When To Hire a New Orthopedic Surgeon

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Objectives: To establish a data-driven framework for determining when a large, single-specialty orthopedic group practice should hire a new surgeon, using longitudinal physician productivity and patient access data as primary decision triggers.

Design: Retrospective, observational, single-practice benchmarking study with a narrative synthesis of strategic, operational, and governance considerations.
Setting: Large, single-specialty orthopedic group practice.

Methods: Work relative value unit (wRVU) output was collected from internal practice records for six mid- to late-career surgeons over five years (2019–2023). New patient wait times were tracked monthly and compared with established access benchmarks (14-day optimal threshold; 21-day patient leakage threshold) derived from Merritt Hawkins, MGMA, and AAOS survey data. External benchmarks served as reference points for regional productivity and access standards. Revenue data for one newly hired surgeon and one concurrently declining senior partner were also extracted from internal financial records over a five-year period (2012–2016) to construct the revenue crossover curve shown in Figure 1.

Results: The mean wRVU output per surgeon declined from 15,877 in 2019 to 13,406 in 2023, a 15.6% decrease and a total practice-wide productivity loss of 14,824 wRVUs — roughly equivalent to one full-time surgeon FTE. New patient wait times consistently exceeded the 14-day optimal benchmark and neared or surpassed the 21-day patient leakage threshold, despite operational efforts such as APP expansion, extended hours, and schedule optimization. The revenue trajectory of a newly hired surgeon crossed that of a concurrently declining senior partner within approximately two years, demonstrating that a well-timed hire can offset senior partner productivity decline without net revenue loss to the practice. These findings informed the practice's decision to hire 7 new surgeons. Five core decision triggers are proposed: patient access metrics, physician productivity trends, APP utilization limits, financial readiness, and strategic alignment.

Conclusions: Recruitment decisions based on quantitative productivity and access thresholds—rather than partner consensus or reactive needs—are linked to sustained practice growth and competitive positioning. A governance-driven, data-informed hiring framework that incorporates wRVU trajectory, new patient wait-time monitoring, APP saturation signals, and financial modeling provides a reproducible, objective decision-making structure for orthopedic group practices in workforce planning.

Level of Evidence: Level IV — Retrospective Observational Benchmarking Study

Key Words: Physician recruitment, orthopedic workforce, private practice management, healthcare economics

INTRODUCTION

The current healthcare landscape is highly competitive and rapidly consolidating (1–3). Hospitals and private equity–backed entities are hiring new graduates at unprecedented rates, fundamentally reshaping the traditional private practice landscape. New graduates, often concerned about business aspects, burdened by debt, and seeking better work-life balance, are becoming more risk-averse about entering private practice and more interested in employed positions that offer predictable salaries and structured benefits, even if it means sacrificing autonomy and ancillary income. Hospitals offer fixed hours and guaranteed salaries, but this comes at the expense of individual control, ancillary service revenue, real estate opportunities, or gainsharing. Large orthopedic group practices need to adapt to remain competitive in this environment. They must be flexible

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Table 1. RVU generation by specific mid-to-late career surgeons within our practice showing peak and decline.

Surgeon	wRVUs 2019	2020	2021	2022	2023
A	19,091	17,822	19,194	16,242	15,660
B	17,515	16,409	16,781	14,959	12,900
C	17,951	16,455	15,646	15,456	14,696
D	11,142	10,282	11,120	10,298	10,283
E	14,796	17,241	18,033	16,247	15,868
F	14,767	13,871	12,678	11,047	11,031
Total	**95,262**	**92,080**	**93,452**	**84,249**	**80,438**

rather than static—expanding service lines, increasing operational efficiency, and integrating vertically across the continuum of care (1–3). Recruitment is crucial but must be data-driven and carefully considered to prevent failure.

Multiple scenarios can necessitate recruiting new associates. Facility expansion or entry into new markets increases overhead per surgeon full-time equivalent (FTE) and reduces revenue per square foot. The aging of productive physicians leads to declining collections and longer wait times, which drive patient leakage to competing practices (4). Expanding access through orthopedic urgent care clinics, implementing alternative payer models, increasing marketing efforts, and opening new locations in other cities can quickly grow the business. Growth and diversification are now vital strategic priorities rather than optional ambitions (1–3). Recruitment is therefore a data-driven strategic function, not a reactive process.

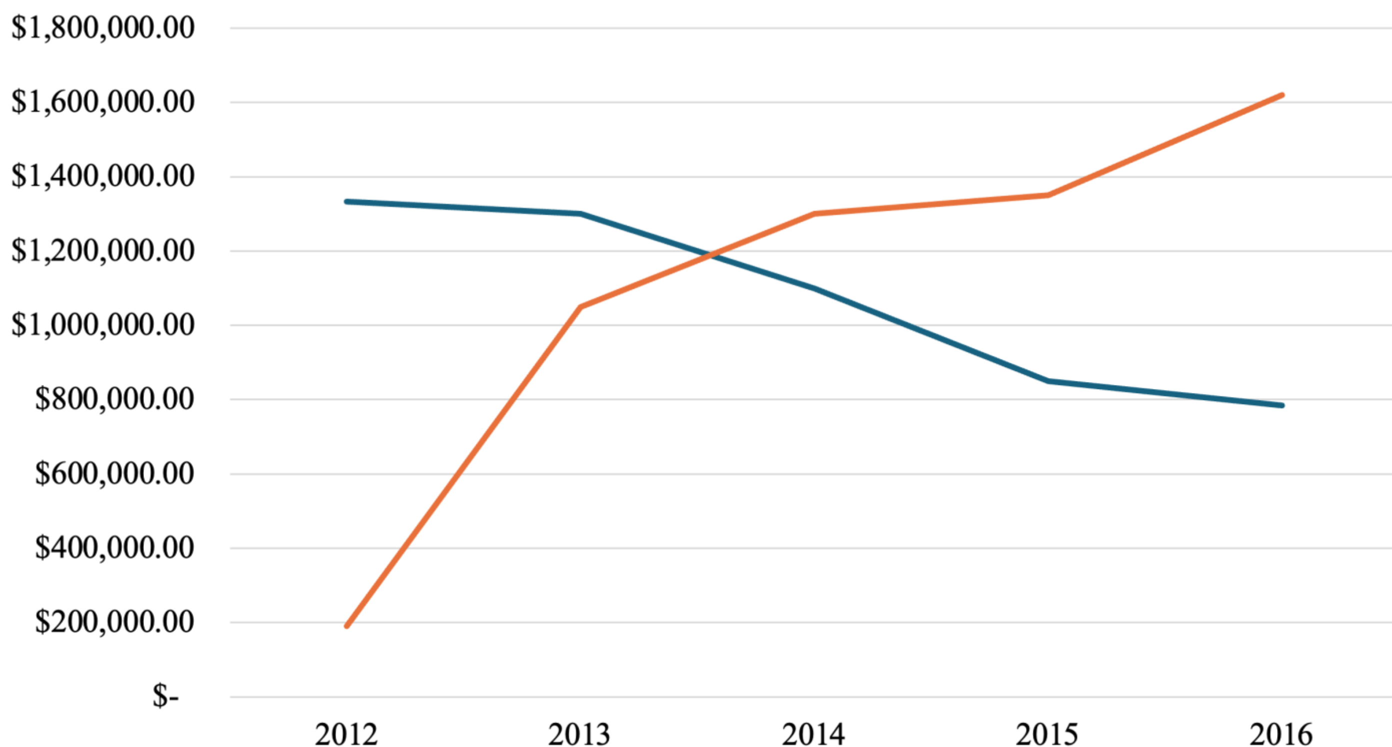
METHODS

This manuscript presents a retrospective, observational, single-practice benchmarking analysis. Practice-level financial, operational, and scheduling data are used to identify two quantitative decision triggers for physician recruitment: declines in surgeon productivity and deterioration in patient access. No patient-level identifiers are used. Findings are reported at the practice and surgeon-FTE levels and serve as reproducible benchmarks for other orthopedic group practices.

Work relative value unit (wRVU) data were obtained from internal practice financial records for six mid- to late-career surgeons over a five-year period (2019–2023). Annual wRVU totals for each surgeon and overall practice productivity were recorded in the practice's compensation and billing systems. These surgeons were selected to represent the mid- to late-career group, whose productivity trajectory informed the recruitment decision. Revenue data for one newly hired surgeon and one senior partner experiencing a concurrent decline were also collected from internal financial records covering a five-year period (2012–2016) to develop the revenue crossover curve shown in Figure 1.

New patient appointment wait times were recorded monthly using internal scheduling data. These figures were compared with two established access benchmarks: the 14-day optimal threshold and the 21-day patient leakage threshold, as defined by Merritt Hawkins survey data (4). Operational measures taken during this period—including APP expansion, extended

Figure 1. Example breakdown of revenue generation by a new physician coinciding with the slowdown of a mid-to-late career surgeon.



clinic hours, and schedule optimization—were documented to provide context for the access trends.

External productivity and workforce benchmarks were drawn from the Medical Group Management Association (MGMA) 2023 Provider Compensation and Productivity Report (5), the American Academy of Orthopaedic Surgeons (AAOS) Orthopaedic Surgeon Census Report (6), and the AMN Healthcare/Merritt Hawkins 2022 Survey of Physician Appointment Wait Times (4). These sources served as regional comparators for productivity norms and access standards.

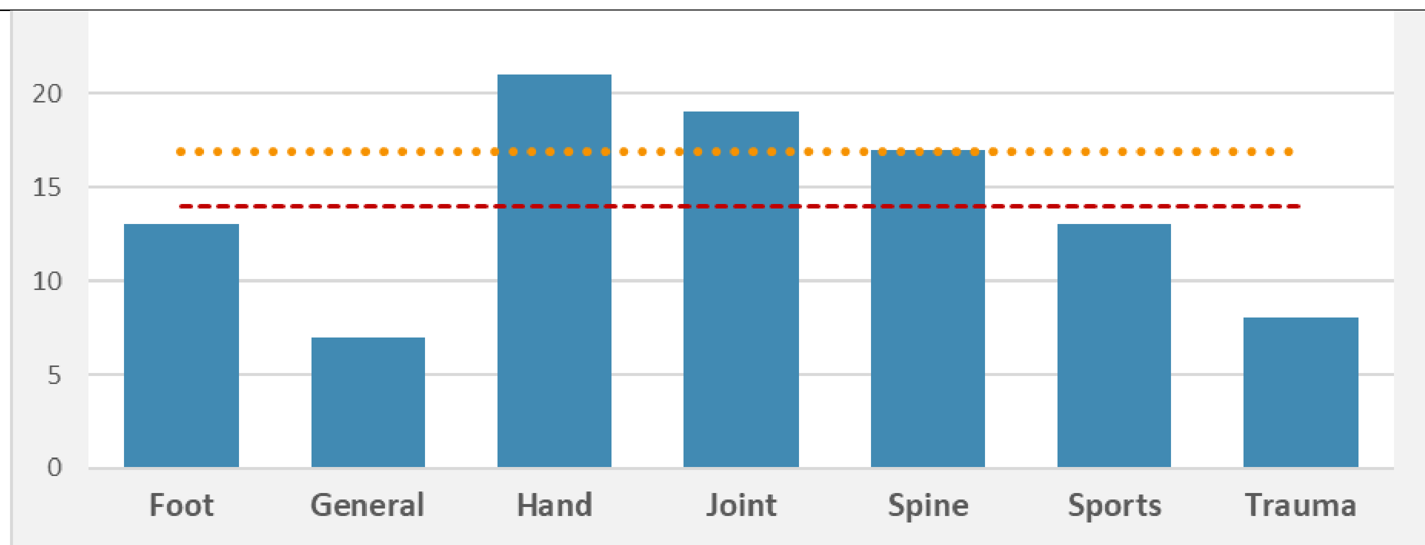
RESULTS

The mean wRVU output per surgeon among the six tracked surgeons decreased from 15,877 in 2019 to 13,406 in 2023—a 15.6% decline (Table 1). Practice-wide output fell from 95,262 to 80,438 wRVUs over the same period, a loss of 14,824 wRVUs, roughly equivalent to one full-time surgeon FTE. Individual surgeons varied, with the largest declines occurring among the highest-volume producers, consistent with the expected slowdown pattern for mid-to-late career surgeons.

New patient wait times (Figure 2) at the authors' practice consistently exceeded the 14-day optimal access benchmark throughout the observation period and, at multiple points, approached or surpassed the 21-day patient leakage threshold—the point at which 22% of patients seek an alternative provider (4). These trends persisted despite operational interventions, including APP expansion, extended clinic hours, and schedule optimization, indicating that demand had outpaced the capacity of non-physician staffing solutions.

As shown in Figure 1, the revenue trajectory of a newly hired surgeon crossed that of a concurrently declining senior partner within roughly two years of the new hire's start date. The new hire's annual collections rose from about $150,000 in year one to over $1,600,000

Figure 2. 2023 average wait time for new patient appointment in days by team compared to national benchmark. Where new patient wait times consistently exceed 2–4 weeks despite optimization efforts including the use of APPs, extended hours, and schedule adjustments.



by year five, while the senior surgeon's collections fell from approximately $1,300,000 to $750,000 over the same period. The crossover occurred in year two, consistent with the 2-year ramp-up period noted in the literature (5,6). This trajectory demonstrates that a well-timed hire can offset a senior partner's productivity decline without causing a net revenue loss for the practice, provided recruitment occurs before the steepest part of the slowdown curve.

DISCUSSION

Impact of New Physicians

Adding new associate physicians can significantly drive growth. When well integrated, new surgeons increase access, boost throughput, and stabilize revenue, especially when structured through tiered partnership models. A new associate's collections from call pay, surgical volume, and ancillary use can offset fixed overhead and enable senior partners to shift to reduced schedules. The timing of this transition should align with practice buy-in and revenue streams. Although external recruitment firms might charge $80,000–$100,000 with uncertain results, internal recruitment committees—using professional networks and postings on specialty society websites—can achieve similar outcomes at much lower costs of only $500–$700 monthly (6). Still, timing is key: ramp-up periods vary widely by subspecialty, and poor timing between a partner's decline and a new hire's ramp-up can lead to underused capacity or financial difficulties (5,6).

Provider Mix

The wRVU trajectory in Table 1 aligns with typical mid-to-late-career surgeon slowdown patterns and supports interpreting the provider mix as a key recruitment indicator. Thorough analysis of the current provider mix is essential to meet future demands. The aging orthopedic workforce is a pressing national issue; roughly 50% of practicing orthopedic surgeons are over 55 (4). As surgeons near retirement, a gradual slowdown typically begins 5–7 years earlier, manifesting as reduced operative volume and clinic throughput (**Table 1**).

Table 2. Overview of the hiring framework for a practice

Patient Access Metrics
○ Average wait time for new patient visits
○ Percentage of patients lost due to delays (>14 days)
○ No-show and cancellation rates tied to long waits
Market and Competitive Pressures
○ Number of comparable specialists in the area
○ Growth of urgent care and alternative providers
Capacity and Resource Utilization
○ Operating room occupancy rates and allocation between physicians and APPs
○ Support service capacity (imaging, therapy, surgical availability)
Financial and Strategic Alignment
○ Projected patient volumes
○ Alignment with long-term growth and expansion plans

The ramp-up period for a new orthopedic surgeon usually lasts up to 2 years. The only exception is a traumatologist, who can quickly attract new patients through previously untapped clinical access points (such as emergency departments, orthopedic-specific urgent cares, and rural hospitals) and trauma call pay. Trauma physicians ramp up quickly because they have immediate call access, whereas mostly elective-based arthroplasty surgeons take longer and rely heavily on their reputation. Additionally, traumatologists can perform fracture cases in half the time and at half the cost compared to their non–trauma-trained counterparts. This further frees up block time and resources, allowing other specialists to focus on their elective practices. Coordinating this ramp-up with the expected slowdown of partners is key to recruitment planning (1–3) (Figure 1).

Provider Productivity Levels

The productivity decline shown in Table 1 supports using wRVU monitoring as an objective, early indicator of when recruitment is needed. As noted earlier, a slowdown among high producers is expected later in a career and signals when to start recruiting (4,5). Tracking provider productivity metrics such as work relative value units (wRVUs) per year, new patient visits, total patient visits, and patient wait times (for both new and established patients) is crucial. When current physicians reach or exceed 85–90% of their capacity, it's time to consider bringing in new physicians. Over the past decade, graduating surgeons have chosen to work fewer hours than their predecessors (5,6). In the authors' practice, high producers previously generated around 20,000 wRVUs annually. Today, a full-time orthopedic surgeon typically produces between 9,000 and 12,000 wRVUs per year (5). This shift reflects generational priorities focused on work-life balance and team-based care. Often, hiring two new surgeons is necessary to replace a mid-career surgeon (around 55–60 years old). As a result, replacing a single high-producing partner may require adding two younger surgeons or a mix of surgeons and advanced practice providers (APPs) (7). High utilization of APPs, including nurse practitioners (NPs) and physician assistants (PAs), can signal

readiness for a new physician who can generate more revenue and increase surgical capacity (7).

Market Demand Indicators

Several demand indicators are clear, including population growth, aging demographics, and shortages of orthopedic specialists (4,6). Market-specific indicators such as regional population growth, referral volumes, and competitive presence help gauge when hiring new staff is needed. In mid-sized U.S. markets, average wait times for orthopedic appointments approach 17 days, and 22% of patients seek alternative providers if delays exceed 14 days (6). Maintaining access within these thresholds is crucial for patient retention and growth.

Hire when patient demand exceeds provider capacity by 10–15% for at least six months and when operational and financial conditions indicate that the new physician can be productive and sustainable within one to two years. This typically occurs when wait times for new patients are longer than 14–21 days, physicians operate at 85–90% capacity, and infrastructure can support the additional provider (6).

Financial Readiness

The practice must be financially prepared to support a new physician. New associate physicians offer a unique opportunity to maintain or increase revenue, especially in ancillary income, during slowdowns caused by mid-to-late-career surgeons. Orthopedic practices generate significant profit from vertically integrated service lines—such as imaging, therapy, and ASCs—which boost margins and protect against declining professional fees (5). Ideally, a new hire should increase utilization of these ancillary services without exceeding operational capacity. The current payer mix and reimbursement rates must sustain revenue for the additional FTE (5). Ancillary services must also have sufficient capacity to handle extra volume; otherwise, the new hire—and the entire practice—will have limited room to grow. Economic modeling tools that estimate the contribution margin of new hires—considering overhead, ramp-up time, and expected case mix—can help evaluate financial viability (7).

Strategic Alignment

Recruitment decisions should be guided by the group's long-term strategic vision (1–3). Expanding into new geographic markets may require developing new subspecialty service lines, such as sports medicine, hand, or spine. In rural markets, general orthopedic surgeons can be especially important, even though urban practices often rely heavily on subspecialists because of a more sophisticated and discerning patient population. A new physician's skills should align with identified service gaps in future growth areas. Conversely, low-margin specialties like pediatric orthopedics and oncology might be better supported through co-management agreements or hospital alignment to share salary risk.

Facility & Resource Capacity

Ideally, practices will align their clinical space with their number of surgeons to prevent gaps; however, construction costs have risen more than 20% since 2020 (7). In response, some groups choose to overbuild in anticipation of future expansion to benefit from lower construction costs and less practice disruption caused by builders and contractors. Physicians must recognize that the practice incurs overhead on underutilized or unused clinical space. Clinic space, including exam rooms, imaging capacity, and surgical block time, must be considered individually. A new physician requires approximately 130 operative days per year (or 2.5 per week) for optimal productivity. Underutilized space results in financial loss, but a lack of space can limit growth (7). If the necessary space doesn't exist but a practice wants to expand, it must seek additional office

space elsewhere, extend clinic hours (e.g., instead of 0800-1700, have shifts from 0700-1200 and 1300-1900), or open on weekends until space becomes available through construction or acquisition. Conversely, if excess space has been allocated for future growth, groups often rent out unused areas to help offset costs.

Patient Access Thresholds

The wait time data in Figure 2 meet and exceed the access thresholds described below, confirming their usefulness as objective triggers for the recruitment decision. In orthopedic surgery, the ideal benchmark is under 14 days for a new patient appointment; exceeding 21 days often results in significant patient leakage to competitors or urgent care (6). In mid-sized markets, the average wait time for a new orthopedic surgeon appointment is 16.9 days. Surveys indicate that if a patient must wait more than 14 days, 22% will seek another provider, and satisfaction and net promoter scores drop sharply beyond this access window. In the authors' group, this was a key factor in deciding to hire 7 new surgeons (6) (**Figure 2**).

Impact of Extenders

The addition of APPs can improve patient access, but it is a poor long-term solution (7). In the authors' practice, a well-utilized APP can reduce patient wait times by 25%, demonstrating that expanding provider capacity through nonphysician clinicians can be a short-term fix. However, at some point demand still exceeds supply, and new physician hires become necessary. While APPs are valuable for nonoperative and postoperative management, they collect 80% of the physician fee for new patients, cannot match the training or efficiency of a fellowship-trained physician, and cannot perform their own surgeries (7). Over-reliance on APPs may limit long-term growth and reduce surgical throughput. Optimal staffing models balance APP use with physician hiring to maintain both access and profitability (7). Although APPs are very helpful in reducing physicians' daily workload, they generally lose money year after year. As a result, the authors' practice has employed two dedicated trauma PAs for clinical and operative assistance, in addition to enlisting two hospital-employed PAs at the main trauma center.

Non-Orthopedic Specialists

In the evolving healthcare landscape, diversification can offer protection and new opportunities for growth (1–3). Hiring plastic surgeons with fellowship training in hand surgery brings partners who can handle hand call duties and perform flap and soft-tissue procedures for a busy trauma service. The authors' group employs two fellowship-trained plastic reconstructive surgeons in this role, significantly increasing access to essential soft-tissue procedures for patient care, the hospital trauma team, and the ASC (8). Considering the addition of vascular surgeons offers another opportunity, given their vital role in hospital limb preservation and trauma services, which enhances care and cements a group's position in hospital call negotiations (9–11). In the office setting, vascular surgeons can utilize underused space and boost ancillary services, such as CT scans, and increase ASC volumes (12). Large practices may also consider employing rheumatologists and geriatricians to complement an orthopedic center of excellence focused on joint pain and osteoporosis management (4–6). Hiring nonoperative sports physicians, physical medicine and rehabilitation specialists, and pain management experts has also proven successful for some groups (7). Overall, these multispecialty additions can be highly effective, though care must be taken given differing compensation models, overhead costs, and collection practices for non-orthopedic and non-surgical partners (1–3,5).

Framework for Hiring

Based on the information above, group practices should track patient access metrics, market and competitive pressures, capacity and resource utilization, and financial and strategic alignment to determine whether (and when) to hire a new physician (**Table 2**). Hiring should not, and does not, occur simply because the practice believes it should. These decisions must be grounded in clear data, and each category should have a data point before hiring (5–7).

Hiring Process

After collecting data to evaluate market forces, future needs, and growth opportunities, clear financial justifications for hiring new physicians do not always persuade current partners to make the best choice for the practice. Partners often worry about losing patients or income, even when data point to increased success for the practice as a whole (5–7). Governance structures that place hiring authority with an executive board rather than a full partnership vote have been associated with more objective, data-driven recruitment outcomes in large group practices (1–3). Experienced executives or practice managers rely on a board to make hiring decisions. In the authors' experience, an executive board ensures decisions are data-driven and strategically aligned. This approach prevents unfounded fears voiced by some physicians from hindering the practice's progress. Involving multiple specialties in the interview process promotes cultural fit, but the final hiring decision should remain with leadership to maintain objectivity. Clearly communicating the financial benefits and long-term advantages can help reduce resistance from current partners (1–3,5–7).

CONCLUSION

Deciding to hire a new orthopedic surgeon for a large, single-specialty group is a multifactorial decision that should be objective. It requires balancing data analysis, strategic insight, and operational readiness. Early hires can lead to underutilization of resources and higher costs, while delaying a new hire threatens a thriving, expanding practice. Based on the authors' experience, the most successful groups rely on quantitative benchmarks (capacity ≥85%, wait times >14 days, demand growth >10%) and qualitative foresight (partner slowdown, strategic expansion). Practices that establish a governance-based, data-informed hiring process are best positioned to maintain growth, stability, and a competitive edge in an evolving healthcare landscape. The benchmarks and framework presented here are adaptable to orthopedic group practices of various sizes and structures and offer a reproducible, data-grounded foundation for workforce planning beyond the single-practice setting in which they were developed.

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