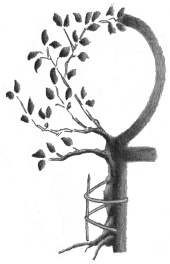

RJOS Resident Mentor Pamphlet

The Ruth Jackson Orthopaedic Society has developed this pamphlet for female orthopaedic residents as a service. It is a synopsis of the different types of orthopaedic practices and specific orthopaedic subspecialties. Several women orthopedists donated their time and effort to this project to help you, female orthopaedic residents, better understand what options are available to you on completion of your residency. Any of the listed contributors would be willing to talk with you about practice options and/or fellowships. The current chairperson of the mentoring committee of the Ruth Jackson Orthopaedic Society is Ginger E. Holt, MD, ginger.e.holt@vanderbilt.edu, office phone (615)322-8890. Please feel free to contact her or any member of the mentoring committee.

SOLO PRACTICE URBAN

Solo practice offers the opportunity to definitively design and implement a practice specific to your individual needs and style. In more conscious locations, being a woman can be an advantage, both from referring primary care physicians (other women) and self-referrals from patients and physical therapists. The financial rewards can be significant if one runs a tight, efficient business, and the personal rewards can be equally great, deriving self-satisfaction from a practice managed and designed by you. The disadvantages include potential contracting difficulties with managed-care organizations due to the solo nature of the practice, unless you join a local *IPA* that does contracting for the group as a whole. Vacations and on-call coverage must be shared and as solo practitioners become more extinct, this may prove difficult at times. You need to be prepared to enjoy the challenge of managing and monitoring the business aspect and be comfortable with taking on the risk yourself for that business. You may find that the greatest portion of your time and energy is spent in not only seeing patients, but also dealing with this aspect of the practice, which can be frustrating and time consuming, especially as it involves the staffing, personnel, and keeping up with the changes in managed care. This may not be a very viable option for new graduates in the most metropolitan areas at this time due to the changes in health care delivery systems.

ACADEMIC

Academic practice is more interesting than private practice because every day is different and responsibilities so varied. One always works with students and residents which helps keep one on their toes. There are educational commitments (lectures and conferences), research endeavors, university and college activities (committees and societies), as well as an active clinical practice. In a university setting, the cases are complex and unusual. It is hard to become bored, but then pay is less than outside of academia. Hours are still reasonable and mostly controllable. It is a good balance between clinical service, intellectual activities, and the joy of passing on orthopaedic knowledge.

MILITARY

The military medical environment offers the opportunity to practice orthopaedics without risk of economic complications for the doctor or the patient. Patient care decisions can be made with remarkably little outside interference. All ages of patients are represented, and while there is a large amount of trauma work, there is also a full range of orthopaedic conditions to manage. Moving every two or three years may be a problem for some, but it does allow for experience in a variety of locations and practice settings that just cannot be obtained in civilian life without financial risk. It is even possible to move between clinical practice and academia research or medical management. The quality of care provided in the military setting equals or exceeds that found in the civilian arena and military pay with benefits is quite competitive.

SOLO RURAL

Solo rural practice requires self-reliance and a great deal of ego strength because there are no colleagues with whom to share your problems or your triumphs. In a small community the hospital and the doctors are mutually dependent to a much greater degree than they would be in larger cities. To practice orthopaedics successfully you must have a financially stable hospital with leadership that is willing to work in partnership with you. Support staff will likely know little about orthopaedics except for what you teach them. Your biggest challenge will be deciding which cases your environment can handle safely and which cases should be referred. Many "interesting" cases well within your capabilities may need referral simply because the technical requirements or the potential financial drain on the hospital cannot be justified in your small town setting. On the other hand, rural life is serene and safe -- an ideal area to raise a family. Your practice demands will likely give you more time to spend with your family; however, the financial rewards will not be as great as you could achieve by working to your maximum in an urban setting.

GROUP PRACTICE

Group practice in a single specialty was the standard orthopaedic practice not long ago. With the coming of managed care and HMO's this type of practice may go the way of the dinosaur. There are many advantages that may also be considered disadvantages. The main point of this type of practice is autonomy of practice. You control your equipment, your environment, your billings, your assistants. This takes time and requires participation in the running of your practice. Fortunately, in a group the financial risk is less and the responsibilities of the practice are usually shared. Your partners are like family; you must trust them and work fairly and equitably with them. You share call but this can be both good and bad depending on the size of the group. Monetary compensation can be much above managed care or may actually be less in a competitive market. Early income is often somewhat less because of buy-in arrangements. There also is some instability in today's health climate. Despite all of these factors, most orthopedists are in single specialty group practices and wish to remain as such.

MULTIPLE SPECIALTY CAPITATED PATIENT POPULATION

Working in a multiple specialty clinic with a large number of capitated patients allows one to work in partnership with other physician specialists who share a single chart on each patient and therefore have more of a sense of total shared responsibility to provide a broad based health care service. One can meet with other orthopaedic partners to discuss cases and clinical issues. Capitation challenges one to provide cost efficient services and work closely with discharge planners and home care departments. Payment is by salary and not on a per procedure basis. There is the opportunity to be involved in management committees of the clinic and thus be able to develop leadership skills and learn the nuts and bolts of contracting, finance issues, and other business realities of health care. Drawbacks of this type of practice include a clinic structure and division of resources not as focused on some special needs of an orthopaedic surgeon.

SPECIALIZED PRACTICES

ONCOLOGY

Orthopaedic oncology deals with the treatment of both benign and malignant tumors of bone and soft tissues of the limbs, limb girdles, and sometimes the spine. The majority of orthopaedic oncologists take care of both children and adults, although some do limit their practice to one or the other. Orthopaedic oncology offers the advantage of seeing a wide variety of patients with challenging clinical problems and operating in many different anatomic locations. The wide variety of presentations of tumors allows for constant diagnostic challenges, and allows the surgeon to be creative in devising treatment strategies. Multidisciplinary approaches to patient problems require the close collaboration with physicians from other fields including radiology, pathology, medical and pediatric oncology, as well as radiation oncology. Most orthopaedic oncology practices are university-affiliated, although a few surgeons have practices in a private setting.

TOTAL JOINT AND ADULT RECONSTRUCTIVE SURGERY

A review of the demographics of the US and Canadian populations shows that the average age of the population is increasing and will continue to increase in the foreseeable future. This, coupled with a longer lifespan and healthier and more active senior citizens, results in a large population of individuals who will be requiring joint reconstructive surgery. The clinical practice is very interesting with a variety of surgical procedures. The expansion of technology has made hip and knee replacement commonplace, as well as shoulder and elbow replacement. The surgical practice is challenging and rewarding in seeing improved function and decreased pain in our patients. The specialty includes primary joint replacements as well as revision surgery often with extensive use of bone graphs. The potential disadvantages of the field are that the fellowship-trained joint replacement surgeon is competing with the general orthopedist for primary joint replacement patients. There is greater tendency for the fellowship-trained surgeon to be doing the complex revision procedures. These are technically more demanding and longer procedures that give less reimbursement per unit time to the surgeon and often are not profitable for hospital centers.

SPINE

The advantage to specialization in spinal surgery is that it allows you to know more about a specific area. Spine, being a difficult area, is both continually changing and challenging. There is a wide variety of patient problems: cervical to lumbar, congenital, acquired, and degenerative. One can also be trained in scoliosis and spinal deformity surgery. Treatment decisions and spinal instrumentation and fusion are unique and difficult for this patient group.

The disadvantages are that your training, experience and ability were once highly regarded and well compensated. The shift to managed care keeps people you could help away. This expensive surgery is not recognized or is ignored by many insurance companies, making compensation difficult. Choices in the future may be doing surgery nearly for free or not at all. A source of general orthopaedic patients to fall back on appears to be a wise choice.

FOOT AND ANKLE

This is a relatively recent area for subspecialty, thus the field is not crowded and the opportunities for advancement exist. Problems in the foot and ankle are diverse, allowing one to focus on certain patient populations depending on the type of practice you have or wish to develop, e.g., sports and dances aspects of the foot, pediatric deformities, diabetic foot, forefoot deformities, reconstructive foot - post-traumatic, degenerative and rheumatoid or acute trauma such as Lisfranc; calcaneal and talar fractures.

Financially, the foot and ankle area is not the highest reimbursed of subspecialties, depending on the type and location of your practice. You are competing in many areas with podiatrists and your patients and physician colleagues may believe that "orthopaedic surgeons do not treat feet," thus many general practitioners may not refer foot difficulties to an orthopedist. Giving lectures may be necessary to develop referral patterns.

SPORTS MEDICINE

Sports medicine is a practice that emphasizes early diagnosis and aggressive treatment for injuries that occur in the athletic arena -- organized and recreational levels. Emphasis on clinical skills for immediate diagnosis so athlete, family, and coach can be informed of plan of treatment is most important. Advanced arthroscopic skills are necessary to restore joint normality. Knowledge of specific rehabilitation programs and communication with the athletic trainer, physical therapist, and coaching staff is of paramount importance. Time demands are great during the fall with football and soccer, particularly Friday and Saturday nights. The reward is seeing the athlete return to the athletic field, and "working" while observing athletic events is the exciting doctor's trophy of sports medicine.

TRAUMA

The orthopaedic trauma surgeon specializes primarily in acute fracture management and stabilization, and secondarily, in post traumatic reconstruction. The scope of practice is wide, varied, covers all anatomic regions and is not limited to a specific age group. Subspecialty areas of interest (upper extremity, pelvis and acetabulum, etc.) may also be developed and pursued. The unpredictable schedule, the long and frequently inconvenient hours, and the challenging work environment occasionally may offset these advantages.

A specialty trauma practice generally requires an urban location with multi-disciplinary service support; and while opportunities exist in both academic and private practice, most orthopaedic trauma surgeons practice in a group setting.

HAND SURGERY

The practice of the hand surgeon is often university based or university affiliated. The subspecialty of hand surgery permits care of a variety of patients with problems affecting the hand and upper extremity. This breadth of exposure is hand surgery's greatest advantage. In any given week, the hand surgeon may treat sports injuries, congenital anomalies, perform tendon transfers for a quadriplegia, and replant multiple amputated digits. There is an increasing trend for the hand surgeon who is trained in orthopaedics to tailor his or her practice to the entire upper extremity – hand, shoulder, and elbow.

Hand fellowships are the most structured of the orthopaedic fellowships and completing one is a requirement for membership to the American Society for Surgery of the Hand. In addition, a Certificate of Added Qualification in hand surgery is also mandatory for membership, to date the only such requirement for a subspecialty organization. Despite the current trend in health care for orthopaedic surgeons to pursue a general practice, many hospitals require or prefer that hand surgery be performed by surgeons who are fellowship trained.

The major disadvantage is the relatively low reimbursement per surgical procedure compared to spine surgery and arthroscopic surgery. This discrepancy, however, may diminish as health care continues to change.

PEDIATRICS

As an orthopaedic subspecialty, pediatrics has the greatest diversity in the types of procedures performed and the number of diseases managed. Though the patient population is limited to children, every part of the body is involved. While many children are followed for years with physical therapy and braces, their changing growth, development and personalities provide constant excitement. More patients must be treated in the office for each operative case in comparison with other orthopaedic subspecialties.

A practice in pediatric orthopaedics usually follows a one-year fellowship. A Certificate of Added Qualification is currently not available. A full-time practice limited to pediatric orthopaedics usually requires an academic center or large pediatric hospital setting to provide the multidisciplinary care needed for many complicated cases. As children are the most under-insured sector of our population, the financial reimbursement to pediatric orthopedists is less than to other orthopaedic subspecialists.

Locating a practice

When starting to look for an orthopaedic practice, you should consider many different areas. First is the practice type, then practice locale. Three major areas of consideration include professional, financial, and personal. Also to be considered is what type of area – big city, small city, suburbia, or rural. The big city offers privacy and anonymity, but competition is often greater. The small city and suburbs offer an attractive living arrangement and usually easy driving distances. The more desirable areas will also have increased competition. The rural practice tends to be less busy, with patients driving longer distances to visit and less competition. Some cities and states have a predominance of HMO's, multi-specialty clinics and capitation. California is the best-known state. The Midwest cities of Minneapolis, MN and Madison, WI are other examples.

In the realm of the personal, one should consider what activities are available and try to match your desires with the given area. The type of education and family activities may be important. Each area has advantages and disadvantages in both these concerns.

If possible, contact a female orthopedist in the area for more information. A directory is available via the RJOS.

Contracts, Buy-Ins and Malpractice

To start, it is always a good idea to have a lawyer review your contract. This is true no matter what type of practice you consider, of course excepting solo practice without affiliation. Many contracts have clauses that are not legal or not binding and should be discussed prior to finalization. The nature and type of buy-in can be as varied as much as the private practices that the buy-in pertains to. Some practices offer full partnership, which should include ownership of the practice facility building, share of the accounts received, stock, and equipment. This is the preferred arrangement and the one most equitable. Some will offer only participation in the accounts but not the depreciable assets. The length of buy-in is also variable, running from 6 months to 3 years. The most common time is 1 year. Prior to the buy-in it is customary to have a guaranteed salary. Salaries also vary extensively depending on the area of the country and the locale of the practice, i.e., rural vs. large city. One should be very careful to have the details of the buy-in settled and understood before accepting a position. Be wary of joining an orthopedist or group hesitant to discuss financial details of a buy-in.

The contracts for HMO's and multi-specialty groups are not usually negotiable. There is not the usual buy-in, and salary computations can vary from group to group. Some organizations offer a salary without production considerations. Some will allow for increased payment with increased production. Again, it is best to know in advance which system you are joining and to weigh the pros and cons to your own personality and practice preferences.

Academic positions can likewise vary in nature. Some institutions pay set salaries, but most base payment on production with a set salary to encourage teaching and research.

Malpractice

There are basically two types of malpractice insurances available to orthopaedists. The first is Claims-Made; the second is Occurrence coverage. The Claims-Made coverage is based on incidents (or malpractice claims) that take place **and are reported** at the time of the coverage. The premiums for this are based on the potential for a claim against a physician. As the length of time a physician practices increases the potential for a claim also increases, therefore the premiums mature. The advantage of Claims-Made coverage is the premiums are based on actual past and current experience and usually are less expensive. The liability limits may be easily changed to reflect changes in the professional liability climate. The disadvantage of Claims-Made coverage is the need for "tail" coverage for any malpractice suits, which occurred during the time of the coverage but were not reported until after the coverage stopped. This occurs when changing practices, changing companies, or moving to a new state. This additional coverage must be purchased from the carrier whenever leaving the insurance company. The ability to purchase such coverage should be guaranteed prior to accepting the coverage. The length of tail coverage should also be known. Each state has different statutes governing how long after an incident a suit can be filed, i.e., three years in the state of Wisconsin. A good insurance policy will offer tail coverage at no charge at a given age, or for permanent and total disability, or in the event of physician demise.

Occurrence coverage insures the physician for any incident (or malpractice claim) that occurs while the policy is in effect, regardless of when the incident is reported. Premiums are based on projected possible suits. Rates may fluctuate and tend to overcompensate for our litigious society. Premiums are more expensive than Claims-Made coverage. The advantage is coverage without need of "tails" when changing companies or practices.

Many orthopaedic specialty societies are listed on the AAOS Home Page, several of which are listed below.

AACPDM	American Academy for Cerebral Palsy	www.aacpdm.org
AAHKS	American Association of Hip and Knee Surgeons	www.aahks.org
AOSSM	American Orthopaedic Society for Sports Medicine	www.sportsmed.org
ASSH	American Society for Surgery of the Hand	www.handsurgery.org
ACPOC	Association of Children's Prosthetic Orthotic Clinics	www.acpoc.org
ASES	American Shoulder and Elbow Surgeons	www.ases.org
CSRS	Cervical Spine Research Society	www.csrs.org
HS	Hip Society	www.hipsoc.org
JRGS	J. Robert Gladden Society	www.gladdensociety.org
KS	Knee Society	www.kneesociety.org
MTS	Musculoskeletal Tumor Society	www.msts.org
ORS	Orthopaedic Research Society	www.ors.org
OTA	Orthopaedic Trauma Association	www.ota.org
POSNA	Pediatric Orthopaedic Society of North America	www.posna.org
RJOS	Ruth Jackson Orthopaedic Society	www.rjos.org
SICOT	International Society of Orthopaedic Surgery & Traumatology	www.sicot.org
SRS	Scoliosis Research Society	www.srs.org

Home Page Internet/E-mail References

ABOS	American Board of Orthopaedic Surgery, Inc.	www.abos.org
AOA	American Orthopaedic Association	www.aoassn.org
AAMC	Association of American Medical Colleges	www.aamc.org
AAOS	American Academy of Orthopaedic Surgeons	www.aaos.org
AMA	American Medical Association	www.ama-assn.org
AMWA	American Medical Women's Association	www.amwa-doc.org
AWS	Association of Women Surgeons	E-mail: AWS@adminsys.com