Breaking bad news to patients

Whether it’s a vision-threatening disease or a physician’s error, how you deliver bad news to patients can make a difference

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Engaging Gen X and Baby Boomers about Presbyopia

As Gen X and Baby Boomers get older, they may experience changes in their near vision that lead them to research what’s happening to their eyesight.

With so much information available online, patients are able to learn about presbyopia, but may be less familiar with available treatment options.

Patty Casebolt, Clinical Director, Medical Eye Center, and Markey Ratliff, Manager of Refractive Services at John-Kenyon American Eye Institute share tips to help your practice attract and convert more patients of these generations.

Build a Relationship Patients Can Trust
For patients who are near-sighted, they may be familiar with taking their glasses off and still being able to read up close. Even patients who want LASIK may not realize that their near vision can still get worse as they get older. Understanding how patients think about vision changes can help you better connect and form a relationship with them.

TIP: “Anybody who is 40 or above, we’re discussing presbyopia with them. Even if they’re in their late 30s, we want them to understand this is going to happen regardless of whether they have LASIK,” said Casebolt.

By teaching patients about vision changes they can expect, you could help them see you as the expert and keep them coming back for your recommendation. This could even help their children feel comfortable coming to you for their vision care, helping you see more patients of all ages.

An Educated Staff Equals Informed Patients
Patients may see their parents and grandparents wearing readers, but may not understand it’s due to presbyopia. That’s why it’s so important to include your entire team in educating patients about age-related vision changes and the treatment options available to help them see clearly without glasses.

TIP: “We’ll have an evening seminar where we cater in a meal and the doctor is there to present. The more educated we are with what we’re offering, the better we’re able to explain it to our patients,” Ratliff said.

To help ensure your staff is prepared to discuss presbyopia with Gen X, Baby Boomers and other patients, provide opportunities for them to learn throughout the practice. Try incorporating one-on-one coaching after an appointment, sharing articles about customer service best practices, or hosting after-hours learning sessions into your routine.

Financing Can Help Them Move Forward
Cost may keep Gen X, Baby Boomers and other patients from getting the presbyopia treatment they want or need. Whether they choose monovision LASIK or refractive lens exchange, the CareCredit credit card can help them move forward with your recommendation.

TIP: “We send a packet of information that includes a CareCredit brochure,” Ratliff said. “They could print it online, but just receiving a package in the mail simplifies the process.”

CareCredit also provides your practice with the support you need to help you reach your goals. “Our CareCredit Practice Development Manager comes in three or four times a year and shadows our staff, does presentations and reviews our stats from CareCredit reports,” Casebolt said.

Baby Boomers are influenced by physicians, but research options, challenge assumptions and rely on conversations to make healthcare choices.1

As patients get older and experience changes in their vision, they look for providers they can trust to educate them about their eyesight and recommend the best treatment options for their lifestyle. By ensuring your staff can discuss presbyopia with Gen X and Baby Boomers and tell them about financing options available to help pay for treatment, you could help more patients enjoy precise vision for years to come.

To learn how to engage effectively with every age group, call the CareCredit Practice Development Team at 800-859-9975, option 1, then 6 to request Generational Insights Series Quick Guides.


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All physicians aspire to provide compassionate care of the highest quality, and one aspect of that is delivering bad news to a patient, whether that be a vision-threatening disease or a physician’s error. In this issue of Ophthalmology Business, we explore this topic in “Breaking bad news to patients.” The article contains helpful tips for discussing negative outcomes, such as recalling from previous interactions how the patient might prefer to receive such news and focusing on positive attributes of the situation.

It’s a scenario that is becoming more and more common: In late 2016, Horizon Eye Care was attacked by ransomware, malicious software that blocks access to files until a ransom is paid. “As an administrator—and I know this is true for the doctors, too—you always think that this is not going to happen to us, we’re doing all the right things. It was a big wake-up call for us,” said Suzanne Bruno, administrator at Horizon Eye Care. Read “Cyber security: Protecting patient data” to learn how the practice handled the attack and how you can protect your practice from one.

Also in this issue, we discuss the advancement of artificial intelligence in ophthalmology and what it means for clinicians. There is research in this area that focuses on retinopathy of prematurity (ROP), one of the most common causes of childhood blindness in the world. “We have developed computer systems to analyze images and make a diagnosis of ROP, and we’ve shown that these computer systems perform comparably and often better than most experts for diagnosing this disease. The computer systems are objective and reproducible,” said Michael Chiang, MD. In “Robot doctors?” Dr. Chiang and Michael Abramoff, MD, share their research as well as important factors in the implementation of these systems.

There is a rising trend in the “incidental medical traveler,” one who is going to travel anyway and seeks light medical care, according to Josef Woodman, founder of Patients Beyond Borders, a publisher and purveyor of information about medical tourism. This medical care is usually minimally invasive with predictable outcomes and short recovery periods. In “Medical tourism in ophthalmology,” we explore the reasons why American patients might engage in medical tourism, as well as why patients are coming to the U.S. for medical care. The article also contains helpful information for counseling patients on medical tourism, such as encouraging patients to research the doctors’ and clinic’s credentials.

As 2017 comes to a close, we would like to express our gratitude to the readers of Ophthalmology Business. We look forward to bringing you more helpful articles in 2018, so please contact us if there is a topic you would like to learn more about.

Happy holidays!

Donald Long, Publisher
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Cyber security: Protecting patient data

by Ophthalmology Business Contributing Reporter
In late 2016, Horizon Eye Care, a large regional practice on the east coast, was attacked by ransomware, malicious software that blocks access to files until a ransom is paid.

“Our IT administrator was doing routine maintenance after patient hours were over, and she was unable to get into the system,” said Suzanne Bruno, administrator at Horizon Eye Care.

When their IT administrator tried to log into the system, she received a message that said all the passwords were invalid. There was a link to how to create a new password, and then another message that said their data had been hijacked.

“They hacked everything—drives not related to patient data, things just related to internal management, our financial analysis, our personal Microsoft files,” Ms. Bruno said.

The practice is just one of many healthcare facilities that have fallen victim to the malicious software since it surfaced in 2012.

According to Fortune.com, a 2017 Verizon Data Breach analysis found that ransomware was #22 on the list of the most common types of malware in 2014, and this year it was #5. The report also found that ransomware was responsible for 72% of all healthcare malware attacks in 2016. The only industry more targeted than healthcare is the financial services sector, the report said.

As Cal Francis, director of strategic accounts at Veracode, an application security company in Burlington, Massachusetts, explained, “Healthcare is one of those areas where people spend a lot of money and there’s a lot of money invested. If you’re able to get massive amounts of data, you’re able to discern where drug prices are going, you’re able to manipulate insurance markets.”

It won’t happen to us

“As an administrator—and I know this is true for the doctors, too—you always think that this is not going to happen to us, we’re doing all the right things. It was a big wake-up call for us,” Ms. Bruno said.

Included in the message was a demand for payment to a bitcoin account in order to regain access to their files.

“We didn’t do it,” Ms. Bruno said.

Fortunately, the practice had a backup that was only minutes old, and they were able to get their IT manager to restore all the data and create new drives for everything, with no consequence to the patient data.

The hackers were unable to get into anything thanks to the multiple firewalls that had been set up.

Another fortunate thing for Horizon Eye Care was that the episode occurred over a weekend, which meant it didn’t affect their ability to see patients. Partial resolution, where the staff was able to get into the system and do some work, took about 12 hours. Full resolution took about 36 hours.

“The only thing we had to do was pay our IT manager overtime. But what happened was scary,” Ms. Bruno admitted.

Not so lucky was another eyecare practice 50 miles north of Horizon Eye Care that also suffered a ransomware attack.

“They couldn’t get their data back without paying the ransom. They paid $5,000, and 2 weeks later, they were rehacked and had to pay again,” Ms. Bruno said.

Not taking any chances

Following the incident, Horizon Eye Care engaged a security expert for high level security systems to look for areas of vulnerability in their system and help them plug the holes.

“We had done a lot already by having more than one firewall, by having our servers onsite versus cloud-based servers. Those are things that we had done to protect our information in the first place, but we did even more after,” Ms. Bruno said.

One of the changes the practice made after engaging the cyber security expert had to do with passwords.

“We were remiss in not regularly changing our passwords, and we allowed people to select their own passwords. We now have four levels of passwords, and every level is a different password for every person. So when I go to sign onto our electronic health records, I have four different passwords before I finally get in,” Ms. Bruno said.

continued on page 4
Employees no longer get to pick their passwords. They are assigned and regularly changed.

According to Mr. Francis, the reason for changing passwords frequently is, "When you've been hacked and they've got your password, they can continue to use your account. Once you've changed your password, they can no longer use it until you've been hacked again."

The biggest lesson the practice has learned is to pay more attention to their data security.

"There are so many demands on your financial resources that you're constantly trying to figure out whether or not you should spend more money on making your practice more secure," Ms. Bruno said. "I think that when you get that message on your computer screen that you have no access to your information, you will wish that you had taken the time and spent more money to make sure that did not happen to you.

"We have learned that we need to continually engage cyber security experts to have them regularly assess our systems and tell us where the holes are, then do what we can do to plug them," she said.

**No one is immune**

Apart from ransomware, phishing attacks are also common, Mr. Francis said.

In cases of phishing, "the attacker may send you an email that appears to be from someone you trust like your boss or a business that you're working with. The email seems legitimate, and it will typically have some sort of urgency attached to it to make you click on the link or the document that they've sent you. It's the clicking of the link that sets off the attack," he explained.

One of the easiest ways to determine if you're being phished is to hit reply and look at the email address. If the actual sender sent it, there will be a real email address as opposed to some random one that you're not familiar with, Mr. Francis said.

Everyone will get hacked at some point, Mr. Francis said. "No one is immune. There's very little that most of us can do."

He continued, "Anti-virus software is useless. It protects about 15% of new threats, and that's because it's lucky."

Anti-virus software typically looks at past cyber attacks, and it's slow to incorporate those past cyber attacks into the software, Mr. Francis said.

**Not all is lost**

Fortunately, data security is not a lost cause; there are more sophisticated ways in which data can be protected. One of them is through a defense in depth strategy.

"Think of a castle with a moat around that castle. Defense in depth says have five moats around your castle, you have a perimeter that you need to shore up," Mr. Francis said.

Firewalls, intrusion prevention systems, intrusion detection systems, and things like that on the perimeter stop some attacks.

Other ways to protect data are through network layer protections and endpoint security that are on your laptop or PC to guard the potential entry point for security threats, Mr. Francis said.

"Then there's data center security so you can stop information from going out. If they get in that's one thing, but you don't want them to exfiltrate information," he said.

There are tools that will help to detect if someone is trying to exfiltrate data, and once your security is compromised, being alerted is key. "Sometimes these attacks take time, they can take months to fully execute." If you have strong detection tools and you're able to detect it at one of the "moats," then you can potentially halt the attack.

"Teach your employees not to surf the web and not to open any emails that they're even remotely worried about. If you're worried about it, get your IT person to look at it," Mr. Francis advised.

In addition, do not put off software updates, he warned. "A lot of organizations call it patch Tuesday; that's when Microsoft typically releases the latest patches."

When it comes to patient data specifically, Mr. Francis said that it is important to limit the number of people who have administrative credentials and have access to patient data.

"Once administrative credentials are compromised or stolen, then they've really got the keys to the kingdom," he said. 

**Contact information**

Bruno: sbruno@horizoneyecare.com
Francis: cfrancis@veracode.com
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Prevent falls at your practice

by Vanessa Caceres, Ophthalmology Business Contributing Writer

Falls are a small percentage of legal claims but can lead to significant injuries, dissatisfaction

Patient falls at your office may not be foremost on your mind, but there are good reasons to think about how to prevent them.

Falls are more common in older patients and those with significant health issues or a history of falls. That probably sounds like a lot of the patients you see every day, said Anne Menke, RN, PhD, patient safety manager, Ophthalmic Mutual Insurance Company (OMIC), San Francisco. Dr. Menke addressed falls during her presentation at the 2016 American Academy of Ophthalmology (AAO) annual meeting.

Dr. Menke reviewed falls claims handled by OMIC, shared relevant data, and provided tips on how ophthalmic practices can help patients avoid falls.

The OMIC analysis found that while falls were only 1% of total OMIC claims, company leaders know that many more falls have occurred at practices without any legal claim involved, she said. Of the 50 claims in her analysis between 1987 and 2015, 41 patients were involved. The numbers are not equal because some patients sued more than one person, she explained. Of the 41 patients, 31 were older than 60. Three of the patients died within the first year after falling. Almost all—40 of 41—had significant injuries, including fractures.

Falls are the leading cause of fatal and nonfatal injuries for those age 65 and older, according to the Centers for Disease Control and Prevention. Twenty percent die in the first year after a fall, Dr. Menke reported.

During her presentation, Dr. Menke presented data on four specific falls claims and revealed the outcome for each case. Here are some details and pearls from those cases.

**Slipping off a stool**

In the first case, an older woman slipped off a stool while waiting for an eye exam and fractured her spine. She never walked again, and she died 9 months after her fall. “For some elderly patients, [a fall] is the absolute turning point,” Dr. Menke said.

As it turned out, the patient had significant medical problems and needed regular transfusions. The stool had wheels, and it was stated that no one helped her when she sat down.

The case eventually settled for $60,000, a relatively small amount because the patient had fewer medical expenses due to her death, and most of her care was likely covered by Medicare.

With this case, Dr. Menke prompted the audience to consider environmental factors that could increase the likelihood of a fall, including wet floors, poor lighting, and clogged hallways. These are in addition to an older age, health problems, and the use of certain medications.
Dilation and a fall

In the second case, a 79-year-old woman had her eyes dilated for an exam. When she left the practice and was walking outside, she fell and broke her hip. Although the policy at the practice was to offer sunglasses after dilation, the patient declined and went from the darker office into the sun, lost her balance, and fell on some steps.

The first step was 8 feet away from the office door, and there were three handrails around the steps. Each step was 1 foot 8 inches long with black edge painting. The plaintiff’s attorney could not find a legal expert to criticize the practice as the steps were perceived as reasonably safe, Dr. Menke said.

“Even if there’s a poor patient outcome and a terrible event, you’re not held legally liable if there’s nothing you could have done to prevent it,” Dr. Menke said.

When a fall happens, let both your professional liability carrier and your general liability carrier know, Dr. Menke recommended. It’s not always clear which type of insurance should handle a claim, but it’s better to keep both informed.

Most practices make darker glasses readily available after dilation, and Dr. Menke said that staff should let patients know before dilation that it could make it harder to see and that they may have trouble driving.

An unexpected hip injury

In the third case, a 90-year-old woman had a dilated eye exam. As she went to stand up, she scuffed her shoe on the floor, twisted her body, and fell. A technician caught the patient’s head, preventing a head injury. She didn’t want ER care but she was in so much pain the next day that she went to the ER. She was diagnosed with a hip fracture on her right side, but the doctor noticed she had screws in her left hip from a previous fracture. Her recovery for the right hip fracture took 90 days.

“Here’s a case where you try to figure out, did she fall because her hip broke spontaneously, or did she fall and then break her hip?” Dr. Menke said.

Eventually an orthopedic surgeon medical witness said that the patient had a condition that caused her to fall and there was nothing the technician could have done to prevent that. The case went to mediation, and a settlement of $100,000 was determined. The ophthalmic practice and general liability carrier split the settlement costs in half.

In this case, the patient’s daughter had been waiting in the car during the incident, although she did initially help bring her mother into the office. When family members show up to help those with mobility issues, advise them to stay with their loved one for safety reasons, Dr. Menke said.

A problem with the wheels

The fourth case involved an 82-year-old woman who was sitting on a chair with wheels and fell when moving into that chair. She fractured her hip, and the patient needed surgery and nursing home care. There were $100,000 in medical expenses, but when Medicare learned how the fall occurred, they did not want to pay any of those costs. “We settled for $235,000. This is the highest amount we’ve paid for a lawsuit about a fall,” Dr. Menke said.

Those involved with the case agreed that patients should not be left unattended in seats with wheels, especially older or frail patients.

Final pearls

There are a few more ways you can prevent falls at your practice, Dr. Menke said.

1. Ask some preliminary questions to determine fall risk. These can include:
   - Have you fallen in the past year?
   - Do you feel unsteady when you stand up?
   - Do you worry about falling?
   - Are you dizzy or lightheaded sometimes?

   You could ask these in the waiting area before patients are seen for an exam. If patients answer yes to these questions, alert your staff to provide extra monitoring and support.

2. Be aware of depression. One major risk for falls is depression, and a depressed patient is less likely to keep a close watch on his or her own health. Naturally, ophthalmologists aren’t in the position to diagnose mental health or prescribe anti-depressants, but they can monitor for someone’s general mood during an exam. If the patient seems depressed, this would be another reason to stay close when he or she moves.

3. Use signs. In exam rooms or exam lanes, you can have simple signs that say “Stand up slowly” and “Stand still a minute after you stand up.” Near the exit, your signs can remind post-dilation patients to take their time and wait for their eyes to adjust.

4. Refer to other facilities as necessary. You don’t want your staff to risk an injury when transporting a patient who’s at a high risk for falls but who is hard to move for various reasons. If necessary, refer these patients to a hospital or other facility where that person can be moved around safely with the help of assistive equipment.

Editors’ note: Dr. Menke has no financial interests related to her comments.

Contact information

Menke: amenke@omic.com
Medical tourism in ophthalmology

by Liz Hillman, Ophthalmology Business Staff Writer

Josef Woodman, founder of Patients Beyond Borders, a publisher and purveyor of information about medical tourism for international health ministries as well as consumers, was recently in Mexico, a few miles from the border and Yuma, Arizona, on business. While there, he was surprised by the number of vision clinics he saw, he told Ophthalmology Business.

“We are seeing a rising trend for what I call the incidental medical traveler, one who is going to travel anyway and seeks light medical care while on the road,” Mr. Woodman said, noting that this medical care is usually minimally invasive with predictable outcomes and short recovery periods.

There are some who see an opportunity for medical tourism in the ophthalmic space, both for outbound patients leaving the U.S. to pursue procedures elsewhere as well as international inbound patients.

The U.S. Centers for Disease Control and Prevention (CDC) defines medical tourism as the act of someone traveling to another country for the expressed purpose of receiving some sort of medical care. Patients Beyond Borders estimates that 1.4 million Americans engaged in medical tourism in 2016, but Mr. Woodman admitted that there are few reliable sources of medical tourism data. Stats quoted by Mr. Woodman and Patients Beyond Borders come from government health ministries, hospitals and clinics, and accreditation agencies.

According to a 2015 executive briefing from the U.S. International Trade Commission on “Trends in U.S. Health Travel Services Trade,” “exports (i.e., travelers coming to the United States) have doubled and imports (U.S. travelers going abroad) have increased almost ninefold from a low base in the early 2000s.” In 2013, this translated to $3.3 billion spent in cross-border exports, compared to $1.6 billion spent in 2003. Imports for medical tourism resulted in $1.4 billion in spending in 2013, compared to $168 million in 2003.

The largest providers of health services on the global medical tourism market, according to the brief, are Thailand, India, and Singapore.

Medical tourists are seeking quality care, reduced wait times, and/or procedures that might not be available in their home country, according to the executive brief.

According to Patients Beyond Borders, the top categories for medical tourism are cosmetic surgery, dentistry, cardiovascular surgery, orthopedic surgery, reproductive treatments, weight loss surgery, and other testing, screening, and second opinions.

Though ophthalmic procedures are not necessarily on the top of
the list for medical tourism, Arturo Chayet, MD, CODET Vision Institute, Tijuana, Mexico, and Ming Wang, MD, founder, Wang Vision Institute, Nashville, Tennessee, and CEO, Aier Eye Hospital-USA, think there is a market for it.

**Outbound Americans**

According to the aforementioned executive briefing about trends in medical tourism, the most common reason Americans cite for engaging in medical tourism is cost savings. Mr. Woodman provided a few cost comparisons, but noted there is “scant reliable international research for vision procedures.”

However, Dr. Chayet said he doesn’t hear price as being the main reason for medical tourists coming to CODET. Most patients come for a procedure they cannot receive elsewhere and because they trust CODET’s reputation, he said.

“One of the reasons why medical tourism has been so popular here is oftentimes we have access to technology that’s not available in the U.S.,” said Daniel Chayet, CEO and president, CODET Vision Institute. “We do a lot of clinical trials and work with startups, so we have access to a lot of technology the startups develop once it’s approved for commercial use.

“The most recent example is we have access to the AcrySof IQ PanOptix IOL [Alcon, Fort Worth, Texas]. It’s not available in the U.S., and we’ve been performing surgery on many patients who are coming from the U.S. looking for the latest but who don’t have access to it,” Mr. Chayet said.

According to Dr. Chayet, about 50% of CODET’s patients are from Mexico, while the other 50% are considered medical tourists (49%, he estimated, are from the U.S., while the other 1% come from other countries). For patients considered medical tourists, Mr. Chayet said roughly 80% are coming to CODET for LASIK/refractive surgery while 20% are coming for cataract/IOL surgery.

Before arriving at CODET, Dr. Chayet said the patients are provided with preoperative instructions—such as not wearing contact lenses, if they’re coming for refractive surgery, or not wearing makeup—to help ensure the preoperative process onsite runs smoothly to remain on schedule for surgery. Refractive procedures, which are often bilateral, are frequently performed the same day as the preoperative visit. Cataract surgery, on the other hand, is performed the day after preoperative evaluations, and if bilateral cataract surgery is required, the second operation takes place 48 hours later. Patients can go home on postop day 1 after their last procedure.

Though rare, there are times when patients might arrive at CODET only to find they are not candidates for the procedure they wanted.

“That’s a very important part of our business model. We won’t perform surgery on just anyone,” Mr. Chayet said, noting that patients are forewarned of this possibility. “We have the volume to be able to pick and choose. Our reputation was built on only performing surgery on the best candidates.”

Dr. Chayet said he thinks there is an opportunity for international doctors receiving medical tourists to work with physicians in the patient’s home country for preoperative assessments and postop care.

“It’s a good way to learn before you have [new technology] available,” Mr. Chayet said. “We cooperate with a few doctors across the border already as part of our day-to-day operations. They love working with us because they get to learn about the new technology before some of their peers do. I think in the future there will be more opportunity for this kind of collaboration.”

Dr. Chayet said the percentage of Americans who are pursuing ophthalmic procedures outside the U.S. is so small, he doesn’t think it impacts the bottom line of U.S. ophthalmic practices.

“I think we’re at a tipping point where medical travel is becoming more popular,” Mr. Woodman said. “Doctors are hearing about it more, even if it might not be hurting their industry, and I do think it is a time when doctors of all disciplines should be more sensitive about people requiring care overseas [due to cost]. I think it’s time for doctors to become more collaborative.”

**Inbound patients**

The type of collaboration Dr. and Mr. Chayet envision among doctors performing the procedure and those in the patient’s home country is what Dr. Wang and the Aier Eye Hospital group—with 300 locations in China, Hong Kong, Europe, and now the U.S.—hope to establish in the U.S. for medical tourists from China.

The hospital group is establishing Aier-USA at the Wang Eye Institute in Nashville, which it acquired in April 2017. Dr. Wang explained in a Forbes article earlier this year that Aier-USA will seek to serve U.S. patients in more rural areas of the
country but told Ophthalmology Business it is also working on establishing a system that will bring people from China for ophthalmic procedures they can’t otherwise receive in their home country.

Surgeries offered in the U.S. but not yet in China, Dr. Wang said, include some of the presbyopia-correcting procedures, like intracorneal inlays. Patients would be managed by Aier physicians at local clinics in China, but they would come to the U.S. to receive the procedure.

“When you have patients traveling in either direction, you’ve got to have a well-established system to ensure quality of care,” Dr. Wang said. “We think our Aier platform will ensure quality of care for medical tourism.”

Dr. Wang said Chinese citizens have a keen interest in traveling to the U.S. for general tourism and they are also now more likely to have U.S. buying power. A report from the credit card company VISA projected that China would be the top spender in global tourism by 2025. This same report stated that “medical tourism is primed for accelerated growth,” in general, “as more of these older travelers seek new treatments, as well as lower-cost, higher-quality care not available in their home country.”

Alan Mendelsohn, MD, Eye Surgeons and Consultants, Hollywood, Florida, said medical tourism for plastic surgery, including oculoplastics, is a “booming industry” in South Florida. Though he doesn’t perform oculoplastic procedures, he has had a small volume of medical tourists, most commonly from Central and South America, come to the U.S. for other ophthalmic procedures.

“They are usually referred by a friend or relative who had the surgery performed by me, and they come to the U.S. to have femtosecond laser cataract surgery because it is not available or more commonly, if the surgical outcomes and visual results tend to be suboptimal in their home countries,” Dr. Mendelsohn said. “Less commonly but occasionally, Canadians opt to pay out of pocket for the surgery because of long waiting lists or quality concerns. Canadians tend to have their surgeries in the winter months, escaping the brutal weather and enjoying the Florida sun and activities with their families for a prolonged vacation.”

Counseling a patient on medical tourism

U.S. patients are generally squeamish about going outside the country for medical care if they don’t have to, Mr. Woodman said, which is in part due to the positive reputation of the U.S. healthcare system. He said, however, there are many hospitals around the world with equal or better success rates.

Dr. Wang expressed a similar sentiment, saying that while the U.S. still has “the best quality of healthcare in the world,” he thinks people are starting to realize that other countries have improved quality of care.

Though Dr. Wang said he has not had a large number of American patients approach him about going elsewhere for ophthalmic procedures, some are informed of procedures or devices not yet available in the U.S. and might be willing to leave the country to pursue them.

For a patient who is insistent on going outside his or her home country for a procedure, the American Medical Association released guidelines on medical tourism. These include that patients be referred to institutions accredited by international accrediting bodies, that coordination and financing be established before traveling to ensure postop care upon return to the U.S., and that patients be educated about the risks associated with traveling for medical procedures, as well as various other recommendations.

Among the general risks mentioned by the CDC on its webpage about medical tourism are communication issues that could arise due to language barriers, counterfeit or poor quality medications, antibiotic resistance, and blood clots associated with flying.

U.S. physicians with patients seeking medical procedures elsewhere should encourage patients to do their homework not only on the procedure but on the doctors’ and clinic’s credentials and patient references or reviews, Mr. Woodman said.

References


Editors’ note: Mr. Woodman, Dr. Chayet, Mr. Chayet, and Dr. Wang have financial interests with their respective institutions. Dr. Mendelsohn has no financial interests related to his comments.

Contact information

Arturo Chayet: daniel.chayet@codetvision.com

Daniel Chayet: daniel.chayet@codetvision.com

Mendelsohn: karensuedennis@gmail.com

Wang: drwang@wangvisioninstitute.com

Woodman: jwoodman@patientsbeyondborders.com
Breaking bad news to patients

by Liz Hillman, Ophthalmology Business Staff Writer

“Bad news in the ophthalmologist’s office can be devastating, and the artful delivery of bad news can prove your compassion and ensure patient comfort with your continued care.” —Jeffrey Maehara, MD
Whether it’s a vision-threatening disease or a physician’s error, how you deliver bad news to patients can make a difference

Providing compassionate care of the highest possible quality is what Paul Lee, MD, F. Bruce Fralick professor, chair of ophthalmology and visual sciences, and director, Kellogg Eye Center, University of Michigan, Ann Arbor, said all physicians aspire to do. One aspect of that, however unfortunate, requires physicians at one point or another to deliver bad news to a patient.

For ophthalmologists, this can range from a cataract surgery not reaching its desired refractive outcome to irreversible, blinding retinal diseases to cancerous tumors that could have an impact beyond the patient’s eyes.

“Being able to communicate both good and bad news to our patients, and if they wish, their loved ones, is an important aspect of taking care of patients,” Dr. Lee said.

Appropriate communications are part of the National Academies of Sciences, Engineering, and Medicine’s definition of diagnostic accuracy, Dr. Lee pointed out. The Health and Medicine Division (previously the Institute of Medicine) defines diagnostic error as the “failure to a) establish an accurate and timely explanation of the patient’s health problem(s) or b) communicate that explanation to the patient.”

“It’s not just being able to make the right technical diagnosis but being able to communicate that to the patient,” he said.

Beyond how the news directly impacts the patient, how these situations are handled by the physician and perceived by the patient can have implications for the physician and practice as a whole.

“Patients’ word of mouth referrals and their willingness to come back are heavily impacted by their perception of how well their physician communicates. It’s important for practice-building and retaining patients to have good communication with patients,” Dr. Lee said.

This could also have legal implications.

“Compassion is the heart of a patient-physician relationship,” said Jeffrey Maehara, MD, Maehara Eye Surgeons, Honolulu. “Bad news in the ophthalmologist’s office can be devastating, and the artful delivery of bad news can prove your compassion and ensure patient comfort with your continued care. It is critically important that patients feel secure with the fact that the physician is truly here to support them in every way through this period. Maintaining patient rapport through these times is also an excellent way to keep you out of court if legal action is a possibility."

Discussing negative outcomes

Dr. Maehara said he does not think physicians in general are directly trained enough to break bad news to patients, nor are they “innately gifted at gentle delivery of such news.”

In a survey of 54 residents and attendings in the Department of Surgery at Baylor University Medical Center, Dallas, which was conducted to determine if a didactic program was needed to enhance these communication skills, 90% said they think being able to deliver bad news to patients is an important skill for a physician to have, but only 40% said they felt trained enough to do so effectively.

“Experience and personal connection to patients may be responsible for some of the disparity in skills we see in this area,” Dr. Maehara said, adding that ophthalmologists in certain subspecialties, such as retina, might have more experience dealing with situations like loss of vision.

Learning how to communicate bad news, and communicate effectively in general, is being incorporated into medical school training, but a lot of this learning is picked up from mentors and role models. “There’s that direct observational ability to do things in addition to classwork that’s going on in medical schools around the country today,” Dr. Lee said.

Observing patients for how they prefer to receive information is important as well. Dr. Lee said one needs to recall previous communications with the patient, picking up on clues as to what his or her preferred communication style may be. One should also act in accordance with your relationship to that patient. You may act on a more familiar level, for example, with a patient you’ve been treating for years compared to a patient you’ve only seen a couple of times.

“Certain people like things presented certain ways,” Dr. Lee said. “There are some patients who love to have a detailed discussion about the various options they have, and other patients who when I am having an in-depth discussion of the options got more and more concerned. Part of that is to get a sense of how patients would like to get information.”

How do you learn this about a patient?

“A big piece when you first meet folks is to listen to what they have to say after an open-ended question and not interrupt them,” Dr. Lee said. “You’ll get a sense of how patients like to talk, and doing some reflective listening is helpful so patients know you’ve heard what they’re trying to communicate. Have appropriate body language or posture so patients know you’re paying attention. That’s particularly important for new patients in the world of electronic health records, because so many electronic health records are set up so that the doctor may not be looking at the patient when they’re putting information into the record.

“If you have a new patient and you’re typing in information as they speak but you’re not looking at them, patients don’t feel that you’re paying as much attention as they’d like.”

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In these situations, Dr. Lee said he will engage with the patient in direct conversation. When the patient offers information that he thinks is important and limited to what he can remember, he’ll say, “If you’ll excuse me for a second, I’m going to enter this into the computer, then I’ll ask you some more questions.”

At the 2017 Women in Ophthalmology (WIO) Summer Symposium in August, Dr. Lee gave a presentation on delivering bad news. “Breaking Bad: Empathetically Delivering Bad News to Patients,” where he said that it’s important to “be the doctor who communicates information; don’t delegate it to a team member, resident, fellow, or colleague. ... Don’t be the person who says, ‘I think you’re going to be OK, but go see Dr. Smith.’”

It’s also important to prepare the patient preoperatively for complications and surgical risks.

“It’s a whole different ball game if you’ve talked to the patient about what could happen,” Dr. Lee said. “I’ve had my fair share of complications, and having spent the extra couple of minutes ahead of time, the patient remembers, ‘You did say that could happen.’ That changes the conversation of why did this happen, what can we do? Minutes here can save hours and days and weeks if it ends up in court.”

Dr. Maehara offered similar thoughts. “This is where an ounce of prevention goes a long way. Setting realistic expectations when we first meet a patient or encounter a new consequential problem can significantly ease the transition to bad news,” he said. “If we are taking a ‘final shot’ at something, we should make this clear to a patient. It is always better to underpromise and overdeliver.”

Dr. Lee said when a negative outcome is the result of a physician’s mistake, it’s important to be upfront about it.

“Patients sue to get information because they feel they’ve been stonewalled. We’re in this as a team; let’s be honest and tell them what happened,” Dr. Lee said at the WIO meeting. “The results of doing so are good for patients and good for physicians and the health systems, based on experience at the University of Michigan.”

When a patient acts emotionally

In addition to considering how you deliver bad news to patients, physicians need to consider their response to patients’ reactions.

“Having an appropriate, compassionate reaction is something I try to do with folks,” Dr. Lee said. “For example, if they’re crying, offer them a tissue. Depending on the relationship, help reassure them. If they’re angry, let them express themselves and work with them on how to address their concerns.”

Dr. Maehara said in addition to being supportive and explaining that these emotions are normal, it can be helpful to provide examples of how things could be worse and emphasize positive attributes that remain, even if it’s the other eye.

In these situations, Dr. Lee said it’s often helpful to have a patient’s loved ones engaged in the conversation. A close friend or family member can provide support to the patient receiving negative news as well as a second set of ears to help process the information.

In tense times, Dr. Lee said it’s important to ask patients to repeat back what they’ve heard so the physician can be sure they fully understand the situation.

“When breaking bad news, it’s often overwhelming for the patient, so it is best to ensure family members are present and to summarize where the patient was before, the unfortunate events that have occurred, and what positive things remain,” Dr. Maehara said.

Scheduling a follow-up appointment after delivering bad news might not help soften the blow, but it provides reassurance to the patient.

“A 7- to 10-day follow-up appointment to check on how the patient is doing is not a bad idea and reinforces that the patient is not alone despite a permanent condition,” Dr. Maehara said. OB

References
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that play chess and can beat the world’s best chess players. There’s an expert system with a general knowledge base that has beaten the best Jeopardy players in the country. I think it’s a natural extrapolation—can we build better machine learning systems that can help doctors make a better diagnosis?” Dr. Chiang said.

**AI in medicine**

The system that defeated the best Jeopardy players is IBM’s Watson, a supercomputer that in the health field not only stores medical information, but finds meaning in it—in other words, learns.

Michael Abramoff, MD, PhD, Department of Ophthalmology and Visual Sciences, University of Iowa Hospitals and Clinics, Iowa City, Iowa, has been working on AI in medicine for the past 30 years.

The retinal specialist explained that there are different types of AI or machine learning systems, depending on the goal. It can be used in discovering new associations or for diagnosis.

“Let’s say you have a bunch of images or data and you want to see whether that predicts some disease and what can be helpful; you can use machine learning or AI to discover the associations,” Dr. Abramoff said. “Our partner, IBM’s Watson, uses AI a lot for scientific discovery,” he said. “They say, there’s all this scientific literature out there, so let’s build an algorithm that can analyze the literature and advise on the condition [according to] what is the most valid evidence from the scientific literature.”

Google (Mountain View, California) is also investing in AI for the...
health industry. In the U.K., Google’s DeepMind has been in collaboration with the National Health Service. Most recently it partnered with Moorfields Eye Hospital (London, U.K.) to see if its algorithms can pick up early signs of age-related macular degeneration (AMD) using 1 million anonymous optical coherence tomography (OCT) scans, according to a report by Business Insider.

Tech companies aren’t the only ones studying the use of machine learning systems in medicine. In January, a group of researchers at the Zhongshan Ophthalmic Centre, Sun Yat-sen University, Guangzhou published a study in Nature Biomedical Engineering that demonstrated an AI system for identifying congenital cataracts. The machine’s algorithm was able to diagnose the disease with more than 90% accuracy.

Dr. Abramoff’s own research focuses on using AI for automated diagnostics to be used on the front lines of care, and he founded a company (IDx LLC, Iowa City, Iowa), to commercialize this use of AI.

“We build devices that analyze images from the retina for hemorrhages and other abnormalities and decide that these patients are likely to have diabetic retinopathy from the images, without a human evaluating the images,” he said.

Dr. Abramoff’s artificial intelligence device is available for use in Europe and has completed clinical testing, and he is working with the FDA toward clearance in the U.S.

“We hope that someday, just like in Europe, these systems will be in primary care and find those people who have diabetic retinopathy and are at risk for going blind,” he said.

Most of the work in ophthalmology has centered on computer-based image analysis, according to Dr. Chiang.

“The rationale is it allows ophthalmic diagnosis based on what is essentially visual pattern recognition,” he explained.

Fit for ophthalmology
Dr. Chiang’s research in this area focuses on retinopathy of prematurity (ROP), one of the most common causes of childhood blindness in the world.

“The problem is we as experts are often not consistent about diagnosing a baby who has ‘plus disease’ [the key marker of severe ROP]. Studies have shown that there will be people who look at the same retina and come up with a different diagnosis because the way that we diagnose is qualitative. Machine learning systems can help make a better diagnosis and a more consistent diagnosis,” he said.

Several groups have done work in ROP, trying to build systems that help experts make a better diagnosis, Dr. Chiang said.

“We have developed computer systems to analyze images and make a diagnosis of plus disease and ROP, and we’ve shown that these computer systems perform comparably and often better than most experts for diagnosing this disease. That part is compelling. The computer systems are objective and reproducible.”

Much of the artificial intelligence work in medicine has been focused on diabetic retinopathy, Dr. Chiang said.

In diabetic retinopathy, like several diseases in retina, there are very specific classifications for level of disease and how you treat it, which makes it more straightforward to build computer systems, he explained.

In a similar vein, Dr. Abramoff said, “I would argue that ophthalmology is special because we have so many clinical studies especially about diabetic retinopathy that establish

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our current practice. I bet if you look for AI in medicine, you will find a lot of it in diabetic retinopathy. It’s because the classification systems and management guidelines are so well worked out.”

He continued: “There’s a lot of scientific evidence on why we do the things we do, what to do with these types of patients. We have drugs, lasers, treatments, and we know exactly when and where to use them. There’s a preferred practice pattern, recommendations on how to treat patients that are very specific. You don’t see that as much elsewhere.”

**Safe use**

Of course, patient safety is the most important factor in implementation.

Dr. Abramoff, who is currently leading the development of guidelines for using artificial intelligence for autonomous diagnosis in the retina, said, “If you have a diagnostic device, I think it’s important you know what that device does. It’s not enough to show this device is doing well when tested, you have to be able to say, ‘Here is where it’s analyzing hemorrhages and how many, here is where it detects the optic disc.’ You need to be able to explain how the system does these things.”

Otherwise we’ll lose the trust of patients, he said.

“It’s crucial that we keep paying attention to safety, that we explain what we’re doing, why we’re doing it, that we don’t try to push it too fast,” Dr. Abramoff said.

It’s important for doctors to understand the limitations of these computer systems, if we end up using them, Dr. Chiang said.

For example, the diagnostic systems for identifying and classifying diabetic retinopathy are often not good at recognizing when a patient has a disease other than diabetic retinopathy.

Dr. Chiang continued: “With diabetic retinopathy, one of the characteristics is hemorrhages and neovascularization in the retina. With central retinal vein occlusion, there are also hemorrhages in the retina, but they’re a different pattern. It’s very easy to recognize that when we [as experts] are looking at a retina, we’re looking at a central retinal vein occlusion, not diabetic retinopathy. But computer systems often get confused by that, so the scope of their capabilities is limited in this regard.”

In addition, he said that to make an accurate diagnosis, you have to have high quality images, and some of these systems are not as good at recognizing when they have sufficient quality of an image to make the right diagnosis.

“Machines are not perfect. Their strengths are different. Ultimately it’s doctors who take care of patients, not machines—but the machines can help,” Dr. Chiang said.

**Assisting, not replacing**

Dr. Abramoff said he thinks diagnostic AI systems need to go where the patients are, which is primary care.

“People with diabetes are managed there, diagnosed there, and when they’re abnormal and need specialist care, they end up with a specialist,” Dr. Abramoff said. “I think a lot of the routine diagnostics that we do now are going to shift to automation, to primary care, then we as clinicians will be able to do more complex treatments, more complex management. We gain time for taking care of our complex patients because we lose the routine tasks; they go to front line and there will be more complex management of gene therapy and stem cell therapy, for example. We’ll need the time because there are so many patients needing it, and we can’t handle them now.”

A lot of doctors get nervous when they see these computer systems because they’re worried, “Is it going to take my job away?”

Dr. Chiang said, “We hope that they’re not going to take your job away. We hope that they’re going to help you do a better job at what you do in diagnosing and managing patients.”

There are many aspects of diagnosis and management that are uniquely human, he said, like how a doctor connects with patients and gets information from them.

These systems are not as good at asking patients what’s wrong, what their symptoms are, what priorities they have, and they’re not as good at figuring out what to do after a diagnosis, Dr. Chiang said.

“What goes into a management plan is not just algorithms, it’s got to do with patients’ risk aversion, their priorities, what they value. I think management is a more subjective thing. Diagnosis is more objective,” Dr. Chiang explained.

His hope is that doctors will embrace these technologies because “whether we like it or not, these systems are coming. I think it’s natural to assume that someday, more of them are going to be able to make a more accurate and reproducible diagnosis than many doctors.”

**Reference**


**Editors’ note:** Dr. Abramoff has financial interests with IDx LLC, which commercializes diagnostic devices for diabetic retinopathy and other diseases, and Alimera Sciences (Alpharetta, Georgia). Dr. Chiang has financial interests with Novartis (Basel, Switzerland).

**Contact information**

Abramoff: michael-abramoff@uiowa.edu
Chiang: chiangm@ohsu.edu
You’ve carved out a niche for yourself in ophthalmology and now you’re interested in writing a book. It may not be something you have any experience with, and you may have trepidations about also handling your busy practice. One ophthalmologist, Constance Okeke, MD, assistant professor of ophthalmology, Eastern Virginia Medical School, and Virginia Eye Consultants, Norfolk, Virginia, said that this can be done in conjunction with handling practice demands and more. Dr. Okeke speaks from experience as the author of The Building Blocks of Trabectome Surgery, Volume 1: Patient Selection.

Dr. Okeke’s book grew out of an article she had written for a journal. “I decided I could take this article and make it into something more detailed that could be a primer for helping physicians learn how to select patients for the Trabectome [NeoMedix, Tustin, California] so that they could have better outcomes,” she said. “I had research on the topic of success with the Trabectome, so I thought I had a good basis to break down information that could be easily absorbed by other physicians who were new to the procedure.” What began as an idea for a 30- to 40-page booklet evolved into something more. Before Dr. Okeke knew it, she had a 300-page document.

This is something others can do as well if they have the right topic. “I think it’s important to have a passion about the topic if you’re going to write about it because writing a book is a labor of love,” she said, adding that there are going to be frustrations, and it’s going to take willpower to get from start to finish.

Starting out
The topic should be relevant, Dr. Okeke noted. “You want [to write] something that people will utilize that will be helpful and practical,” she said. The concept of how to select patients for microinvasive glaucoma surgery (MIGS) was something that physicians were asking her about a lot, so she knew that people wanted to know more about this.

She broadened the book’s appeal by encompassing the wider world of MIGS instead of focusing solely on the Trabectome. “As I was working on it and doing other MIGS procedures, I realized that with a lot of MIGS procedures there are concepts that are general for all MIGS,” she said, adding that she went into how to select patients and talk to them about a MIGS procedure, as well as how to perform shared techniques.

Dr. Okeke advised practitioners who have an idea for a book to begin with an outline. “You need to know what the general concepts are and what it is that you want to talk about,” she said. From there, you can elaborate, but you are not tied to following this in a particular order. “I didn’t necessarily write from the beginning to the end,” Dr. Okeke said. “I chose chapters that I thought would be more difficult to write so that I could get them out of the way.” For example, a chapter on gonioscopy was one that she knew was much more detailed and would require a lot of time, so she did this early on.

She also recommends having a timeline to serve as a progress guide-post. Dr. Okeke set one for about a 6-month window, although she admitted she had to be flexible. “But it is good to have a timeline because it motivates you to adhere to it,” she said.

For most practitioners, writing a book will be a balancing act with other responsibilities. “I ended up

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doing most of my writing in the evening hours after I put the kids to bed,” Dr. Okeke said. “I wanted to make sure that I had time for my family, so it wasn’t something I did every night, but there were certain nights of the week that my husband knew I was going to want to write.” There were also some times, such as when her husband traveled, that Dr. Okeke burned the midnight oil trying to get writing done. “Because I was passionate about it, this wasn’t a chore,” she said.

She encourages practitioners to share their manuscript with others in the field. “I utilized a number of beta readers,” she said. “Beta readers are people who read your finished product and give feedback, and that could change the course of the book.” She received feedback from practitioners who ranged from ophthalmology residents and optometry interns to glaucoma specialists. “I had feedback from multiple levels,” she said, adding that this enabled her to write a book that was appealing to a wide range of audiences.

**Getting published**

Dr. Okeke started looking for a publisher toward the beginning of the process, before she started writing intensively. “I had a passion, a concept, a good outline, and an understanding that it was a good topic before I went to the publisher,” she said. “When I looked for a publisher, I went to those that I was familiar with in terms of books that I owned.” She went to those publishers and told them about her book idea and asked if this was something they would be interested in publishing.

While self-publishing is also an option, Dr. Okeke pointed out that you don’t have as many resources to market your book if you go that route. A publisher can help get the word out about the book, do promotions, and go to different conferences to sell the book.

Dr. Okeke encouraged others to give real consideration to writing a book even if they think this may be difficult to fit in with their current responsibilities. She has a husband and three children who were 7 and younger at the time. “I had a busy life and I’m a full-time physician and the lead glaucoma specialist at our practice,” she said. “If your passion is there, it can be done.” Ultimately, there is nothing like holding the finished book in your hand, knowing that the concept you have had for years is now an actual entity, Dr. Okeke said. “It came from you, and it’s a wonderful feeling and well worth the effort.”

**Contact information**

Okeke: iglaucoma@gmail.com
Practical steps to ensure that partners and practices share common goals to further success

Practices can be challenged when their strategic plans differ from the professional goals of a partner.

To avoid this situation, John Pinto, president, J. Pinto & Associates Inc., San Diego, said the first step is to identify what’s in each partner’s “bucket.” That will differ between a solo practice and a group practice.

“For a solo practice, it’s what do we want to see him do, and that will drive the doctor’s personal financial plan, which will drive the strategic plan for the practice,” Mr. Pinto said. “If the doctor wants to retire early and sail around the world and he or she has sufficient funds to do so now, the strategy would be to sell the practice and retire early. Alternately, if the doctor has had financial reversals and has had to work into his 70s, the strategic plan for the business is going to be a work hard and don’t take chances plan.”

Young and entrepreneurial physicians with high economic aspirations should tune their strategic plan to that.

“We don’t put pen to paper to write the strategic plan until we are clear about what the doctor’s personal desires are for the rest of his life and the doctor’s personal financial situation,” Mr. Pinto said.

Generally, there is very little misalignment between what a solo practice physician wants to do personally and the practice’s strategic plan.

But a group practice involves different types of clinical practice and career stages, which requires going through the exercise of determining each partner’s vision and financial status to draw a composite plan that threads through their common denominators. The result is a strategic plan that gives each doctor options with which he or she is comfortable.

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For instance, “Dr. Smith is nearing retirement so maybe we don’t have him invest in the building because he is less risk tolerant,” Mr. Pinto said. “There are ways of blocking individual doctors from risk and giving risk opportunity for doctors who are risk tolerant.”

Practice responses
When Mr. Pinto talks to practices about that kind of approach, the compliance rate is high because only 5–10% of practices have a written strategic plan.

It’s also important to draw a distinction between strategy and tactics. Strategy is typically a 5- to 10-year plan that includes determining the service area, service mix, provider mix, growth rates, institutional structure, and succession plans. Tactics are nearer term.

For example, the strategic plan may aim to annually grow the practice at 10% rather than 5%, and tactics would aim to increase marketing to drive that level of business growth.

Few practices have created strategic plans for numerous reasons, Mr. Pinto said. The most common reason is what he calls “the ophthalmic personality.”

“This personality flows from having been guided by the people in his life: parents, teachers, and professors, pushing him along a medical career pathway,” Mr. Pinto said. “Many ophthalmologists tend to be more outer directed than inner directed as far as planning their life and career, so when they get back in the world post-graduation, they haven’t had a lot of practice at deciding their own long-term destiny. They’ve put one foot in front of the other. This resonates with the work schedule of their average day.”

Ophthalmologists are not trained in long-term thinking, as is emphasized in business or political science educations.

Partner splits
In cases of partners disagreeing on strategic plans, Mr. Pinto has found it helpful to offer practice boards five different strategic ways to look at the issue. Practice board members can then have a pre-vote on the options.

“We draw up for the board up to five different strategic destinies for the practice. Then we take a vote and see where each partner stands on these five destinies, and that will help us see where the center is,” Mr. Pinto said. “If we have agreement on some areas, we draw up the description of what that might look like, then we have another vote on these consensus options.”

A majority vote allows the board to finally take an agreed strategic direction.

In practices with just two partner physicians it can become more difficult when they can’t find common ground. In such cases, Mr. Pinto sets the strategic planning process aside and works to make progress on obvious tactical priorities, which are likely indicated under any strategic plan.

“We then circle back to the strategic plan and say, ‘We’ve had some success taking care of a few tactics; now let’s return to the strategic plan with our renewed confidence and make decisions about the longer-term future.’”

Conflict impacts
Differences between the career goals of practice partners and the practice’s strategic plan can cause frustration for administrators whose efforts are impacted by this incongruence, said Corinne Wohl, MHSA, COE, president, C. Wohl & Associates Inc., San Diego.

“They can be frustrated for years without having a clear strategic direction from the board,” said Ms. Wohl, a former practice administrator.

“Because practices often depend on their administrator for guidance, it is imperative that the goals are clear. When an administrator is pointed in many different directions by the board, it’s challenging for them to be as effective as they can.”

Among the ways Ms. Wohl has seen practices avoid such disjointed approaches is for the practice to add partner-track physicians to the group who have similar long-term career and practice goals.

“Ideally you are hiring doctors who have the same desires about practice growth and culture,” Ms. Wohl said. “But even if you hire two doctors who started out on the same path, people change over time and they could still end up being drawn to different goals.”

Changing career goals can be addressed through better communication. “Without open communication and compromise you can expect constant conflict,” Ms. Wohl said.

Whether a practice has two physicians or 20, all practice sizes are vulnerable to the impact from a lack of strategic coordination and planning.

Practice partners developing or updating strategic plans can benefit from data-driven research, such as identifying realistic growth opportunities in a specific geographic area.

“Skilled administrators can assist owners in the development of their strategic plan in this way. Another example includes meeting with regional hospital systems to understand the local healthcare marketplace,” Ms. Wohl said. OB

Contact information
Pinto: pintoinc@aol.com
Wohl: Czwohl@gmail.com
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