Why simulators help pilots and surgeons alike

Simulators are often mandatory for pilots; should they be for surgeons? P.10
NOW you KNOW where to find the money button

- Easily integrate on any chair and stand
- Shave minutes off every refraction
- See more patients daily
- Gain greater practice efficiencies
- Display old and new Rx instantly
- Achieve seamless EHR integration
- Generate patient time for optical
- Provide more quality time for doctor consultation
- Eliminate transcription error and reduce costly lens remakes
- Sustain less staff turnover and provide higher quality of practice life
- Eliminate down time from repetitive stress injuries to staff
- Elevate patient experience for greater satisfaction and referrals

Are you pushing the right buttons?  
Arrange your free practice assessment or product demonstration at www.whosincontrol.info and receive your free NOW button.

The Difference is Marco™
Thank You for 25 Years of Support.

Twenty-five years ago, with the support of the American Academy of Ophthalmology, OMIC opened for business as the nation’s first, and only, professional liability insurance carrier exclusively for ophthalmologists. We extend our gratitude to the 800 ophthalmologists who believed in OMIC in 1987 and to the nearly 4,500 who believe in us in 2012.

Please join us in celebrating this milestone

OMIC Anniversary Reception
Sunday, Nov. 11, 3:00 to 5:00 pm
OMIC Exhibit Booth 1104, McCormick Place

( Popular OMIC risk management courses at the AAO meeting. See www.OMIC.com for details.)

All OMIC insureds will be automatically entered in an anniversary drawing for a new iPad. Winners will be announced at the anniversary reception and on www.OMIC.com.
Confused about CMS and Multi-Use?

[Diamatrix Can Help You Solve The Problem]

- Designed to Meet OSHA Sharps Safety Requirements
- Validated for Multi-Use & Autoclaveable
- Cost-Effective
- Consistently Sharp

ProTekt Sharps Safety Knives are available in a wide variety of blade sizes and configurations for ophthalmic surgery. All are available for complimentary evaluation.

Scan the Code for additional information on ProTekt Knives.

DIAMATRIX
Because the Future is Clear

Diamatrix Ltd
1544 Sawdust Rd, Suite 502, The Woodlands, TX USA 77380
www.diamatrix.com info@diamatrix.com
800-867-8081 (US) 281-387-6001 (T) 281-292-5481 (F)
Doc 20120503
From the publisher

Ophthalmologists know plenty about being on the cutting-edge of technology. From tiny devices used to enlarge a pupil or drain aqueous humor directly from the anterior chamber into Schlemm’s canal, to precision lasers used to create LASIK flaps or the perfect capsulorhexis, anterior segment surgeons remain at the forefront of scientific discovery.

How, then, do you stay at the top of your game? The answer may come from another high-tech field.

In this issue of Ophthalmology Business, contributing writer Matt Young talks to Steven C. Schallhorn, M.D., a former fighter pilot and military eye surgeon, about how high-end simulator technology can help ophthalmology, much like it has assisted the commercial airline industry (“Why simulators help pilots and surgeons alike,” page 10).

An online presence is a technological must, too. Writer Maxine Lipner talks to surgeons and experts about how to draw patients in using the Web (“If you build it, they will come,” page 8).

Ever been asked to be a witness in a court case? Contributing writer Michelle Dalton examines the pearls and pitfalls of agreeing to testify in “Preparing for trial,” page 14.

Finally, marketing expert Debi Dilling shares valuable tips about transitioning current employees to management positions—a decision that is not always an easy one to make (“Employee to manager: Making the transition,” page 22).

Thanks for reading.

Donald R. Long
Publisher, Ophthalmology Business
Contents

5 From the publisher

8 If you build it, they will come
   The importance of creating a solid online presence for your practice
   by Maxine Lipner

10 Why simulators help pilots and surgeons alike
   Simulators are often mandatory for pilots; should they be for surgeons?
   by Matt Young

Special feature

14 Preparing for trial
   Experts weigh in on how to evaluate claims in cases where you’re asked to be an expert witness
   by Michelle Dalton

18 Retirement done right, part 3: Setting the date
   Things can become “very real” when deciding on a time to stop working
   by Jena Passut

22 Employee to manager: Making the transition
   A look at a few of the reasons employees may be considered for management and why not all are a valid indication of a good manager
   by Debi Dilling
On-Demand Access to the ASCRS-ASOA Symposium & Congress

Paper Sessions • Symposia • Surgical Videos • Films • Posters
Courses • Cornea Day • Glaucoma Day • Business Management • and More

Explore over 1,300 educational sessions from the 2012 ASCRS-ASOA Annual Symposium and Congress

With additional access to Cornea Day, Glaucoma Day, and PROBE (Practice Revenue Optimization & Business Efficiency).

ASCRS • ASOA:
Adding new value to membership
If you build it, they will come

by Maxine Lipner Senior Contributing Writer

The importance of creating a solid online presence for your practice

In the internet era, whether your practice is in cornfield country or a major metropolis may not matter. When you’re swinging for the fences to attract new patients, a solid online presence with a well-designed website at the hub is pivotal, according to Lance J. Kugler, M.D., director, Refractive Surgery, University of Nebraska Medical Center, Omaha, and in private practice. “In 2012, online is how people find every service,” Dr. Kugler said. “In a 12-month period, I think that we had three people tell us that they found us through the Yellow Pages—everyone else said that it was through the website or something else.”

Brian Boxer Wachler, M.D., director, Boxer Wachler Vision Institute, Los Angeles, agreed. He likened not having a website to using an abacus rather than a calculator to solve math equations. “Every practice needs to invest in a website—I think that it’s essential,” Dr. Wachler said.

Filling a need

Even those patients who are not plugged into the internet themselves often have family members who are, finds Alan N. Carlson, M.D., professor of ophthalmology, and chief, Corneal and Refractive Surgery...
Service, Duke Eye Center, Durham, N.C. “You may, for example, have an 85-year-old patient with an 86-year-old spouse, neither of whom have a computer, but they often come with their daughter who may be sitting on the side and may not be as engaged as you would like,” Dr. Carlson said. “By having a website and giving them the link, you can immediately give them much more detailed information that would otherwise be extremely repetitive.” For example, Dr. Carlson finds he can put his post-cataract regimen on the site, which will save the staff from having to repeat the same information to patients continually.

On the other end of the spectrum are patients who have spent most of their lives online. Richard L. Lindstrom, M.D., adjunct professor emeritus, ophthalmology department, University of Minnesota, Minneapolis, and founder, Minnesota Eye Consultants, Minneapolis, thinks that it’s critical to reach these patients online.“Definitely the Generation X and the Generation Y (patients) are on the Web more so than anywhere else,” he said. Likewise, the Baby Boomers have adapted here as well. Many have found Minnesota Eye Consultants via the Web. “About 10-20% of our patients will say that they found us or were encouraged to come to us via their experience on our website,” Dr. Lindstrom said.

His practice has invested fairly heavily in trying to create a high quality website. Dr. Lindstrom recommended that those still in the web-building process begin by looking at other websites. “[Pick] a few prominent practices or people that you think might be good examples and look at their website,” Dr. Lindstrom said. “For example ours is www.mneye.com, and we’ve had quite a few of my friends around the country who have looked at our website and said, ‘Wow, we like your website, who did it?’” He refers them to a company called Glacial Multimedia (Westbrook, Maine), a leading medical website design firm.

Website essentials
Regardless of whether you hire someone or do it yourself, there are some things that every website should have. Dr. Boxer Wachler says the contact information needs to be prominently displayed. “A lot of times people are searching the website to get in touch, so you don’t want to have your phone number and address hard to find,” he said. “Don’t make people dig for it.”

If you publish studies or papers, Dr. Boxer Wachler recommended that you include these pieces as well. In addition, he suggested including your curriculum vitae and a photo of yourself on the site. “Include things that you would like to see if you were looking for someone and wanted to learn more about him or her,” he said.

He also urged practitioners to periodically update the site. “The search engines like to see changes in the web pages,” Dr. Boxer Wachler said. “They don’t like to see something that stays stagnant for years.”

Dr. Kugler agreed. He pointed out that the website is not just another brochure. “I think that nowadays, because of social media and blogs and all these ways that we have to communicate, the website needs to be an extension of the communication of your office, not just a static brochure that never changes,” he said. He feels confident that such an informative site will be easily found. “If you have a good site with original content that is dynamic (meaning that it’s being updated and it’s considered a good source of information by others), then it’s going to naturally search well,” Dr. Kugler said. “It’s pretty hard to trick Google anymore—you either have a good site and Google knows it, or you’re not a good site and you won’t do well.”

Dr. Carlson finds that having links on other sites that point back to yours can be helpful in generating traffic and getting a site noticed. He noted that there are currently 35 million websites out there. “Right now, I have 269 sites linked into my website,” he said. “My ranking worldwide is 580,000, so I’m in the top 0.2% of websites right now.”

Meanwhile, Dr. Lindstrom invested in his practice’s website and upgrades it every year because technologies keep changing. “We keep adding new offerings,” he said. “On our website we have the Eyemaginations [Baltimore] animations available; we have live video of the procedures; we also have videos of each of us talking about various technologies.” This allows patients to decide which of the practitioners best resonates with them. In addition, the website includes plenty of patient education handouts.

It’s also possible to link your website to YouTube, where you can store video material and which can be searched there independently as well, Dr. Kugler pointed out. “You can put a channel on YouTube,” he said. “We have a channel where we put videos, and then we link the videos from there to our website.”

Overall, as Dr. Boxer Wachler sees it, when it comes to having an online presence, there really is no choice. “It still surprises me to hear that people don’t have one,” he said.

Contact information
Boxer Wachler: 310-860-1900, bw@boxerwachler.com
Carlson: 919-684-5769, alan.carlson@duke.edu
Kugler: 402-509-2201, lkugler@me.com
Lindstrom: 952-567-6051, rlindstrom@mneye.com
Why simulators help pilots and surgeons alike

by Matt Young Contributing Writer
Simulators are often mandatory for pilots; should they be for surgeons?

As a former fighter pilot and military eye surgeon, Steven C. Schallhorn, M.D., is quite familiar with simulators—both for flight and for eye surgery.

“I think they are pretty similar in concept and in execution,” said Dr. Schallhorn, now medical director, Optical Express. “Pilots have to learn how to look at displays or gauges and quickly understand and appreciate them. It’s a learning process because if something is going wrong with the display or gauge, you become fixated on it to the detriment of safe flying. That same thing applies in ophthalmology. You have to look at the entire operating field to appreciate things that might be going on and not just on the tip of one instrument. These are learned skills, and simulators teach both pilots and ophthalmologists.”

But while commercial pilots for major carriers are tested yearly in flight simulators to make sure their emergency-related skills are up to speed, ophthalmologists are not put to similar tests regularly, Dr. Schallhorn said.

“There’s nothing like that” insofar as mandated simulator requirements, Dr. Schallhorn said.

Nonetheless, because high-end simulator technology does exist, certain hospitals and even ophthalmologists may be interested enough to invest in it. There’s nothing like being on the cutting-edge of performance, and simulators can help achieve that.

Simulator applications

At training institutions, it’s important to develop requisite skills to operate on human eyes, and simulators can be important tools in this process.

But Cordelia Pawlik, sales and marketing manager, VRmagic, Mannheim, Germany, which manufacturers medical simulators for ophthalmology, has noticed some other interesting trends.

“What’s important with simulators is that they’re there all the time,” Ms. Pawlik said. “People can train on them on a regular basis.”

VRmagic has developed simulators for cataract and vitreoretinal surgery, as well as for diagnostic purposes.

Ms. Pawlik gave the example of a doctor who goes on holiday for 2 weeks and then returns to the office.

“After that, the doctor is not going to be as good as usual,” Ms. Pawlik said. “When you go to a sports studio, if you don’t do exercise for 3-4 weeks, you’re not as good. It’s the same [with surgeons].”

Ms. Pawlik knows of a surgeon who teaches with a VRmagic unit who uses the simulator himself to get back into shape, so to speak.

“One Monday mornings, he trains for 15-20 minutes to warm up,” Ms. Pawlik said. “On Monday, a surgeon is not going to be as good in the morning as on Wednesday when he’s in the flow of things. So there are surgeons who use simulators to warm up.”

Further, in real life, certain pathologies may present often in certain parts of the world, but rarely in other parts of the world. Yet with a diagnostic simulator like Eyesi Indirect (VRmagic), one can consistently train to identify any pathology anytime.

“Everyone who has learned with this machine knows all these pathologies, or at least should,” Ms. Pawlik said.

While there are some physicians interested in pushing forward simulator tests, the movement has not yet come of age, Ms. Pawlik said.

continued on page 12

VRmagic cataract simulators can be used for training, as well as for physicians who need a refresher.

Eyesi Cataract

Simulation of Cataract Surgery

To permit training of anterior segment surgery, the platform of Eyesi Surgical is equipped with a cataract eye interface, a cataract instrument set and foot pedals. The simulation environment can easily be configured for superior or temporal access to the patient’s eye. A series of incisions is provided on the model eye to allow instrument insertion according to the surgeon’s preference.

Cataract Training Modules

All Eyesi cataract training modules offer an immersive surgical simulation environment for training of anterior segment surgery. Frequent practice using these modules refines proficiency in critical steps such as capsulorhexis, hydrodissection and phaco. The phaco machine settings can be changed in order to explore the effects of parameter changes. Complex interaction between instruments and discrete tissue and intracocular structures can be experienced in real time. Trainees therefore become acquainted with the “Divide and Conquer” technique step by step.

The number of Eyesi cataract training modules is being constantly extended. Eyesi Surgical units can be upgraded when new modules become available. For information on all the currently available cataract modules, please contact VRmagic.
“In England there is a movement of doctors who are keen on installing the Eyesi eye surgery simulator as a mandatory part of education for teaching hospitals,” Ms. Pawlik said. “They are saying no one should be able to educate without that.”

Ms. Pawlik, who did not comment on system costs, simply said, “It’s an investment; it’s not something that everyone can buy.”

Teaching hospitals would consider the Eyesi a valuable investment, according to Ms. Pawlik, but it may be harder to justify the purchase for the average private clinic.

Another option
For surgeons tempted to give simulation a try after a long holiday away from the operating room, consider a relatively less expensive tool: the Phake-I (Eye Care and Cure, Tucson, Ariz.).

“The Phake-I is modeled after the human eye, is dimensionally correct, and approximates the shape, size, and feel of the human eye,” said company CEO Johan T.W. van Dalen, M.D. “One of the advantages of our product is that, unlike virtual systems, one can use one’s own instruments. Another advantage of our training eye is the fact that our cornea has all the thickness features of the human eye, such as central and peripheral thickness and ‘feel,’ while the cornea of an animal eye clouds up often.”

Meanwhile, a complete Phake-I training system costs just $340 and $15 per additional training “eye.”

“The major users of our training eye are physicians in ophthalmic residency programs and ophthalmologists who want to perfect and improve their surgical skills,” Dr. van Dalen said.

The Phake-I also appears to be extremely versatile. “Our system allows not only for cataract surgery/phacoemulsification and IOL implantation, but also for other procedures such as corneal suturing, scleral flaps, limbal relaxing incisions, and corneal transplants,” Dr. van Dalen said. “In addition to our basic Phake-I training eye, we have developed subspecialty models, such as a Phake-I muscle system for the practice of eye muscle surgery, a model that allows for retinal membrane stripping, and a model that allows practicing inserts into the trabecular meshwork.”

It may not be as electronically sophisticated as other simulators, but it might be a good start for trainee surgeons and those who wish to improve in a safe, relaxed environment—and get up to pilot-like speed.

OB

Editors’ note: Ms. Pawlik is sales and marketing manager, VRmagic. Dr. van Dalen is CEO, Eye Care and Cure.

Contact information
Pawlik: +49 621 4004160, pawlik@vrmagic.com
Schallhorn: sschallhorn@yahoo.com
van Dalen: 520-321-1262, jvandalen@eyecareandcure.com

The Phake-I approximates the shape, size, and feel of the human eye
The only meeting dedicated to the precise needs of the anterior segment specialist aligned with the most established practice management program for comprehensive ophthalmology and subspecialties.

Registration Opens
October 10, 2012
www.ascrs.org or www.asoa.org

Follow @ASCRStweets on Twitter.
#2013ASCRSASOA

SanFrancisco 2013
American Society of Cataract and Refractive Surgery
American Society of Ophthalmic Administrators
Preparing for trial

by Michelle Dalton Contributing Writer
Experts weigh in on how to evaluate claims in cases where you’re asked to be an expert witness

One day you might be called upon to be an expert witness in a lawsuit alleging malpractice, misconduct, or some other malfeasance by a colleague. But with careful planning and negotiations, being an expert witness does not have to be a daunting experience. Ophthalmology Business spoke to three physicians to glean pearls and potential pitfalls that can be associated with agreeing to testify.

Negotiation starts immediately

If or when your office is contacted as a potential expert witness, “negotiate a fee up front,” said I. Howard Fine, M.D., clinical professor of ophthalmology, Oregon Health & Science University, Portland, and in private practice. “If you don’t discuss your fees and you’re summoned in the case, you’re paid the same rate as a juror,” he said. Dr. Fine said he turns down most requests to be an expert witness, more so because of the time involved in preparation that took him away from patient care than because he thought true treatment mismanagement occurred.

And when you do agree a case has merit (or clearly is lacking merit), be prepared, said Ray H. Brown, M.D., in private practice, Atlanta.

“It’s not for the faint-hearted,” he said, adding he believes he made an effective expert witness because he only took the occasional case. “Plaintiffs’ attorneys usually have a professional expert witness, someone who does this for a living. Those witnesses charged much more than I did, but they weren’t necessarily accomplished in ophthalmology.”

Regardless of which side makes the initial contact, “forget that and look at the records completely and objectively,” said Anthony J. Aldave, M.D., associate professor of ophthalmology, and director, Cornea Service, Jules Stein Eye Institute, Los Angeles. “Make sure you’re an expert for the truth, not for the plaintiff or the defense.” For instance, a career oculoplastic surgeon is not likely to be familiar with potential complications or how to manage those in a retina case, and vice versa.

Being an expert witness can help physicians become better doctors, Dr. Brown said. “It helped me find the weak spots in documentation or where communication can break down. It also gives you incredible experience with medical records from practices outside your own.”

Dr. Aldave cautioned physicians who “may not have much surgical experience or may not be aware of the standard of care for complications” in the particular case should probably recuse themselves, but often do not.

How to prepare

When first contacted by an attorney, detail what your fees will include, Dr. Fine said. “After I’ve gone through the literature, I write what amounts to a deposition but is really a summary statement of what I’m planning to say in my deposition. I send that and my full CV (150 pages of it) to the lawyers. That summary outlines what I think are the weaknesses of the case and the strength of the defense,” he said, adding he’s only agreed to be a plaintiff’s expert witness once. Typically, he’s called upon where indications for surgery are being questioned, in cases of supposed untimely referrals, or in cases of poor outcomes.

“I’d encourage ophthalmologists to participate as an expert witness,” he said. “But be sure to write to the attorneys and indicate what the fees are—there should be a fee for reviewing the case, for conducting research and writing a response to the complaint, for the time away from delivering patient care to be deposed, and for each day out of the office in case of trial.”

Dr. Brown said although the experience was valuable, physicians should prepare to be verbally attacked on the stand. “It helps if you’ve stated for the record you will only be an expert witness in cases you think are righteous and where you deem the merits of the case are clearly in support of one side or the other.”

In Dr. Aldave’s case, he’s only served as a witness for the plaintiff once—and that was in a case where the plaintiff’s attorney argued a failure to irrigate the patient’s eyes at the site of the car accident, failure to irrigate during transport to the hospital, and failure to irrigate upon arrival at the hospital resulted in more severe damage to the eye than if emergency responders had irrigated. Dr. Aldave’s extensive literature research did not uncover any evidence to support the claims, which he put in his deposition as the treating physician to the attorney along with his fee for services rendered. The plaintiff’s attorney noted the declaration was “inadequate,” Dr. Aldave said he was unwilling to alter his position. The attorney also refused to pay the fee, saying the declaration was “most unhelpful” to the case.

“Be very clear in how you’re being viewed—as a treating physician or as an expert witness, or both,” he said. “And make sure you sign a retainer before you review the case.”

continued on page 16
Dr. Aldave’s top 10 tips for expert witnesses

As told to Dr. Aldave by Jim Lynch, J.D., American Academy of Ophthalmology’s legal counsel

1. Do not choose sides. Be as available to the plaintiff as you are to a defendant, regardless of personal consequences.

2. Ensure you completely understand the particular treatment modality. Hands-on knowledge of a particular treatment and its possible complications lends credibility to your level of expertise.

3. Educate yourself on the issue at hand before agreeing to provide expert testimony. Perform as much research as appropriate, and review all the relevant documents, including those that might be potentially damaging to the side that retained you.

4. Be honest. That includes revealing the bad news as well as the good news.

5. Testimony must be without bias. Don't exaggerate, but do acknowledge facts helpful to the opposing side.

6. Be able to define standard of care at the time of the occurrence. Juries are instructed to find physicians negligent if/when the physician “fails to exercise the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would possess and use in similar circumstances.” Juries are instructed to base their decisions solely on the testimony of expert witnesses.

7. Be able to discern what is medical malpractice and what is an undesirable medical outcome that may occur even when standard of care is observed.

8. Accept compensation commensurate with the time and effort exerted.

9. Document your fees, percentage of income those fees represent, and the number of times you’ve testified. Be willing to have your depositions and trial testimony submitted for peer review.

10. Ask for clarification if a question is unclear. Don’t be afraid to answer, “I don’t know.”

If the case does proceed to court, “look at the jury and talk in very simple terms,” Dr. Fine said. “My lawyer’s advice—relax, be calm, and try to remind yourself that the litigation may be the only way for patients to understand they received adequate care. Plaintiffs’ attorneys can be unbelievably aggressive on cross exam. The lawyer’s abuse isn’t going to change the outcome.”

Our litigious society

Dr. Fine said he’s seen an increase in litigation from 30 years ago, but “I’m usually impressed by the fact there’s not a lot of strength to most of these cases,” he said. But the advances in pathophysiology and epidemiology as well as technical advances in diagnostic tools and in treatments have made it harder to educate the jury, he said. “The issues today are more complex than they used to be. When I started, we were doing intracap with a pair of scissors and sutures. That was much easier to explain than phacoemulsification and premium IOLs.”

Dr. Aldave has sat on the American Academy of Ophthalmology's ethics committee for 7 years, and during that time only “Rule 16” has been added to specifically address expert testimony.

Dr. Brown said participation in these cases “can be aggravating. It’s more combative these days than it used to be. But I’ve always learned from the cases I was involved in—how to document better and write more legibly, although that may become moot with electronic records.”

Providing expert witness commentary “is a complicated business,” Dr. Fine said, and can be time consuming, but he’s “always gained a measure of satisfaction when I could help show someone had been incorrectly or unjustly accused.”

“If you’re willing to put in the time and handle the stress, it’s worth it,” Dr. Brown said. “There’s a huge benefit in understanding the importance of medical documentation in every patient’s case.”

Contact information

Aldave: 310-206-7202, aldave@jsei.ucla.edu
Brown: 404-252-1194, reasmary@comcast.net
Fine: 541-687-2110, hfine@finemd.com
Let Us Welcome You to Chicago!

Plan to visit Booth #3262
at the AAO Joint Meeting* in Chicago, November 10–13, 2012
Access iPads and laptops to experience the ASCRS•ASOA MediaCenter global classroom

www.ascrs.org

Come Early to Receive Complimentary
Patient Education Flash Drives
Publications • Refreshments

Follow @ASCRStweets on Twitter.
#2013ASCRSASOA

*Not affiliated with the official program of the Joint Meeting.
Things can become “very real” when deciding on a time to stop working

When retiring, a physician needs to keep several numbers first and foremost in his or her mind—and believe it or not, it’s not all about money. Instead, setting a date for leaving the practice is vital during the retirement process, experts say.

That can be an emotional time, according to psychologist Tom Fauria, Ph.D.

“At the point a physician begins talking about setting a retirement date, things shift from the hypothetical future to becoming very real,” Dr. Fauria said. “The physician quickly is forced to embrace the ‘blunt reality’—moving from feeling important to feeling unimportant.

The realization of becoming ‘unimportant’ may be conscious or unconscious. In either case, it can bring forth a number of reactions, thoughts, feelings, pertaining to personal and professional pride, status in the community, status among professional colleagues and authority, as well as distress about losing control of the practice, relationships with patients, and their care.”

Dr. Fauria, along with I. Howard Fine, M.D., Oregon Eye Associates, Eugene, and his partners, Richard S. Hoffman, M.D., and Mark Packer, M.D., took part in a panel discussion on retirement that is the focus of a series of articles in Ophthalmology Business. Clinic administrator Laurie Brown, C.O.M.T., C.O.E., O.C.S., and medical consultant Bruce Maller also participated in the panel discussion, which began with talk about
building a practice before leaving it and continued with discussions on reducing responsibilities and selling a practice.

Setting a date for retirement was the third part of the discussion, and of this series.

Dr. Fine: Setting the date was very easy for me. I meant it when I said at the purchase of the first half of the practice, or 48%, I wanted to be fair to my associates and not have them burdened by my hanging around too long. I had written into the initial sale the fact that they had the option to buy me out — years later. For a long time in my career, I knew that I did not want to stay in practice at anything less than the peak of my surgical skills. I had seen examples of people who stayed too long. I was determined not to have that happen to me. So I picked a 7-year term. I knew that I would be 73 at the end of that term and would have practiced for 40 years. I was going to make myself ready to give up surgery, which I loved, and to be less involved in patient care, which I loved. I didn’t have trouble setting the date. It was actually my 73rd birthday.

Ms. Brown: Bruce helped us a lot when we were 2 years out to set up what I have learned now is a Gantt chart. It’s a timeline of all the steps you need to consider working toward the sale of the practice. Some of the headings, which were arranged by months, were to gain consensus on physician work objectives, draft the project plan, review the plan with the doctors, clarify the doctors’ objectives, and to request a “perfect plan” from each doctor—each doctor sat down and wrote out his perfect plan for the next 2 years and his career. We needed to know what their picture of a successful career looked like in detail.

We modified the doctors’ schedules to conform to the objectives spanning 18 months. We developed a communication plan for staff and patients. You can’t just start something new one day after you’ve been working on it for a while but haven’t been communicating all of your thought processes to your staff. You can’t just start one day throwing around the word “retirement” for the leader of the practice. These are all things we needed to talk through. I needed to recognize that information that we were thinking about but hadn’t yet communicated to the staff was likely to get out. We needed to be communicating everything so our employees felt comfortable and reassured that our vision was still our vision, even though they were hearing new information.

Communication was a huge part of the process leading to successful retirement and business transition.

Some of our action items from our Gantt chart were developing a task force of our management personnel to assist with implementing the plan and setting objectives and milestones for them all the way through the process. For example, we needed to come up with, as Dr. Fine was stepping down, the amount of hours he was in the practice.

Scripts like, “Dr. Fine would love to see you, but his next available appointment is ... Is that too far away for you? He’d like us to offer his associates for this next visit.” There are all kinds of communication pieces that you need to work on so your practice as a whole is communicating what you want them to in order to move the vision of the practice forward.

At a specific point in time, we sent letters to patients referring them to Drs. Hoffman and Packer as Dr. Fine was less available to schedule appointments. Presenting this to your staff first is essential. You don’t want a patient hearing something before your staff knows what’s going on. There was also a section for reviewing governance issues and drafting legal documentation.

Another item we needed to do was to agree on group representation. Dr. Fine was the managing partner for all aspects of the practice. Now, Dr. Hoffman is the medical director and Dr. Packer is the managing physician. These things needed to be worked out. The new partners are 50-50 partners, so even though Dr. Packer is the managing physician, we need to make sure that we’re agreeable on everything.

Yet another issue was MD-owner-administration communication lines. This was a big one because I shared an office with Dr. Fine. We had communication without words most of the time. I saw what he did. He saw what I did. We were on the same page. It became apparent early on that I would need that kind of communication from our new managing physician, so the doctors switched offices so that the managing partner and I are able to work together with direct communication. That was a model Dr. Fine set up that served us well for many years. The move was also a sign that things were changing but were not going to change for our staff or how we organize the practice and move things forward.

Dr. Hoffman: I think setting the retirement date is probably one of the most important tasks. It should be the easiest, but it is probably one of the hardest things that you have to do. Howard probably doesn’t remember this, but I’ve been in Eugene for 16 or 17 years. When I first came, he was talking to me about the opportunity, and he said, “I’m going to be retiring in 5 years, and this will all be yours.” Then 5 years later we were having a conversation, and he said, “I’m going to be retiring in 5 years.” ... It’s because of the trauma that Tom talked about. I think there’s this natural desire to

continued on page 20
keep putting it off. In your mind you’re saying you’re going to retire in 5 years, but when that moment comes, it’s very easy to put it off. By setting that date, it allows you to make that plan a year or two ahead. I think it’s easier to come to grips with it. Howard is not really retired. He’s still working, but the practice was turned over at that point. Setting that date, that line in the sand, is very important.

Mr. Maller: For the last 20-plus years that I have been consulting, the 5-year perpetual retirement plan is a chronic issue. Yesterday I ran into a friend of mine and he said, “Bruce, aren’t you thinking about retiring from the practice?” and I said, “Maybe in about 5 years.” I caught myself doing the same thing.

But the establishment of a date from a business-planning standpoint is important. It allowed, in this case, Laurie and her team to manage the process operationally with patients. It does put some added burden on the retiring doctor to think through and be comfortable around that transition plan. Laurie called me and gave me the news and said we need your help, and that’s when I thought, let’s put together a project plan. Laurie did a great job of summarizing the plan that she and I collaborated on. When we created the plan, it was a draft plan. We decided that the best thing to do was to sit with the doctors. Each person had a draft of the plan. We talked through it together. That was really helpful because in that process, we identified some issues that we hadn’t addressed adequately in the plan. I went back and I modified the plan.

What was great was that everybody, the doctors and Laurie, bought into that plan and that became a living, breathing document to check how we were doing against our plan. That was a good takeaway. If you’re going to do this, do this in a sensible fashion and get the folks around you bought into that and have some organized program that keeps you on track.

Dr. Fauria: Silent thoughts and worry when setting the date may take the form of, “I’ve worked hard at establishing a profession, establishing credibility, serving patients, and I’ll no longer feel like an all-star—no longer in charge, no longer feeling the same sense of importance.” That can be a difficult paradigm shift. That’s why setting a date is challenging. Retirement suddenly becomes real, [and] a cavalcade of events unfold.

Some things that can help offset the negative aspects of retirement transition include finding humor in the process and tapping into your support system—family, friends, colleagues, consultants. Not so much relying on people who say, “Retirement should be easy for you. You’ve worked hard and earned it.” That message is not particularly helpful because there are so many negative dimensions to giving up a practice. Those physicians most vulnerable to difficulty in retirement have not developed support systems and alternative fulfilling activities and relationships. Dr. Fine talks about the importance of starting retirement planning early, having other activities in life that provide meaning, recreational activities, outdoor pursuits, winemaking, golf, being a Boston Red Sox fan—whatever you enjoy consistent with your interests and values. OB

Send us your favorite

Have a favorite app that helps you with business or personal activities? Email smajewicz@eyeworld.org with the app name and how it helped you.

Apps selected will be published in Ophthalmology Business and their submitters will receive a $50 iTunes card. You may be selected for a brief interview.

Editors’ note: For parts 1 and 2 of this series, see the September and October 2011 issues of Ophthalmology Business.

Contact information
Brown: lkbrown@finemd.com
Fauria: tfauria@cascadehealth.org
Fine: lfine@finemd.com
Hoffman: rshoffman@finemd.com
Maller: bmlaller@bsmconsulting.com
Packer: mpacker@finemd.com
Revitalize Your Practice.

Innovate and Strategize in a Relaxing Environment.

Attend the Educational Retreat for Anterior Segment Surgeons.

Join us for an open exchange of ideas and solutions to help improve your practice.

Cataract | Cornea | Glaucoma | Refractive

www.WinterUpdate.org
t is not uncommon in many practices to find employees who have worked their way up through the ranks to become department managers or administrators. However, is that promotion always in the best interest of the employee as well as the practice? It stands to reason that one of the first considerations for such a move is longevity of the employee. Is it a fair assumption that the employee who has been there longer will possess the skill sets required to be a good manager? What about the employee that accepts the responsibility of becoming management for the mere reason that it typically warrants an increase in salary?

Let’s examine a few of the reasons employees may be considered for management and why not all are a valid indication of a good manager.

The employee has been with the practice for a certain number of years, is very competent in his/her current position, and is a team player. While these are outstanding attributes and certainly should be taken into consideration for promotion, they may also be detrimental to the success of the employee and the practice. Longevity may be looked at favorably, but longevity can also lead to complacency. Many times employees are so comfortable in their position and ability to do it well, it could lead to a lack of motivation to move out of that comfort zone. Their position becomes rote and easy to manage with little effort. Being a team player is also a positive attribute when looking to promote from within. The employee works well with co-workers and physicians and again feels very comfortable in that role. What happens when that employee becomes management and now has to lead, discipline, and perhaps dismiss that co-worker who is also a friend? This can easily result in a stressful situation for all parties involved.

What are the determining factors when looking to make that change from employee to manager?
Ralph Simone, administrator, Eye Associates of Boca Raton, Fla., looks at three different scenarios. “I do consider longevity and dedication to the practice first, and then I look at the employee's current job performance. Just because you are good at what you do doesn’t mean you can get others to do it.” Lastly, Mr. Simone believes the employee must be able to make the mental transition from employee to manager and said, “This may be the hardest task of all.”

We have all witnessed successes and failures of employees who have been promoted. There is the power hungry, “I am now better than you” type, the “now that I am the boss, I don’t have to work so hard” type, and the “it’s not my job anymore” type. Over the course of my career I have promoted and been promoted myself in various positions. The one thing that I look for first in an employee is always motivation. If I see a person with a desire to keep learning, growing, and moving forward, that is my first key indicator. The next step is an in-depth discussion with that employee regarding his/her individual goals and aspirations. You may be surprised that some people will work in their current position for many years and remain happy doing so. Adding responsibility and stress to their lives would not be in their best interest.

Another key indicator for me is a person who can problem solve. He/she becomes aware of a situation or issues and then brings a solution to fix the problem without being told to do so. This person will offer suggestions and contribute to staff meetings with confidence and does not fear ridicule or concern for what co-workers will think.

Third, I look at the demeanor of an employee being considered for management. Does this person carry himself/herself in a fashion that favorably represents my practice both in and out of the office? How does this individual react to emergent problems or working under a deadline?

The final determination for the transition from employee to manager in my opinion comes down to one word: respect. If an employee has the respect of his/her co-workers, the transition comes much easier and will likely prove advantageous for the practice. Those who are respected become great motivators for the entire staff.

“If your actions inspire others to dream more, learn more, do more and become more, you are a leader”
—John Quincy Adams