

## Editorial

# "In My Experience™...Preserving the Doctor-Patient Relationship in Practice"

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Now, when asked about building facilities and the associated economics, at the end of the day, we need to centrally focus on that premise of the preservation of the doctor-patient relationship. Because if you look at large health systems, there are layers and layers of bureaucratic administrators and they have to be paid from revenue stream. As we educate young physicians, unfortunately many of them, like myself when I graduated fellowship I hate to admit, don't understand the flow of money for the work that you do.

That's sort of a basic premise in anyone's career, anyone's job, no matter what it is. But in medicine, we don't do a good job teaching our residents or fellows about the economics. So, they come out and we explain to them: "when you do a surgery, you get a professional fee. When you do it in a facility, there is a facility fee that is way bigger than your professional fee. Like, way bigger!" They don't even know how much bigger. It's on an order of magnitude bigger, like in the tens of thousands versus your Medicare \$1,200 for doing a hip or knee replacement that you then have to pay your overhead, which can be 50% - 60%. I would say with inflation and labor costs, it's probably more like 60%. That gives you \$500 left over. By the way, you're going to get taxed by the government on your income after that.

When you work through the math, it's not as glorious as one might think when they decide to go to med school. So, what we're doing in the Indiana Orthopedic Institute has just been the culmination of a lifelong interest to preserve the doctor-patient relationship. You cannot sustain a pri-

vate practice anymore just on professional fees. It is literally impossible unless you would want to make less than your physician assistants by the time you're done paying all your staff. The only way that you can preserve private practice is to get part of that facility fee. But, if you get that facility fee and you are hospital employed, you have to pay layers and layers of other people with it, then pretty soon, you're going to end up with the same problem: there's not much left for you and your staff.

So, if you look at it from that vantage point, what we built, what that facility is, the vertically integrated ambulatory surgery center with a medical office building and physical therapy, it is basically what we had in the Indiana University Hip and Knee Center without all the administrators. It literally takes those entire cost layers and removes them. You have surgeries, you have your clinics, you have physical therapy. We, because we have focused on research for so long, have a gait lab and space for research people. That's not revenue-generating per se, but it's a labor of love, so we do that regardless. But everything else in that building, for the most part is revenue-generating space that has removed the bureaucratic costly layer from it.

So why is that important?

Number one, for our own viability to maintain private practice. Number two, because we know that the payers and the government are clearly pushing people towards the ambulatory surgery centers (ASCs.) They're directing them because it's a lower-cost site of care for them. So, in order for us to deliver a low-cost site of care, we had to build one. And we had to form a business that delivers a low-cost, high quality orthopedic procedures with great outcomes. At the end of the day, it is to preserve the doctor-patient relationship. Because all those other things get in the way. And if we can't have private practice anymore and everybody's

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consolidated and either employed or part of someone like Optum, that's not going to decrease the cost of care. Cost actually increases with consolidation due to the decrease in a free market choice for consumers and it also decreases access. That was the original impetus to start the Indiana Orthopedic Institute and then to build this facility because we knew we couldn't just start the group without a facility to capture the facility revenue. So that's what that is. It's a low-cost site of care where we've been very encouraged by both the payer response to this and the community response.

The only people not cheering us on are the other orthopedic groups in Indianapolis. That's because, unfortunately, there is some threat there and of course competition in the market. But I'm excited about reaching out to them very soon once we get up going and working on another revenue stream that is value-based care in a clinically integrated network, that is going at risk for musculoskeletal health lives.

If you can go to Anthem or United or whoever and say, "Well, in central Indiana, we're going to work with other groups to go at risk and put in standardized protocols and streamline all of our resources that we utilize to take care of patients. We can drive the cost of care down and improve quality, we'll share in that savings." I'd say that's more future-looking, but that's a great way to add revenue streams to, again, preserve private practice. The problem is if private practice goes away, then you lose the free market aspect. Many people believe that will immediately drive up the cost of care even higher. So that's sort of the impetus, the rationale for why we started the group and why we have the facility.

When we started this, when I left my employed position, I had a two-year, 50-mile non-compete. I either had to move my family or I had to drive out of that non-compete radius. I have four children that are ages 6 to 11. I have two in college as well, but I have four children who are happy in school and a wife who's happy. So, I didn't want to uproot them. I did that once before when I went to Connecticut, avoiding a non-compete early in my career. I wasn't going to do that again. That was too disruptive to the family. So, I just drove every day. I was very blessed that my entire team went on this journey with me. My nurse Shelly, she's been with me for 20 years, she was with me from Indiana to Connecticut and back. My physician assistant, Dan, has been with me for a decade and a half. Then my head of anesthesia and my director of research, they all believed in what we were doing together. So, we all uprooted and drove. We drove an hour and a half each way every day. An hour and a half to go do surgery. We'd get up, we'd be in the car on our surgery days by 5 a.m. We'd start our incision at 6:45, an hour and a half away. We'd do surgery all day. We'd get in the car. We'd drive back. It was a long two years.

Everybody was really happy when my non-compete expired because my non-compete was their non-compete, unfortunately, in practical terms. But that allowed us, interestingly, to truly form a statewide orthopedic program. So, at first, we thought, "We have to go to the smaller town

on the Indiana-Illinois border," my hometown Terre Haute, "We have to go there to practice."

We formed a professional service agreement. We structured that with a hospital there. What's great about professional service agreement is the hospital subsidizes you, compliantly. You basically form a partnership with them where you perform the orthopedic services and they pay you for it at fair market value. It's a nice way to de-risk your enterprise. So, when we started, we were going there for that reason. As we were practicing there, we realized, "Well, wait a minute. If we can build up this site on the Indiana-Illinois border, it's the only thing between Indianapolis and St. Louis, really, other than Effingham, Illinois. We could build this up and there's enough market data to show us that we can probably do 2,000 joints a year there. Well, why don't we make that a permanent place and build another ambulatory surgery center and then start to scale this?" Then with scale, you can also decrease your costs, etc. So, that's what we're doing. That's going to be a permanent site for us. We have an agreement and a partnership there with the local engineering school, Rose-Hulman Institute of Technology, and building a facility that's on the university's campus. It'll be unlike anything in the United States.

We're going to have an ASC, medical office building, on the university campus attached to an engineering school and the students can walk right back and forth. Engineering students can be in a class learning about polyethylene or biomaterials or knee kinematics and they can walk right across and watch a surgery. Come into surgery, then go right back into the class and learn about it. What a great way to facilitate innovation in the orthopedic space. We're very blessed to be able to do that. So that's Terre Haute. We did that while we were building our flagship ASC facility in Indianapolis, which is now open. So, we got to build the one in Terre Haute, but everyone, both boards, the hospital board and the university board have all signed off on it and everybody's excited about it. It's really cool. It's kind of like the old phrase turning lemons into lemonade, that's kind of what we did. It's a long process to do it, but it's pretty exciting.

The one facility in Terre Haute will be a joint venture between the hospital and us. Our flagship facility in Indianapolis is 100% owned by us and run by us. So, we don't have any other investors or anything like that. It's been interesting doing this from the ground up. You learn so much. For example, if you have a closed medical staff, if your group owns an ambulatory surgery center and you don't have to open it up to an outside medical staff for business because your own group is big enough to fill it, then the malpractice for the ambulatory surgery center only costs us a hundred dollars a year. If you open it up, then you have to insure their medical malpractice, when other people come in, it'll cover them, but it won't cover them based on the facility. If it's just your own group and you're the only ones in the facility, you tag the facility onto your own medical malpractice. Incredible savings. Who knew? But these are the things you find out along the way being an entrepreneur orthopedic surgeon building your own business.

One of the things we've learned from this process is when you invest this much money, time and effort, you spend a lot of time looking at the future because you don't want to build and then miss the mark. I spend far more time now, probably than ever, really looking at 10 years down the road. What we see is that, fortunately, I think we were a bit ahead of the curve to build what we call "the hospital for the future," which is an outpatient site of care at outpatient cost to the government payers and patients.

But the key to make it feel like a hospital, rather than what typically occurs in the United States right now where ASCs are disconnected. You'll have your practice, typically, the traditional model, you'll have your own Electronic Medical Record (EMR), and then you'll go to some ambulatory surgery center that five other groups are in. Many ASCs in the United States are still on paper. They're not even on electronic health record. Now, in the era of cybersecurity, maybe it's not bad. But, in general, it's hard to be efficient and maximize your billing collections if you're on paper. What we've learned is that there were really only two EMR companies that were in ambulatory surgery centers. Really only two. And bigger ones like Cerner or Epic, they were so hospital-based that they had ignored ambulatory surgery centers. If you're an ambulatory surgery center and you're part of a hospital system, because you're a Hospital Outpatient Department (HOPD) then you tended to have the EMR, and it felt like a hospital.

But as soon as I left Indiana University, I went to an ambulatory surgery center, and I'm like, "Wait, where's the continuity?" I'm like, "I have to learn a whole new EMR?" So, at one point, we were on three different EMRs. I thought, "This is impossible." Then I started realizing, well, wait a minute. I'm experiencing this. I find this very inefficient. But this is what the rest of the world is experiencing. You just don't hear people talk about it very much. But I had just gone from full integration to totally disconnected. It's like, "Well, why is the rest of the world that's struggling out here in private practice, why aren't they integrated? This takes money and time."

We realized we needed to be integrated. I have a really good relationship with HOPCo, Health Outcomes Performance Company. I'm on their executive team now. It's coincidental that at the time we're doing this, they were building up their fully integrated digital platform, EMR patient engagement app. So, when you do surgery, it's immediately talking to the patients, both pre and post. Then they have a business analytics tool called Practice Vitals. They have all this suite of tech products, including the entire complete network solution. Your email, all the Microsoft products, the cybersecurity protection that goes with it, which is *really* expensive to do in disconnected separate software programs, was in one integrated package. What's great about this is our flagship facility is not only our flagship for our practice, but it's the first, basically, test case canary in the mineshaft, if you will, of HOPCO's fully digital integrated platform. So, we have Athena EMR in the clinic, Athena EMR in the ASC. When you're in it, it'll feel like a hospital. But it won't have all those things that I think are hurting healthcare and interfering in the doctor-patient relation-

ship that exists in a hospital, that you hear people frustrated about and complaining about.

As you look to the future, one of the other aspects of this is most ambulatory surgery centers in the United States are being retrofit to do hip and knee replacement. Most of them were doing other types of procedures. Now, if you're building them new, you can do this. But we realized, having done a lot of outpatient same-day surgery over the 10 years, that when we would move this to the ASC, they struggled with sterile processing. They struggled to keep up with the heavy instrument load associated with hip and knee replacement. So, when we were in Indiana University, because they were one integrated health system, we had to legally jump through some hoops. Most of our instruments were sterilized and done over at the hospital where they had the capacity and they would roll it over because we were on one campus.

But ambulatory surgery centers have to be completely separate tax IDs, separate legal entities. What's interesting about anti-kickback law, anti-Stark law, is if you're going to do something, if the hospital does anything for a physician-owned - because there are physician owners in it - if it does anything for that ASC, the hospital cannot give a gift to those physicians of any kind, or it has the appearance of inducement. So, the hospital has to charge the ASC fair market value for the work that it would do to help it. So, there's all this behind-the-scenes stuff going on to make it be integrated.

But when we built our own, we knew we couldn't ship instruments to a bigger health system and then ship them back. I mean, you could, that's really expensive. We spent an inordinate amount of time in the planning phase in sterile processing. If you look at our ambulatory surgery center footprint, you'll see the operating rooms are reasonably sized to do hip, knees, spine, shoulder. But what is larger than almost all ASCs by a lot is the sterile processing department (SPD).

We worked with Steris, the company who did all of our washers and sterilizers. Basically, we did throughput analysis on how many cases we were going to do per unit per day, per room. We built that out to accept that, of hip and knee replacement, which is the heaviest burden. And if you can do hip and knee replacement, you can do hand, you can do elbow, you can do foot and ankle. Because their instrument burden isn't as like hip and knee arthroplasty. So, we built it for the worst case scenario. We should never ever have an issue. The other thing we learned is even the difference of the sterilizers. When we started doing this, I had our industry reps go to all the hospitals that they were in. I wanted them to give an assessment of how these hospitals were performing in their SPD. Because no one knows how sterile processing is working better than the reps. Because when it goes down, and the surgeon starts yelling, who do they yell at? The reps. So, they knew more about sterile processing than any of us. This is the case where you bring your team together and you say, "Okay. Our reps were really good partners. You work with Steris. I'm going to be involved. You know what we need every day. You map out what we need to make that happen."

Steris, originally, had come to us with two different models of sterilizers. One was electric that had internal steam built in. The other one is more expensive, but you have to put external steam separate in your facility so that it's not in the sterilizer. I had no idea and was uneducated. Had I not built this building, I would never have even known the difference between those. Had no reason to. But then the rep said the ones that are electric that have internal steam, they break down all the time. Well, our ambulatory surgery centers are our financial lifeblood. We can't afford it to go down and cancel cases, while we don't have a hospital we can go send the trays to. So, we said, "Let's spend the money then and put the investment in to build external steam. Now, we have an entire room with three external steam generators that are sitting in there that pipe it in. You would not normally see that in many other ambulatory surgery centers. It's crazy.

So, those were a lot of things that we learned. But the great thing about having gone through that is now we can scale that. In the next surgery center, we know what to build. We'll say, "Just build that." We don't have to go through that process again. In fact, the ambulatory surgery center, this is how scaling it can be beneficial. In the other ASCs we're about ready to build, we said, "Well, we already spent a million dollars total on architectural design, all this stuff going through." So, we looked at the hospital and said, "In this era of high costs, why don't we just use this design and save a million dollars?" They said, "Yes." Now we don't have to spend the time doing a throughput analysis again. We can just replicate it. We don't want to reinvent it.

What's weird for us is that you spend your entire early part of your career learning everything you can about how to perform orthopedic surgery. From the day you start practicing, you spend the rest of your career trying to stay up, stay current and be innovative on the clinical side and patient care side. But there's this entire other aspect that you have to learn. That is around business, practice management, and what have you. We don't do a great job teaching our young surgeons what to do. I'm 52, why am I learning it all now?

There's so much to learn. But we're proud of what we've done. And social media has also added a dimension of communication and access to so many colleagues. Like at this meeting, I'm walking around and I have people come up to me because they see it on LinkedIn. I was in the UK last week and I have people coming up to me and saying, "Keep going. We're cheering for you." I had someone yesterday, a well-known surgeon says, "I wish I could do what you're doing. I just don't think I have it in me." But he goes, "But I'm pushing for you. I'm watching it. I hope you succeed." So, now I feel like even if I wanted to give up, I couldn't.

I mean, I'd be disappointing so many people at this point who aren't me even, or my immediate team. It's wild.

As an educator and an academic physician, I just happen to have a lot of entrepreneurial tendencies and also love research and education, I started realizing that the traditional academic model of in-person meetings, that we grew up in, was evolving very rapidly into one that was more multifaceted. Social media was a way to connect with an expanded audience, even much further than I could reach with traditional academic means. There are still in-person meetings. There's still the benefit of like you and I sitting here together in person. It's great. But then there's this whole other new medium for intellectual exchange that occurs digitally. Yesterday, I took the reins of being AAHKS president. In preparation for that, I realized if I'm supposed to serve 6,000 members, 12% or so are outside the U.S., how can I serve them well if I don't understand all of them the best that I can?

I've been in private practice. I've been in academics. I feel like I can represent most of the models pretty well, and I understand and advocate for them. But the thing I was missing was how do I connect with the people whose tendency is to want to connect and learn digitally, not so much in person? So that was one of the reasons. I've enjoyed expanding and participating in Linked and professional "social media". It is interesting because social media is like everybody in the audience has a microphone. I mean it's so wild. Everybody's on the podium.

I realized that this is the power of it, I'll frequently put peer-reviewed publications in there. So now the research reach becomes even bigger. Now I started realizing, wait a minute, if I have 2,000 people view my page in two hours, why am I not putting the research on there? So, I started doing that, tagging that. Then the next thing you know, I'm actually doing a better job of disseminating high-quality research than I was at the podium in front of 60 people.

I learned so much at Mayo Clinic. I could never thank them enough for what they've done for my career. But at this point, having 20 years later, and know myself as an adult out of training, I have too much entrepreneurial inkling to hold back. I wouldn't have been happy. They actually know that. We talk about it. They're like, "You're actually better off being part of the Mayo family, out there running." They actually support that, which is good. That feels good for everybody. So, I can be me. I can be doing what I'm doing.

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