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The implementation of electronic medical records (EMR) is an issue that’s weighed heavily upon the minds of ophthalmologists and administrators for years now. Deciding whether or not to uproot your current system and dive headfirst into the world of EMR is not easy.

In this issue of Ophthalmology Business, D. Brian Kim, M.D., Professional Eye Associates, Dalton, Ga., attempts to answer lingering questions by going over his experience with EMR implementation. In “Growing Pains,” Dr. Kim gives a detailed account of the lessons he learned during the process. Turn to page 14 for his tips.

Of course, EMR adaptation isn’t a single-step process. Once it’s fully integrated into your office, it must be updated and maintained. Contributing Editor Rich Daly points out that the number of vendors offering EMR products to physicians could dramatically decline in the coming years, leaving their former clients without needed support services. Learn how to prepare for the worst-case scenario on page 8.

“‘I was never told,’ is often the trademark statement made by a patient in a malpractice lawsuit,” writes Kevin J. Corcoran, C.O.E., C.P.C., F.N.A.O., in his article “Understanding informed consent.” Surgeons are legally obligated to provide a patient with informed consent, yet as Mr. Corcoran writes, no standard exists to describe how detailed the discussion and the consent form must be. Read his overview of the informed consent process and where to find stock forms on page 6.

As always, thanks for reading.

From the publisher

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Presented By:
“was never told” is often the trademark statement made by a patient in a malpractice lawsuit. According to Ophthalmic Mutual Insurance Company (OMIC), the issue of improper consent contributes to a lost malpractice case but is rarely the sole reason. Some courts require a physician to pay damages if a procedure is performed without informed consent.

Providing informed consent extends beyond the consent form. It is a mode of risk management and a process rather than a one-time event. This article does not purport to provide legal advice on defendable informed consents, but it serves to answer some basic questions.

**Why execute the informed consent process?**

Defense is a practical motive for informed consent. Informed consent documentation aids in the defense of a malpractice allegation. Yet this is not the only reason why this process is necessary. The informed consent process establishes expectations. During the process, the physician discloses the risks, the benefits, and the alternatives to the patient. These should be specific to the planned procedure(s), providing the patient with realistic expectations. The discussion also includes the option of no treatment. This dialogue establishes a deeper relationship between the patient and the physician opening the lines of communication. Without this relationship, the potential for misunderstanding and unmet expectations grows.
Who provides informed consent?
The surgeon is legally obligated to provide informed consent. Staff members provide education and can often provide the surgeon with insight into the patient’s expectations and level of understanding, but the ultimate responsibility for informed consent rests with the surgeon.

How and when is informed consent obtained and documented?
Numerous methods exist to provide and document informed consent. Educational brochures and videos are extremely useful to increase the patient’s understanding of his condition and the proposed procedure. The patient’s medical record should reflect what materials and videos were provided. Consider asking the patient to sign a document indicating receipt of the brochures and that he viewed and understood the video information.

Informed consent must include a discussion between the patient and the surgeon. Do not ask patients to sign a consent form until they have had a detailed discussion with the surgeon and their questions answered. Having a third party (i.e., family member) present is beneficial as long as the patient agrees to it. After the discussion and other educational information is provided, give the patient a copy of the consent form to take home, read, and return, if possible. If the patient signs the consent form without the opportunity to take it home and review, give the patient a signed copy for his records.

A signed consent form merely affirms in writing the patient’s understanding of the risks, benefits, and alternatives to the proposed procedure. It is advisable that informed consent forms with multiple pages contain a patient initial on each page and a signature on the last page. This indicates that the patient had the opportunity to review each page and not just the final page of the form.

The informed consent discussion and the signing of the consent form require that the patient is alert, aware, and able to participate in the process. Therefore, informed consent cannot be conducted after anesthesia induction or when the patient’s eyes are dilated to the point that reading ability is compromised.

What information is required to consider the patient “informed”?
No standard exists to describe how detailed the discussion and the consent form must be. Yet the discussion should include any patient concerns and significant information about the procedure so the patient can decide whether or not to proceed. Procedure-specific consent forms are highly recommended. These forms contain detailed information about the specific procedure, giving patients substantive information. Patients sign the physician consent form in the physician’s office, and it remains a part of the clinic medical record.

In addition to signing consent forms for the surgeon, patients also sign consent forms at the facility (ASC or HOPD). Facility consent forms address issues specific to the facility service and are not specific to the risks and benefits of the proposed procedure. These forms are not a substitute for the physician’s consent form.

What procedures require informed consent?
All services you provide require consent. The question is how much and how to document it? Since the discussion between patient and provider is the most important aspect of informed consent, explaining what is being done and why remains a crucial aspect of patient care. Physicians typically have patients sign consent forms for major surgical procedures and tests with associated risks (e.g., fluorescein angiography). Minor procedures might not have a signed consent but, at a minimum, document verbal consent in the medical record.

Where can physicians find prototype consent forms?
Some physicians write their own consent forms. Any physician writing his own consent form should ask his malpractice company to review it for completeness and defend ability. Check with your malpractice carrier for consent forms. OMIC provides consent forms on its website at www.omic.com.

In most states, failing to secure informed consent is negligence. Combine the lack of informed consent and an unexpected outcome and you tempt your patient to sue. Defending a malpractice suit relies on good documentation of informed consent. Keep the following dos and don’ts in mind as you review your informed consent process.

Do
• Make time for it.
• Document amount of time spent if extensive.
• Answer all questions honestly.
• Provide information in writing.
• Educate staff on the importance of the informed consent process.

Don’t
• Rush the process.
• Delegate the responsibility.
• Rely only on the written consent form.
• Downplay procedural risks.
• Ignore unrealistic expectations.

Mr. Corcoran is president and co-owner of Corcoran Consulting Group, San Bernardino, Calif. He can be contacted at kcorcoran@corcorancg.com.
Physicians should understand

by Rich Daly Contributing Editor

Practical steps can help physicians’ offices avoid investing in EHR systems from health IT firms that may soon cease to exist.
survivability of health IT firms

he number of vendors offering electronic health record (EHR) products to physicians has the potential to dramatically shrink in the coming years, leaving their former clients without needed support services, according to business experts. But specific steps can offer some protection.

The federal push for EHR adoption by physicians’ practices nationwide will help move patient information from paper to more easily accessible and reliable electronic formats, said Thomas O’Connor, managing director, Berkery Noyes, an independent investment bank based out of New York. But that same $19 billion federal incentive program has attracted thousands of EHR vendors that may cease to exist within the next few years, due to bankruptcy or takeover by other firms.

While a firm’s size is not a guarantee of its longevity, Mr. O’Connor said that although about 10,000 such vendors have emerged recently, it is possible that only a handful of the largest firms will survive beyond the next 5 years.

“What we are seeing is that the big vendors are coming up with the unique solutions and a lot of little niche players in software—it’s all software—that people are developing,” Mr. O’Connor said. “There will only be a handful that survive.”

The viability of these firms is a critical question for clinicians buying their products, Mr. O’Connor said, because physicians’ offices will need extensive ongoing support services for those EHR systems.

Some physicians have already experienced the fallout from the turbulent health IT market. For instance, when Allscripts (Chicago) merged in 2008 with part of a rival, Mysis (London), many of the practices operating their former competitor’s EHRs were required to migrate to the new company’s software, said Jeff Grant, president of HCMA Inc., Shell, Wyo., a practice management consulting firm.

“It’s one thing to say ‘It’s my billing and scheduling software and I can change,’” Mr. Grant said. “These are medical records we’re talking about now.”

Both Mr. O’Connor and Mr. Grant urged physicians looking to invest tens or even hundreds of thousands of dollars in the products of digital health records firms to carefully vet them for sustainability.

It is important to reiterate that the firm’s size is not a clear predictor of its survivability, as large firms also are expected to undergo buyouts and bankruptcies, according to the business experts. Additionally, small firms—especially those led by physicians—may offer things that the larger firms may not: more tailored software, more personal service, and even lower prices.

Starting the viability search

Physicians should first and foremost confirm that the EHR system they are considering has received federal certification for meaningful use and guarantees the company will meet the standards for all stages. ASCRS has provided its members with

continued on page 10
access to information about EHR systems at the following website: www.ascrs.org/meaningfuluse-emr/index.cfm. Included on this website is a link to the ONC Certified HIT Product List (CHPL). Next, check their ratings with organizations such as the Better Business Bureau; check online surveys that rank EHR vendors based on physicians’ experience with them; and closely question the clinician referrals those firms provide, Mr. O’Connor said.

Additional steps include questioning firms on the number of practices that have bought their system. If an EHR vendor lacks a large pool of startup capital, Mr. Grant said, it will need to have sold to at least 100 practices and be providing them with ongoing support services to have enough income to keep the company viable.

“They don’t survive long-term because they sell 20 units a year,” he said. “They survive long-term because they’ve got support revenue that funds research and development.”

**Worst-case preparation**

Selecting the biggest provider and utilizing the best screening approach cannot protect a practice from unseen market forces affecting its EHR provider. That is why physicians need to protect their practices from the dissolution of the firm they choose, Mr. Grant said.

“Ask yourself, ‘What is my out strategy? What will I do if it ceases to exist? Can I move easily to another vendor? Can I get to the data and have it converted into another vendor’s format?’” he said.

Some vendors will place the source code for their EHR system into an escrow account for their clients to access in the case of the company going under, Mr. Grant said. Such arrangements are analogous to a builder providing the homeowner with the architectural plans for a house, which another contractor would need to undertake upgrades or rebuilding. Physicians could take that source code to another vendor to keep their system operational, he said.

Physicians also should ask health IT firms whether the license to the software will remain valid if the company goes out of business. Similarly, physicians should ask if they could lose access to their data because the firm ceased to operate and could not provide necessary updates.

**Coming challenges**

Physicians should understand that the health IT landscape is likely to continue evolving even after the culmination of the federal EHR incentive program within the next few years. That is because the federal initiative does nothing to encourage the integration of the EHRs with practices’ other digital record-keeping systems, such as their billing and practice management systems, Mr. O’Connor said.

For example, according to several EHR makers’ websites, the products of different companies cannot communicate without an HL7 interface, which is a technological feature developed by Health Level 7, an international volunteer healthcare standards group.

“Eventually we’re going to have to have a system that is used across a hospital or a physician’s practice that can allow all of them to talk to each other and interact,” he said. “It’s going to take time to shake out.”

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Editors’ note: Mr. Grant is president of HCMA Inc. Mr. O’Connor is managing director of Berkery Noyes.

**Contact information**

Grant: jeff@hcma-consulting.com
O’Connor: tom@berkerynoyes.com

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CHICAGO 2012
Surgeons who provide elective procedures have a growing number of alternatives to malpractice insurance

The refractive lens patient was upset because several days post-op she could not see anything. Instead of hiring a lawyer and heading to court, her daughter notified the surgeon’s warrantee company that the patient would soon file to receive her $1 million in coverage.

But before she was provided the money, a mandatory exam by an outside surgeon found the patient had simple residual astigmatism. The patient agreed to a LASIK touch-up procedure and her visual complaints were resolved.

The case is typical of lawsuits routinely brought against ophthalmic surgeons, said Steven B. Siepser, M.D., Seipser Laser EyeCare, Wayne and Plymouth Meeting, Penn. Such cases are why he developed an alternative to lawsuits that would protect both surgeons and patients.

Two years after his warrantee firm was launched and covered more than 900 eyes, no lawsuits have resulted.

“It derails the very machinations that lead to litigation,” Dr. Siepser said.

The surgical warrantee is based on the consumer-friendly promise that many ophthalmologists have made for years guaranteeing patients a refund if they are unsatisfied with the results of their surgery.

“A warrantee system is only possible because the error rate is so low in eye surgery,” Dr. Siepser said. “It’s
gotten so good that it is now an insurable event.”

**How it works**

Launched August 2009 with three eye surgeons in Florida, VisionLock provides up to $1 million of coverage for certain complications stemming from surgery. Additionally, it covers a second opinion or treatment by an accredited Patient Confidence Corporation of America ophthalmologist. It also would cover half of the cost of services provided by a non-accredited specialist.

Each of the program’s components is designed to address the various factors that drive refractive surgery patients to file suit.

For example, it offers up to $5,000 of coverage for accidental injury causing trauma to the eye. That provision addresses the problem of refractive surgery patients seeking care for minor complications at emergency departments shortly post-op. Although complications in such instances usually resolve quickly, Dr. Siepser said, many decide to sue shortly after receiving the bill for care.

Coverage is obtained by the participating surgeons for $99/eye for LASIK and $199/eye for premium cataract surgery and offered to the patient at no cost.

**Latest alternative**

The VisionLock program is only the latest example of non-insurance alternatives to cover elective surgeries. Other approaches include the BLISCare Complication Protection Program, which aims to protect both bariatric surgeons and patients. The program offers a range of coverage for complication treatment post-op. Additionally, the BLIS program aims to protect patients by prescreening surgeons who apply to participate in the program and accepts only those who clear its reviews of their clinical outcomes.

“Once approved, the BLIS surgeon will undergo continuous evaluation in comparison with the entire population of BLIS surgeons in order to maintain their approved status with BLIS,” according to the company website. “This process, supported by a unique set of BLIS data, helps the BLIS surgeon in their efforts to improve surgical outcomes which helps protect patients.”

It’s a screening approach similar to the one used by the ophthalmic warrantee firm. For instance, surgeons who apply to VisionLock are screened through a variety of quality measures and if accepted are provided a business development trainer to instruct their staff on the parameters of using the warrantee product.

“By pre-selecting doctors who can ensure their outcomes, patients can be assured they are getting the best care and coverage, the best doctor,” Dr. Siepser said.

Another alternative product to malpractice insurance developed in recent years is the CosmetAssure program, which covers the cost of treating complications from certain elective cosmetic surgeries.

Similarly to VisionLock, CosmetAssure employs an approval process to select among its applicant surgeons.

The similar screening of surgeons is a critical component of VisionLock, Dr. Siepser said, because it minimizes the clinical risk for the patient and the financial risk for the program. It serves as an effective marketing tool of participating surgeons for prospective patients who otherwise have no way to objectively assess the clinical expertise of competing surgeons.

“The goal of this project is to back those really fine surgeons, some of whom may not have the best bedside manners because they’ve been too busy becoming very good at what they do,” he said. In the case of VisionLock, it takes applying surgeons about 3 months to clear the pre-screening process, which four surgeons are now moving through.

**Spreading nationwide**

Despite its rigorous standards, the ophthalmic warrantee program has grown to eight Florida surgeons, and Dr. Siepser said it plans to offer coverage in an additional state by the end of the year. By the end of 2012 it aims to offer coverage in five states before spreading nationwide.

Other variations on VisionLock have already come and gone, and Dr. Siepser freely admits the company and its product continue to evolve to address any shortcomings. But its appeal to both surgeons and patients and ability so far to avoid short circuit costly lawsuits clearly demonstrate its potential.

“Why do doctors buy malpractice insurance? What they should be buying is good outcomes insurance,” Dr. Siepser said. “That’s our model.”

**Contact information**

Siepser: ssiepser@clear-sight.com
Growing pains

by D. Brian Kim, M.D.

One practice’s experience implementing an EMR system

Saying that implementing an electronic medical records (EMR) system had its ups and downs is like saying World War II was just a little disagreement. I’m happy to report we had no casualties, but when we were going through the phase-in stages, it certainly made me want to pull my hair out more than once.

Practices that implemented EMR even as long as a decade ago have told me how frustrated they were with the process. For some early adopters, the companies they chose went belly-up. Early adopters have felt a lot of pain experiencing what NOT to do. I am grateful to them for taking this challenge head-on.

Because of their knowledge and experience, we can make wiser choices in this process.

We brought our system online in August 2011. If it weren’t for the penalties the Centers for Medicare and Medicaid Services (CMS) was going to enact, we might not have been motivated to implement the system. CMS has said practices without an EMR system certified for meaningful use will be assessed a 1% penalty, and it grows to 2% in the following year and keeps escalating, beginning in 2015. That’s a pretty big hit for a practice that’s heavily in Medicare. If we had waited another year or started a year earlier, I don’t think it would have made a big difference in terms of our growing pains. We just went ahead and bit the bullet so we would have some wiggle room to work out the kinks. Unfortunately, these EMR systems have also turned patient care from being exam-driven to code-driven.

Point person

Our practice administrator was the key contact person, and the one who really drove the whole thing. She has been under so much stress and

continued on page 16
“Ours is a managerial team, led by our practice administrator, not only manages research, refractive surgery, finance, the business office and the clinic, but also keeps us compliant with Medicare rules and regulations and other regulatory constraints. We can’t imagine functioning so well without the help the team gains through ASOA’s publications, courses and activities.”

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scrutiny (but has done a great job)—
stress as far as picking the product
and scrutiny as far as hearing all of
us in the practice complain about
the whole process. When it comes to
major change, nothing is easy, and
this is no exception. Our budgeting
process also fell on our administrator—she's a member of ASOA and
AAOE and talked with several other
practices that had already gone
through this to develop an educated
estimate based on our practice's
requirements. In retrospect, one of
the physicians should have been
more involved in the pre-implemen-
tation stages. But the reality is that
until you get your teeth into it and
actually start seeing patients and
using the program, you won't under-
adversely impact patient flow/vol-
umes or its long-term effects. Those
demos at medical conferences are
nice, but they don't give you a true
sense of how it will work in the real
world. You have to commit to a sys-
tem upfront. Therein lies the chal-
lenge.

Be prepared: This process will
take a very long time and requires
patience with everyone involved. It
will be fraught with snags, modifica-
tions, and may completely revamp
current processes.

Our administrator initially
looked at 20 different systems, but
took a serious look at four or five.
One thing that helped us choose our
system is that our practice manage-
ment system is from the same ven-
dor. We didn't worry about conver-
sions or integration issues. EMR sys-
tems that are totally different from
your practice management system
will need to have some integration
and some software adaptation. Using
the same vendor for both eliminates
those concerns. (The downside is if
that vendor goes out of business,
now we're out of luck with two
major components of our practice.)

The most important take-away point
is that the system must be certified
for meaningful use and not just
CCHIT certified.

Lessons learned
We've had the system up and run-
nning for a little while now, and I
hope some of our lessons can be
helpful to others:

1. Demonstrating “meaningful
use” with ONC-certified EHR tech-
nology is how a practice can receive
a bonus. Ensure the software you're
evaluating has been certified for all
stages of meaningful use.

2. A big part of the success in
implementing a system is doctor-
dependent. For practices with more
than one physician, whoever is the
most computer-savvy should be the
person to implement it first, and
then bring along the rest of the
physicians. In our case, even though
I'm fairly computer-savvy, it was a
painful learning curve. Although the
first 3 weeks were manageable, week
4 for me was when it all imploded—I
was behind on every patient and I
was at the office late every night
keeping up with paperwork. I identi-
fied most of the major glitches for
our practice; now we are addressing
more subtle issues.

3. Your practice will no longer
be exam-driven. Be prepared to doc-
ument everything. There are clinically
relevant parts of the exam and
there are parts that are completely
irrelevant that we would just
ignore—if the patient was there for a
cataract and also has an eyelid cyst,
for example. We wouldn't document
the cyst since it wasn't the patient’s
complaint. But now the computer
asks about every little thing, and if
you leave something blank, it won't
let you enter the appropriate billing
code.

4. Make sure your system is cus-
tomizable with smart functions/
macros. This will help you to be
more efficient with the patient
encounter.

5. Do your homework. Make
sure whoever evaluates the system—
some combination of the administra-
tor and one of the physicians is
ideal—knows exactly what functions
are mandatory for your practice and
which aren't.

6. Reduce patient volume during
the learning curve or bring only new
patients onto the system. My volume
was trimmed about 40% in the first
week; I added 10% of my volume
back every week. I jumped in with
both feet, but you can start slowly.
It's up to you. But the upside is that
my learning curve was forced to be
quick, and now I wouldn't go back
to a paper system.

7. Be patient and expect the
learning curve to be steep. Seeing
patients on paper charts is a totally
different animal from EMR charts.
The faster you accept that you will
be practicing differently, the easier
and less frustrating the process will
be.

We spent 18 months from start
to finish going through the evalua-
tion process and bringing it fully
online. A practice that's not heavily
reliant upon Medicare may opt not
to participate. The costs may not be
justified, but those decisions have to
be made on an individual basis.

Every EMR system and every
practice is different. Every day I learn
something new that helps me use
the system more efficiently and
effectively. I foresee this learning
process will take months and proba-
bly several years before it's stream-
lined, and I'm glad we have plenty
time to finesse it. OB

Dr. Kim is a partner at
Professional Eye
He can be contacted at
kim@professionaley.
com.
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CHICAGO 2012
Managing the physician-patient relationship

by Michelle Dalton Contributing Editor

How surgeons communicate with patients, as well as how often, may alter patient perceptions

Surgery of any kind can be scary—even when the surgery is elective. “Patients fear blindness far beyond their actual risk of becoming blind. And we, their doctors, fear that we are failing to treat them adequately,” said Reay H. Brown, M.D., in private practice, Atlanta Eye Associates. “We need to emphasize to our patients the success of their therapy.”

With today’s frenetic pace, technology making medicine seem more impersonal, and reimbursement rates plummeting (necessitating an increased patient base), sometimes it’s easy to forget how truly important effective communication can be.

“We have to put patients first; we need to show compassion for their situation,” said Vincent P. de Luise, M.D., assistant clinical professor of ophthalmology, Yale School of Medicine, New Haven, Conn. “Showing compassion goes a long way toward cementing a relationship.” For example, he suggested giving patients a cell phone number in lieu of instructions to call the office with any concerns or additional questions.

Face-to-face time between the patient and the surgeon is crucial, said Gordon Keehn, M.D., in private practice, Garland, Texas, and assistant clinical professor of ophthalmology, University of Texas Southwestern Medical Center, Dallas. He and his partner, John Haley, M.D., clinical professor, University of Texas Southwestern Medical Center, recently implemented an EMR system, which has freed him from having to take notes as he’s talking to the patient (he has a scribe with him).

“You have to build confidence,” he said. “I recap what we’ve discussed once I’m done with the exam and then ask what questions they have. It reiterates for them a comfort level that you’re not racing out the door.”

Dr. Haley agreed, saying the most important aspect about the patient-doctor relationship is “availability has to be number one when the patient has concerns.”

Teaching communication

Surgeons have to be able to “explain conditions in terms the patient can understand,” said Nick Mamalis, M.D., professor of ophthalmology; director, Intermountain Ocular Research Center; and director, Ophthalmic Pathology Laboratory, John A. Moran Eye Center, University of Utah, Salt Lake City. “Find the unique characteristics of their situation and address them.”

Words and word choices are powerful, Dr. Brown said. “Patients listen carefully—not only to you but to your staff, too. But it starts with you. You need a consistent positive message. They can tell what you think,” he said. “They will often take the most negative interpretation.”

For Drs. Haley and Keehn, their practice “has always been relatively high volume and very efficient,” so there is not much room to further streamline, Dr. Keehn said.

That said, however, “You have to connect with the patients. That means chatting with them, letting them share their problems. You need to maximize the visit in terms of how the patients view it,” he said.

Dr. Haley said part of effective patient communication begins with the staff.

“The physician has to be the captain of the ship and set the standard,” he said. “As a surgeon, you have to spend time going to meetings and reading about ophthalmology, but an equal amount of time should be spent building quality staff. Make a personal commitment to them. Encourage them to build a professional career, otherwise they’ll move on.”

Avoiding litigation

Having a good rapport with patients is incredibly helpful if (or when) the possibility of a lawsuit occurs.

“It’s imperative to maintain the best possible communication even under litigious circumstances,” Dr. de Luise said. When patients feel concerns are not being addressed, that’s when they are more likely to seek the advice of a lawyer, he said.

“People need to have that intangible feeling that someone cares. Be their advocate. If you continue to truly listen to patients and be empathetic and sympathetic, lawsuits won’t happen,” he said.

Be “absolutely honest” if there’s a complication or an unexpected outcome, Dr. Mamalis said.

“The worst thing you can do is not tell patients when something went awry. It doesn’t take a tremendous amount of time to allay their
fears. Tell them what happened, but let them know how you plan to address the outcome, so they know you plan to be there with them throughout the process.”

Bottom line? “If patients lose confidence in the surgeon, that surgeon has lost them as patients,” Dr. de Luise said.

Dr. Keehn said if he is in the OR when the unexpected happens, “I share what’s going on with patients. I tell them what’s happening and what the next steps will be as they occur.”

When patients expect 20/20 outcomes on post-op day 1, anything less might not be acceptable if they are unprepared, Dr. Haley said.

“If they have a pre-existing corneal problem and you don’t tell them, when it causes an issue post-operatively they are not going to be satisfied,” he said.

An emergency in Dr. Haley’s practice “is a concerned patient. If the patient has lost his glasses or has a bout of red eye, we will work him into our schedule that day.”

With his glaucoma patients, Dr. Brown said emphasizing a specific pressure “teaches patients to focus simplistically on a very complex issue. And it sets them up for failure because the visit becomes pass-fail.”

Instead, he suggested emphasizing the success the patient has already had (i.e., pressure reduction after only one topical medication).

“You’ll have a happier clinic, and it makes the interaction with the patient go more smoothly and faster. Nothing can slow you down like hanging your head and saying that you don’t know what to do,” he said. “Leave patients with hope. They are worried about blindness. We are providing ‘vision insurance.’ From their standpoint it is our finger that is in the dyke. Our words are a critical part of the exam—and the therapy.”

Editors’ note: The doctors interviewed have no financial interests related to this article.

Contact information
Brown: 404-252-1194, reaymary@comcast.net
De Luise: 203-263-3300, eyemusic73@gmail.com
Haley: 972-272-5591, bigdeyedoc@hotmail.com
Keehn: Drkeeihn@keehnvision.com
Mamalis: 801-581-6586, nick.mamalis@hsc.utah.edu
2011 tax tips for

by W. Ben Utley, C.F.P.
With the top marginal tax rate set at 35% for this year, every dollar you don’t pay in taxes will save you at least thirty-five cents in that bracket. If you live in one of the many states with an income tax, you could save even more. The end of the tax year is at hand, so now is the perfect time to call your tax advisor and work through some tactics to trim your tax bill. The following tips may offer you some sweet opportunities.

**Plug in and save.** With gas prices topping $4 per gallon in parts of the country, you might be tempted to buy a hybrid, but the real tax savings are currently (no pun intended) in electric cars. When you buy a vehicle certified for the Qualified Plug-In Electric Drive Motor Vehicle Credit, you can save up to $7,500 in taxes. Andrew Schwartz is a certified public accountant in Boston, and author of a monthly tax newsletter for healthcare professionals at www.MDTaxes.com. He said, “This is a great tax break for doctors since it’s not limited by the Alternative Minimum Tax (AMT) like the credit for hybrids was.” Mr. Schwartz noted that many of his firm’s married clients were hit by the AMT in 2010, making the credit particularly valuable for doctors who are in a position to purchase electric. To avoid a shock at tax time, consult your tax advisor BEFORE you step into the dealer’s showroom.

**Open a health savings account (HSA).** The health savings account was established in 2003 as an additional tool to help Americans save for medical expenses in a tax-sheltered environment. If your circumstances qualify you for it, an HSA can be a particularly handy tax management tool for physicians. You will never pay taxes on the money (as long as you follow the rules): Contributions are tax-deductible to begin with, they grow tax-deferred, and qualified withdrawals are tax-free. In 2011, you can set aside up to $3,050 in potential medical expenses for yourself, or if you have a family plan, you can contribute up to $6,150. As an added twist, you don’t necessarily have to spend it right away. You can let the money grow tax-deferred indefinitely by paying your healthcare expenses out-of-pocket instead of taking the money out of your HSA.

Before you rush to call your existing insurance broker, know that you can purchase your health savings account and health savings insurance (i.e., your HSA-eligible, high-deductible health plan, or HDHP) from two separate vendors. It can be advantageous to consider separate, best sources for each; by shopping around, you may be able to reduce administrative and investment expenses and improve your investment selections.

**Invest in equity index funds.** While we’re on the subject of investment selections, whether you’re investing in tax-sheltered accounts such as an HSA or in taxable accounts, I recommend viewing your investment activities from a portfolio-wide perspective. The object is to build and maintain an overall portfolio that (1) reflects your personal goals and risk tolerances, (2) uses broad diversification to minimize unnecessary risks, and (3) accomplishes numbers 1 and 2 while keeping costs low.

*continued on page 22*
It’s tempting for physicians to pursue fancier investments, but the truth is, “fancy” is all too often a synonym for expensive and overly complicated, without adding any expected value in return. Instead, consider simple index funds from The Vanguard Group for retail investors, or passively managed funds from Dimensional Fund Advisors for physicians using an approved advisor. Either way, you can accomplish all three goals above hold your funds, rather than fleeing from them during times of market volatility, you can defer capital gains and keep your tax return simple. Your tax advisor will love you for it.

**Turn your losing investment into a winning tax move.** If one of your investments turned out to be a lemon, you can “make lemonade” by selling it for a loss. If you’ve lost $3,000 or more on an asset such as a stock or mutual fund, you can sell before year-end to “recognize” the loss, and offset up to $3,000 worth of ordinary income this year. If you lost more than $3,000, you can “carry forward” your losses into future years to offset future gains or income.

**Give your gains to charity for good.** On the flip side, if you’re charitably minded and you’ve got an asset that has appreciated significantly in value, consider donating the asset “in kind” to a qualified charity. For example, say you own 100 shares of the XYZ Fund that you bought at $50/share, and now it’s worth $75/share. If you sold the fund, you’d owe tax on the $2,500 gain. If you instead gifted the fund to charity (without selling), you’d sidestep the capital gains tax, plus qualify for a tax deduction on your gift. Since it is a non-profit organization, your charity won’t owe taxes on the gift either. The same strategy applies to most assets, including stocks, bonds, mutual funds, or real estate. If you are going to make a donation anyway, you may as well maximize your tax advantage. The devil is in the details, so consult your tax and financial advisors first.

**Save taxes as you save for your kids’ college.** As you set aside funds for your children’s or other beneficiaries’ higher education, consider contributing to a Section 529 college savings plan where the investments can grow tax-deferred and be spent tax-free for qualified higher education expenses.

Most states offer their own 529 plan; you may use your state’s plan, but you are not obligated to. In deciding which plan is best for you, consider factors such as the state-tax benefits your state offers, as well as the quality and expense ratios of the funds available within the plan. Bill Cleveland, a certified public accountant with Preston & Cleveland Wealth Management, Augusta, Ga., commented, “As with all investing decisions, when comparing 529 plans, make sure you understand the cost/benefit ratio. These aren’t like cuts of meat, where the more you spend, the higher quality you get. Costs vary widely, especially between direct-sold and broker-sold plans. Sometimes less is more.”

One of the best places to begin your research is at www.savingforcollege.com, a comprehensive and objective source for clearly disclosed information on 529 plans.

**Working two jobs? Set up a separate retirement plan.** If you’re waiting to make partner in your practice, you might not be covered by your employer’s retirement plan yet. This means you might be eligible to establish your own SEP-IRA, or a Nidek OPD (Nidek, Fremont, Calif.) (40-45 K), or an IOL Master 500 (Carl Zeiss Meditec, Dublin, continued on page 24
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Calif.) or a Haag-Streit LENSTAR (Haag-Streit, Mason, Ohio) (30-34 K) to your armamentarium in the surgical suite, now may be a great time to make that upgrade and invest in your practice.

Thanks to various government stimulus measures, the Section 179 deduction for business equipment purchased in 2011 has been raised to $500,000. You may not speak IRS-ese, so let me tell you that the Section 179 deduction means you can expense an entire purchase this year, rather than spreading the expense—and the tax savings—over several years. For a summary, visit www.section179.org/stimulusActs.html.

Refresh your retirement plan.

If your office uses a SIMPLE IRA or a safe-harbor 401(k) plan, it might be time for a new plan: the New Comparability Plan. Pension consultants will tell you it’s a cross-tested defined-contribution retirement plan for discretionary profit-sharing contributions. But what it does for you is not nearly as obscure as its description. Simply put, it treats highly compensated employees (doctors) more favorably than employees who earn less (staff) by allowing you to put more money into your account than traditional plans do—without breaking rules designed to ensure fairness to all participants. Even though the Treasury Department formed these plans more than a decade ago, implementation is complex, so the adoption rate has been slow among small businesses. If you don’t have time to explore this option, and you don’t have a consultant who can do it for you, visit the American Society of Pension Professionals & Actuaries (www.asppa.org) and find a consultant to assist with the heavy lifting.

Layer on the tax savings.

“To make retirement savings even less taxing, you could layer a cash balance defined benefit plan on top of your new comparability plan,” said Jeff Curl, Summit Benefit & Actuarial Services, Wauwatosa, Wis. According to Mr. Curl, “You can get contributions two to four times higher than what might fit in the new comparability plan, perhaps up to $200,000 for highly compensated doctors.”

Mr. Curl warned that these plans are only appropriate for consistently profitable businesses, as may be the case with larger, more mature ophthalmology practices. But if you explore cash balance plans, watch out for plans that involve life insurance. “They might be a good plan for the guy selling the insurance, but they might not be the best plan for the doctor,” said Mr. Curl.

Contribute to your IRA.

Remember the good old days in residency when you worked your tail off and made so little that you could actually deduct your IRA contributions? In the grand scheme, it’s actually a good thing that those days are gone forever, but you can still make non-deductible contributions to a traditional Individual Retirement Account.

Janet Davis, a certified public accountant with Trusted Advisors Consulting, Tucson, Ariz., said, “The Roth conversion is still available to tax payers in 2011 and later years, regardless of income. Even though you can’t deduct your IRA contributions, it’s still a great idea to make them, so you can convert the IRA later. It makes those IRA contributions even more powerful.”

Ms. Davis is referring to the fact that the Roth IRA conversion option is currently available to high earners, which means you can convert your Traditional IRA account to a Roth, pay the taxes on the conversion upfront, and let your earnings grow tax-free for the rest of your life. Physicians under age 50 can contribute $5,000 to an IRA for themselves and an additional $5,000 for a non-earning spouse (make that $6,000 if you’re 50+), and you can make your 2011 contribution any time before you file your return, which may be April 15 of next year.

When and how to make these sorts of conversions can get pretty complicated pretty fast, especially once you factor in tax-efficient estate planning. However, properly managed, they can be of significant value to your bottom line, so they’re worth considering.

Keep an eye out for Alternative Minimum Tax (AMT). “Physicians earning $200,000–$400,000 per year often wind up paying the Alternative Minimum Tax,” said Ms. Davis. Doctors in the AMT may want to take advantage of the 28% AMT bracket by converting to a Roth IRA, taking deferred compensation, or making other moves to accelerate income into 2011. After all, tax rates are set to rise in 2013, making that 28% rate look like a bargain by comparison.

Remember that most tax breaks come at a price, like increased expenses (interest paid, purchases made, or assets simply given away) or deferred gratification (saving for college and retirement). At best, tax breaks are sweeteners to help you make an otherwise sour decision, and they may motivate you to do something that’s actually more expensive than the alternative, like buying a brand new car instead of a good used one. In the end, tax maneuvers are just one more tactic you can use in your financial plan, so keep your goals in mind and stay focused on reaching them. OB

Mr. Utley helps young doctors get on track with a personalized one-page plan to pay off debt, save for college, and invest wisely for retirement.

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How to know it is time to retire from the OR

Ophthalmologists are used to making tough, on-the-spot calls about patient care. But as decisive as doctors are, there’s one choice that frequently gives them pause: when to retire from surgery. Deciding to resign from the operating room is a deeply personal, multifactorial decision dependent not just on the surgeon’s feelings, but those of his colleagues and family.

During his 32 years as an ophthalmic consultant, John B. Pinto, president, J. Pinto & Associates, San Diego, has seen many surgeons wring their hands over this very issue. Interestingly, he’s found that younger or mid-career clinicians have no problem envisioning their surgical end, typically having a finite age in mind to stop operating. They simply can’t imagine wanting or being able to perform surgery like a 30-something at 70, 65, or even 60.

“As one approaches that punitive hang-it-up date, the calendar tends to stretch out,” Mr. Pinto explained. “For financial reasons, hubris, or the absence of signals, [surgeons] say, ‘At 62 I’m going strong. I’m doing better cases than I’ve ever done. I guess I’ll just keep at it.’”

According to the American Academy of Ophthalmology’s Clinical Education Department, no firm guideline or policy on age limitation and performing surgery exists. Mental and physical skills decrease as people age, but at unpredictable times. One surgeon may cruise through his early 70s while another may struggle before 60. So how are surgeons of a certain age to know how and when to re-evaluate their skills?

One solution Howard Fine, M.D., clinical professor, Casey Eye Institute, Oregon Health & Science University, Portland, and John Polansky, M.D., past president, Oregon Academy of Ophthalmology, came up with was surgical evaluation by an objective but trusted peer.

“Howard and I observed that people struggled with the retirement issue, perhaps worked longer than they should, and were superseded by younger people with better skills and failed to realize it,” Dr. Polansky said. “Howard thought it would be a good idea to have some system to give a clue. He asked me if I would observe

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him annually in a very detailed way.”

Drs. Fine and Polansky rated all the steps involved in modern cataract surgery on a scale of 10—10 being perfect and 0 being disaster. Examples of steps evaluated included the performance of the paracentesis, the continuous curvilinear capsulorhexis, the degree and precision of the overlap of the anterior capsulorhexis on the optic of the intraocular elastic material. Records of the results were kept on an annual basis, enabling the surgeon in question to compare and contrast his scores over years-long periods.

“It’s tricky to implement because in a lot of communities, physicians are in competition with one another,” Dr. Polansky said. “The purpose of it was to give feedback to the physician himself, and to have some objective and trusted colleague to say, ‘You’ve had an A game for 40 years and now you’re hitting singles instead of home runs.’”

“I always felt it was a privilege to be a physician,” said Dr. Fine. “The primary mandate for every physician is above all, do no harm. That’s something I took seriously. I always felt a surgeon should stop at the peak of his skill and ability. The reason for that is it’s a slippery slope. As soon as the surgeon starts to feel less confident, less certain, or he’s having more complications, then he should consider stopping.”

Complication rates, specifically posterior capsular tears and vitreous loss during cataract surgery, are other telling signs. If complication rates are up for these, it may be time to consider passing the surgical baton.

Of course, there are emotional aspects to consider as well, such as if your heart is in the game. Are you still anxious to get back to the office after a vacation, or do you want that vacation to continue on a little longer?

“I think the very first question one has to ask is, ‘Do I still want to do this?’” said Dr. Polansky. “People who are enthusiastic and passionate about surgery keep up with all the little details and give good service to their patients. There’s a certain finesse you need when you’re inside an eye. There’s also a certain stress that comes with that. When you view it as a burden, it’s time to stop. If you view it as a challenge and something you can really do, continue.”

Economics are a third dimension to the surgical retirement question. For example, for surgeons doing 20 cases a month, at a moderate pace, with an hour between each case, the profit-per-hour is less than it would be if they were in clinic doing routine exams.

“There are some surgeons with relativity modest volumes who have realized, ‘I’m doing great surgery, perhaps the best I’ve ever done, but it’s no longer economically effective for me to do this. I’m going to send my cases down the road or to someone else in the practice who is a faster person,’” said Mr. Pinto.

Economics could also be a reason a surgeon stays in the game a little longer than he should.

“They need to have income, and maybe their financial plans haven’t worked out the way they thought. So they come to recognize they have to be productive,” said Dr. Polansky.

If that situation does arise, it’s imperative a colleague step in and talk with the surgeon. The good news is, in Dr. Polansky’s experience, surgeons respond positively to the criticism when given tactfully, although it’s always an awkward situation.

“If a person starts to slip off the chart, you have to ask why,” he said. “What’s in the patient’s best interest? It’s something we have to look at. I think there’s a good gut feeling if you shouldn’t do this anymore. If anything, we are losing talent because people are maybe leaving too soon in that regard. That speaks very highly of the sense of personal ethics I think physicians have.”

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In the April 2009 issue of EyeWorld, Dr. Polansky wrote an article titled “Evaluating continuing surgical competence,” in which he recounted his experiences observing Dr. Fine. In his article, Dr. Polansky listed the steps he evaluates and grades when observing a surgeon. All steps are graded on a 0-10 scale, 10 being perfect and 0 being disaster. The steps are reprinted below.

1. The performance of the paracentesis
2. The continuous curvilinear capsulorhexis
3. The hydrodissection and hydrodelineation
4. The phacoemulsification portion
5. The irrigation and aspiration process if it is performed
6. The temporal clear corneal incision performance
7. The intraocular lens insertion and position
8. The degree and precision of the overlap of the anterior capsulorhexis on the optic of the IOL
9. The removal of the viscoelastic material
10. The sealing of the temporal incision
11. The sealing of the left paracentesis
12. The sealing of the right paracentesis

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Editors’ note: Drs. Fine and Polansky and Mr. Pinto have no financial interests related to this article.

Contact information
Fine: hfine@finemd.com
Pinto: pintoinc@aol.com
Polansky: johndpolansky@yahoo.com
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