usually around year three to five. The guarantee ends, the productivity target arrives, and the surgeon realizes the schedule, the staff, and the OR access driving that target are all controlled by someone else.

> #### QUESTIONS TO ASK BEFORE SIGNING
>
> - What happens to compensation when the guarantee period ends? Show me the formula.
> - How is OR block time allocated, and can it be reduced?
> - Who determines my clinic template?
> - What is the call requirement, and is it capped?
> - Are there any ownership or ancillary participation opportunities, now or later?

MODEL 2

The PSA (Professional Services Agreement)

The structure: You retain your own practice entity. The hospital or health system contracts with that entity for your clinical services. You are not an employee, but you are not fully independent either.

HOW YOU'RE PAID

The hospital pays your practice a negotiated rate — commonly per work RVU, sometimes a fixed fee for a defined scope of services. Your practice then pays you. Because the payment flows to an entity you control, you retain more say in how it's distributed and how the practice operates.

WHAT THE HOSPITAL TYPICALLY HANDLES

Revenue cycle, payer contracting, and facility-side operations. The specifics vary widely — PSAs are far less standardized than employment agreements.

WHAT YOU TYPICALLY RETAIN

Your practice entity and its governance, more influence over staffing and internal operations, greater flexibility to exit without dissolving your practice, and in some arrangements, the ability to maintain outside ancillary interests.

WHY HOSPITALS USE IT

It lets a system align with surgeons who won't accept employment, and it can be structured to comply with Stark and Anti-Kickback requirements when payment is set at fair market value and not tied to referral volume.

WHO IT FITS

Established surgeons with an existing practice who want system alignment — referral flow, facility access, administrative relief — without surrendering their entity. Also surgeons in markets consolidating quickly who want a middle path.

> #### THE MAIN CAUTION
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> PSAs vary enormously in structure and quality. Two agreements with the same name can allocate control very differently. This is the model where a healthcare attorney's review matters most, because there's no standard template to compare against.

QUESTIONS TO ASK

- What exactly is the hospital purchasing, and what remains mine?
- How is the rate determined, and how often is it revisited?
- Who controls staffing, scheduling, and the clinic template in practice — not just on paper?
- What happens to my entity, my staff, and my patients if the agreement terminates?
- Am I restricted from ancillary or ASC participation?

MODEL 3

Fully Independent Private Practice

The structure: You own the practice, alone or with partners. Solo, small group, or large single-specialty group.

HOW YOU'RE PAID

Typically collections-based. Revenue comes in, overhead comes out, and what remains is distributed by whatever formula your partnership uses. Your income tracks your production, your payer mix, and how efficiently the practice runs.

WHAT YOU CONTROL

Everything — schedule, staff, clinic template, EMR, which payers you contract with, and where you operate. Also the ability to build ownership: surgery centers, imaging, physical therapy, DME, and in grandfathered situations, hospital equity.

WHAT YOU CARRY

Overhead — staff salaries, benefits, rent, malpractice, EMR, billing, insurance. Payroll obligations regardless of a slow month. Payer contract negotiation. Compliance responsibility. Real management time that isn't clinical.

THE ECONOMICS PEOPLE MISS

High collections do not mean high income. Overhead in an orthopedic practice commonly runs a substantial share of collections, and ancillary revenue is often what makes independence financially competitive with an employment offer. A group without ancillaries is a harder sell.

SOLO VS. GROUP

Solo maximizes control and carries maximum risk and administrative burden. Large single-specialty groups spread overhead, strengthen payer negotiating leverage, and open ancillary and ASC ownership that would be out of reach individually — at the cost of some individual autonomy to group governance.

WHO IT FITS

Surgeons who want control over their clinical environment and want to build equity in something. Generally works better with some case volume and referral base already established, though not exclusively.

> **QUESTIONS TO ASK**
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> - What is the partnership track — how long, what's the buy-in, how is it valued?
> - What ancillary revenue exists, and do partners participate?
> - What is the practice's payer mix and overhead percentage?
> - How is governance structured — who actually makes decisions?
> - What is the exit or retirement provision?

THREE THINGS THAT CUT ACROSS ALL MODELS

1. **The headline number tells you almost nothing.** A salary figure is meaningless without knowing the structure behind it, the payer mix, the overhead, and the call burden. Two identical numbers can represent very different jobs.

2. **Model choice is not permanent.** Plenty of surgeons start employed, move to independent practice once they've built volume, or move the other direction as they approach retirement. Choose for your current stage, and read your restrictive covenant carefully — it's the clause that determines whether changing your mind is actually possible.

3. **Regulatory context shapes what's available to you.** Stark Law and Anti-Kickback rules govern how physicians can participate in ownership and referrals. Since 2010, new physician-owned hospitals that accept Medicare have been effectively prohibited, and existing ones capped in growth. This narrows the ownership landscape considerably compared to a generation ago.

Before You Sign Anything

Hire a healthcare attorney — someone who reads physician contracts routinely, not a general practitioner. The cost is a small fraction of what a single missed clause can cost. Run the compensation structure past an accountant who works with physicians. And talk to two or three surgeons who have left the practice you're considering, not just the ones still there.

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