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From the publisher

More and more, physicians are planning their work and personal lives to achieve some balance. The key is identifying personal priorities. “Whatever those priorities are for you—whether it’s health, sleep, family, work—and trying to put those all into order, knowing that everything is not going to get accomplished all at once,” said Deborah Ristvedt, DO, a comprehensive ophthalmologist and mother of 3 children. To find out how she and others are striking this balance, read “Maintaining a good work-life balance in ophthalmology.”

Ophthalmology practices can make a lot of errors when it comes to compliance—and some can be downright dangerous. For instance, if you receive an after-hours call from a patient post-surgery, do you always make a record of the advice you gave in the patient’s chart? If you don’t and the patient ultimately develops a complication and decides to sue, it is very difficult to defend against such claims without documentation. “Avoiding compliance mistakes that can attract government attention” contains more information on this topic.

Has a family member or friend of 1 of your patients ever expressed interest in seeing what goes on in the OR? At some forward-thinking ophthalmic practices, family members and friends are able to get a closer look with surgical observation rooms. These rooms contain a wall with 1-way glass, a digital screen connected to the surgeon’s microscope, and a large model eye. The key component is a knowledgeable staff member who can narrate the process. According to physicians who currently have observation rooms in their practices, the rooms help to create an exceptional experience for patients and their family—which may lead to them recommending the practice to others. Learn more in “Letting patients look in at the OR.”

Finally, recognizing personality differences—and matching someone else’s personality type during social situations—can make for a smoother practice, among staff and with patient interactions. At an ASOA course at the recent ASCRS•ASOA Symposium & Congress, 2 speakers described the 4 personality types: Driving, Expressive, Amiable, and Analytical. To learn more about these personality types and how you can utilize this knowledge in your practice, read “Pinpointing personality type helps with workplace and patient interaction.”

All of this and more is packed into this issue of Ophthalmology Business. We hope you find the information useful for both your professional and personal life. Is there a topic that you would like to see covered in a future issue? Please contact us with your ideas. Thank you for reading!

Don Long
Publisher
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“Getting right and left confused is a very common human error,” Dr. Dutt said, explaining that while the app, which works for iPhone and iPads, can be used for any surgery or procedure, it is most useful for bilateral surgical sites, such as eyes.

A separate review of such incidents specifically in ophthalmology published in Archives of Ophthalmology in 2007 found that “relatively little information is available regarding the incidence and severity of the problem in ophthalmology.” Of the surgical confusion cases that were reported, more than half involved the wrong implant, rather than the wrong site, wrong patient, or wrong procedure.

The study reviewed 106 cases recorded by the Ophthalmic Mutual Insurance Company and the New York State Health Department between 1982 and 2005 and found 63% of these cases involved the wrong lens implants. Fifteen cases involved surgery in the wrong eye, followed by 14 wrong eye blocks, 8 wrong patient/procedure cases, and 2 wrong corneal transplants.

Dr. Dutt has been using the Site of Surgery Assistant in his own practice and said the app and bracelet can include specifics about intraocular lenses, if applicable. What’s more, the app provides another opportunity for patient involvement.

“[Patients] feel that they are participating in the surgical process instead of just signing papers,” he said. “They feel reassured that the correct site has been selected. They feel that the office is using the latest tools for their safety.”

There are, of course, already established protocols and procedures to prevent surgical errors.
surgical confusion

One wrong-site surgery event occurs in every 100,000 surgeries.  

The Site of Surgery Assistant app was created by an ophthalmologist to help prevent “never events.” The app is designed to reduce right-left confusion at the time of surgery and reinforce other details for surgical accuracy.

The American Academy of Ophthalmology, for example, produced a Wrong-Site-Wrong-IOL Checklist in 2014 with input from ASCRS and other organizations. These recommendations include confirming the patient’s identity with 2 identifiers such as their name and birth date, confirming the procedure to take place, and marking the operative eye on the cheek or forehead.

This last recommendation could prove troublesome if it is covered with draping or is somehow wiped off. It also might not include as detailed information as that provided on the wristband generated by the Site of Surgery Assistant app.

The app was approved for publishing in the Apple store in December 2015, but Dr. Dutt said if he finds there is demand for Android, Windows, or HTML versions of Site of Surgery Assistant, he will expand to those platforms as well. The app’s initial download is free but there are a couple of in-app purchases for those who might want additional features.

“It takes time to see value in new ideas,” he said. “With more experience, we feel that will be the case for this visual application. We are also looking at bringing this visual system to the rest of the informed consent process.”

From a patient privacy standpoint, Dr. Dutt said the app does not retain patient information.

Find more information about the app in the iTunes Apple store.

References

Editors’ note: Dr. Dutt has financial interests with the Site of Surgery Assistant app.

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Avoiding compliance mistakes that can attract government attention

by Lauren Lipuma, Contributing Writer

Ophthalmology practices can make a myriad of mistakes when it comes to compliance, but some errors are downright dangerous, according to 2 health care law experts. Presenting at an ASOA course at the 2016 ASCRS•ASOA Symposium & Congress, Alan Reider, JD, MPH, and Allison Shuren, JD, MSN, Arnold and Porter LLP, Washington, D.C., highlighted common compliance mistakes ophthalmologists make concerning their relationships with optometrists, the Office of Inspector General (OIG) exclusion list, documentation, and more.

According to Mr. Reider, some compliance mistakes are dangerous in that they are common and can easily attract the attention of whistleblowers or government agencies. Committing 1 compliance mistake could have a domino effect because it could open the door for the government to investigate an entire practice’s operations, rather than just 1 incident, he said. In their presentation, Mr. Reider and Ms. Shuren highlighted the legal and practical risks of certain compliance mistakes, offered strategies for avoiding and dealing with them, and discussed how the government is likely to respond.

**Providing education to optometrists**

Ophthalmologists and optometrists (ODs) can have different kinds of relationships—ODs can refer patients, lease equipment or office space to ophthalmologists, co-manage patients, or even be equity partners in a practice or ambulatory surgery center (ASC).

Ophthalmologists often provide education or professional courtesies to their referring ODs, and while this in itself is generally not a problem, ophthalmologists should be careful about how they do it, according to Mr. Reider. The Anti-Kickback Statute prohibits ophthalmologists from providing anything of value to induce a referral from an OD, and there is no minimum dollar amount that is protected from the law, he said.

Mr. Reider does not think the government would challenge physicians who provide education to ODs, but said he would be concerned when something more than education is involved, such as the provision of continuing education credits, an extravagant dinner, or if the education was provided in a resort during the weekend.

Education is considered something of value, so if you’re providing education to ODs, don’t limit these opportunities to only referring ODs, he said, and keep it simple.

“Make it clear that the purpose of this is not to provide a nice dinner in a nice place for your ODs,” Mr.
Reider said. “Make it clear that the purpose is the provision of education.”

In addition, never accept any sponsorship from industry for these events; there’s no way to justify it, Mr. Reider said. He suggests reaching out to local OD societies and having the society do the sponsoring to avoid any potential problems.

Other OD relationship issues
When leasing space, equipment, or staff from an OD, make sure you have a written lease describing all you are leasing, and make it for at least a period of a year, Mr. Reider said. Also make sure you pay a fixed amount that is fair market value.

Despite concerns over compliance, some ASCs have ODs as equity partners. To reduce compliance risk, the key is to follow as many of the requirements for ASC safe harbor as possible, according to Mr. Reider. You can further reduce the risk of noncompliance by showing that the OD and ASC physicians have a long-standing referral relationship prior to any investment in the ASC, he said.

Physicians will almost certainly increase their risk of noncompliance by offering ODs an opportunity to invest in an ASC in order to change their referral patterns, Mr. Reider continued. The risk will be even greater if ODs are told to change their referral patterns and that they will be offered an opportunity to invest after a certain period of time, he said.

Dealing with the OIG exclusion list
Ophthalmology practices must be vigilant about ensuring their employees are not on the OIG exclusion list for health care workers, according to Ms. Shuren. Every time a practice has a new hire, a new contractor, or a new vendor, checking the list should be first thing you do, she said.

In addition, continue to check the list at least once a year; this includes checking everyone in your practice or ASC and all major vendors. “Checking the list is not a 1-time obligation,” Ms. Shuren said. Some states even require practices to check the list monthly. In these cases, it is easiest and fastest to have the same person check each time, but there are also automated programs that can do it for you, she said.

If you do find an employee is on the list, ignoring it is not an option, Ms. Shuren said. Voluntarily reporting the employee from providing care to federally insured patients while you work with the OIG to sort out the problem and determine a settlement.

Remember that checking the list is the responsibility of the practice, not the employee. “Don’t think that you’re OK if you ask every employee to certify that they are not on the list,” Ms. Shuren said.

Documentation errors
Documentation errors can raise some interesting compliance and liability issues, according to Ms. Shuren. Looking at a recent survey of paid claims, the Ophthalmic Mutual Insurance Company (OMIC) found in many cases that documentation could have made the difference between something considered to be a maloccurrence versus malpractice, for which a physician has liability and can be found negligent, she said.

Failure to document elements of an exam and telephone care are 2 classic examples where physicians can make documentation errors.

Ms. Shuren described 1 case where a physician received an after-hours call from a patient post-LASIK who complained of red, irritated eyes, and was told to use drops for dryness. The patient called again, several days later, complaining of worsening symptoms, and was given the same advice, but it was reported that the medical record did not contain any mention of the calls. The patient ultimately developed an infection and a corneal ulcer and sued the physician for negligence without documentation, it is very difficult to defend against such claims. Complicated or uncompli cated, there has to be a record in the chart, Ms. Shuren said, to protect you from liability and any other issues.

“Telephone care is an extended part of your care,” she said. “If you are taking calls and speaking to patients and providing advice, there should be documentation in the chart that the interaction happened with the patient and what the patient was advised.”

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Women in ophthalmology still behind in pay, leadership roles

by Liz Hillman, Staff Writer

The idea of a pay gap between men and women has been a hot topic as of late, but where does ophthalmology fall on the issue? According to unofficial data, male ophthalmologists make, on average, about $95,000 more than their female counterparts.

Doximity, a social network for physicians, compiled information from its Career Navigator (self-reported salary data and other statistics from its more than 35,000 members) that suggests ophthalmology has 1 of the largest gender pay gaps compared to other medical specialties. According to Doximity’s findings, male ophthalmologists make an average of 36% more than women, while male physicians across the board made an average of 21% more than their female counterparts.

Why the disparity, and why does it appear to be so much greater in ophthalmology than other medical specialties?

The reasons are many, said Linda Christmann, MD, president of Women in Ophthalmology (WIO), a nonprofit organization comprised of ophthalmologists, ophthalmologists in training, and researchers in the vision field. WIO’s mission is to enhance and improve the professional environment for female ophthalmologists.

Perhaps the largest factor is that women, more than men, have chosen subspecialties that are traditionally lower reimbursed. Dr. Christmann named pediatric ophthalmology, medical retina, and glaucoma as a few examples.

“About 40% of pediatric ophthalmologists were women in 2013,” said Dr. Christmann, who has devoted a lot of time to analyzing data—much of it from surveys conducted by the American Academy of Ophthalmology—about gender disparities in the field. “Whereas in refractive surgery, which I think we can all agree is highly reimbursed, there was only about 8% [women] at that time.”

More recent data suggest this trend is increasing. Dr. Christmann said 2015 numbers reveal 43% of pediatric ophthalmologists are women.

As for why women might pick some subspecialties over others, Dr. Christmann speaks to her own experience.

“I would like to think that everyone has equal opportunity for all specialties and people choose what appeals to them. Years ago when I was a medical student and then a resident, I was already a mom,” the pediatric ophthalmologist of more than 30 years said. “Unlike a lot of my colleagues who felt very uncomfortable working with moms and small children, it was perfectly normal to me because I did it all the time.

“I would expect that’s happening to a fair number of women who feel like I did; they think, ‘I’m choosing this because I love children, and I know I will be able to find a job anywhere,’” Dr. Christmann said.

Why would subspecialties like pediatric ophthalmology, for example, have a lower reimbursement rate though?

“One reason is that children take more time, and secondly, a lot of

Some disparity comes down to individual decisions, but other barriers may exist
children that we take care of as pediatric specialists are on Medicaid. It's a problem with the field of pediatrics in general," Dr. Christmann said. She also said glaucoma recently took a hit in reimbursement due to Medicare cuts, so estimating future earnings is harder than ever.

Choice in subspecialty is not the only factor that could have women making less. The type of practice a woman goes into could make a difference. Dr. Christmann said ophthalmologists who are “self-employed” (working in private practice) tend to make more than those who are “employed” (working for multispecialty groups, in academic settings, or for an HMO). Women, she said, are more likely to find themselves in the latter, preferring it perhaps for reasons such as job security.

Still, there’s even more that plays into gender differences in ophthalmology. Other reasons why it may seem women in the field earn less as a whole could be age. Dr. Christmann said while more than 40% of trainees these days are women, ophthalmologists with seniority are far more likely to be men. Less experience in the field, still developing surgical practices, and more could equate to the appearance of smaller overall salaries.

“When you peel the onion to get to the heart of the question, there are some reasons why women get paid less that are based on decisions the women themselves have made,” Dr. Christmann said. “However, there is also unquestionably both conscious and unconscious bias, and that’s what we need to work against.”

To combat this bias, 1 of the factors Dr. Christmann and her fellow members at Women in Ophthalmology focus on is negotiation.

“Women tend not to negotiate, so we’re trying to include education on that in our annual meeting each year,” Dr. Christmann said, noting that negotiation tactics don’t just have to advocate for a higher salary. Things like work from home days for administrative duties and other benefits could “sweeten the pot.”

Ophthalmic Women Leaders (OWL)—an organization of ophthalmologists and ophthalmic business and industry leaders promoting diverse leadership with the goal of enhancing innovation and patient care—conducted a survey in 2015 that found most people—male and female—considered their salaries to be average. However, 25% of female respondents perceived their salary as being lower or slightly lower. The survey also found that women were actually more likely to negotiate than men, but there might be a reason.

“Looking a bit further in the survey results, 70% of male respondents were satisfied with the offer so they didn’t feel the need to negotiate, whereas only 41% of the female respondents were satisfied with the offer they received. This led to more likelihood for them to want to negotiate,” said Heather Ready, OWL president.

Despite more women negotiating, Ms. Ready said 50% of female respondents were not confident in having such negotiations.

“It is important for all employees to feel that they are fairly compensated, so getting comfortable with the negotiation conversation is important,” said Angela Bedell, OWL executive director.

Outside of salary, the survey found there were twice as many men in executive positions compared to females. The majority of female MDs surveyed (85%) said they found it difficult to participate in clinical trials, consult with industry, speak at professional meetings, and/or serve in leadership positions, citing discrimination, time constraints, and contractual issues as reasons why.

Dr. Christmann said that women might see “plum jobs,” like doing clinical research for a company, being offered to men, but on the flip side, she said women also need to have the confidence to ask if they want such opportunities.

“It’s not necessarily the company’s fault. If women are not approaching them, they’re not going to choose women,” Dr. Christmann said, noting that women might not be privy to some of the networking that leads to such opportunities.

Over the last few decades, Dr. Christmann said there has been progress toward giving female ophthalmologists more representation in organizations, bringing them into leadership roles, and increasing their participation in public speaking events, but there’s still more to do.

A study published in JAMA Ophthalmology in 2015, for example, found that the percentage of ophthalmic publications where women were listed as the first author increased from 2000 to 2010.2 Editors though, which Dr. Christmann said are an honor because they are authored by those on an editorial board, a prestigious position, were dominated by men. Of the 38 editorials from 2000 included in the observational retrospective study, 33 were written by men, and 46 of 51 in 2010 were written by men.

While Dr. Christmann said she thinks most are aware of the disparity between male and female ophthalmologists, driving positive change is like “turning the Titanic.”

“I know a lot of physicians have picked up on it. The question is how many will take action?” Dr. Christmann said. OB

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Letting patients look in at the OR

by Vanessa Caceres, Contributing Writer

At the practice John-Kenyon, Louisville, Kentucky, the LASIK observation room has been around since August 2000. “We wanted to offer a viewing room to create an exceptional experience for both the patient and their family and friends who accompany them on the day of their procedure,” said Asim Piracha, MD.

Both John-Kenyon and Center for Sight knew they wanted the observation rooms in advance, so the viewing areas were part of the building design.

The rooms may require extra expense and planning, but they have benefits. The rooms help better educate loved ones—perhaps future patients—about eye surgery, and they can be a marketing tool for the practice.

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Observation area bolsters education and practice transparency

Family members or friends of those having cataract or refractive surgery often wonder what goes on behind the OR’s closed doors. At some forward-thinking ophthalmic practices, they’re able to get a closer view with surgical observation rooms.

Although setups may vary, the basic idea is a small room behind 1-way glass where family members or a loved one can watch what happens during surgery. A key component is a knowledgeable staff member who can narrate the process.

David Shoemaker, MD, founder and director of Cataract & Lens Replacement Surgery, Center for Sight, Sarasota, Florida, decided to add surgical observation rooms more than 25 years ago. He built them into Center for Sight’s first surgery center location and liked them so much that when he expanded the practice, he included observation rooms for femtosecond laser cataract surgery and LASIK in the current ambulatory surgery center. “Gone are the days when you would wave goodbye to a loved one as they were rolled into the surgery center,” Dr. Shoemaker said. He thinks the rooms play a role in the practice’s commitment to transparency and engagement.
practice. “By providing this experience, we hope the person will leave our practice ready to recommend us and refer other patients to us,” Dr. Piracha said.

If you think a surgical observation room would fit in well at your practice, here are a few things to consider.

Explaining it to patients and family
The rooms are usually presented in a straightforward manner, Dr. Shoemaker said. “We tell them we have observation rooms with a glass wall, microscope monitor, and narrator. I personally encourage each and every patient to take advantage of the opportunity and to bring their mobile device and record it,” he said. Patients at both practices will sign a consent form to confirm the observation by others is OK.

At John-Kenyon, 75% of LASIK patients have had someone viewing this year; at Center for Sight, 50% of cataract surgery patients accompanied by family or friends take advantage of the observation rooms.

What happens in the room
It’s important to set up the room for a comfortable but educational experience for those present. Center for Sight’s room has a glass window between the observation area and OR. There’s also a digital screen in the room connected to the surgeon’s microscope to provide a view from the surgeon’s perspective. There’s a large model eye in the room that a narrator will use as necessary to explain where the cataract is located and how the lens is inserted.

There’s a similar setup at John-Kenyon, with Dr. Piracha noting that the viewing room is well insulated, so those in the observation room do not hear anything from the laser room. Additionally, staff in the laser room do not see or hear anything from the observation room (which has 1-way glass), so the surgeon and staff are not distracted.

A key component of the observation room experience is having a narrator to answer questions or to explain what is happening, both Drs. Shoemaker and Piracha said. “Providing a ‘hand holder’ for the family or friend is just as important as providing it for the patient,” Dr. Piracha said.

At John-Kenyon, the observer is able to sit with the patient prior to the start of the procedure. Once in the surgical observation room, the manager of refractive surgery will explain each step of the procedure. That same person points out the accuracy and safety of each laser and talks about different parts of the process, such as why the surgeon creates a corneal flap for LASIK. This is also the time they will go over the postop recovery process and answer any questions the observer may have. The observer then joins the patient again in the post-procedure room to go over postop instructions.

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Marketing surgical observation areas
The surgical observation room at John-Kenyon is promoted on the day of surgery as an added benefit. In addition to internal marketing, Center for Sight sent out a press release earlier this year to tout their surgical observation area and the ability to record surgery. The release led to some local coverage.

What observers ask or say
Naturally, observers want to know how surgery feels. “Most inquiries relate to how the patient is feeling during each step of the process and questions regarding the instruments being used,” Dr. Shoemaker said. This is where the visual aids in the room, such as the large eye model and the sample intraocular lens, come in handy.

“We find that viewers are in awe of the precise and controlled movements the surgeon makes throughout the procedure,” Dr. Shoemaker said. Often, observers return if there is a second eye scheduled for surgery at a later date. However, at that point, they usually don’t need the full narration as they did the first time around.

“While some folks may be hesitant to watch, they are always amazed at the speed of the lasers and the quickness of the process,” Dr. Piracha said.

Asim Piracha, MD

“We wanted to offer a viewing room to create an exceptional experience for both the patient and their family and friends who accompany them on the day of their procedure.”
Maintaining a good work-life

by Liz Hillman, Staff Writer
Striking a good balance was and still is a learning experience for Dr. Ristvedt, who joined the private practice started by her grandfather and operated by her father shortly after residency and having her first child. The continual process of finding this sweet spot, Dr. Ristvedt said, starts with self-examination and identifying personal priorities.

“Whatever those priorities are for you—whether it’s health, sleep, family, work—and trying to put those all into order, knowing that everything is not going to get accomplished all at once,” she said.

Dr. Ristvedt said working 4 days a week, having Friday at home with her kids, gives her more family time. She and her husband make other choices to aid in work-life balance as well, such as hiring professionals for some household cleaning and yard work.

“I realized that cleaning took up a lot of my time. I would rather be at the park with the kids than scrubbing my bathroom floors,” she said. “This is just right now to get us through this busy stage of life ... for us that’s opened up a lot of free time.”

The challenges and choices Dr. Ristvedt faces are not uncommon. Physicians at all stages of life and career can make the decision to maintain a good work and home life.

“It’s a conscious effort. It’s not something that’s going to come to us naturally,” said Linda Christmann, MD, Bradenton, Florida. “Women and men have done a much better job [lately] thinking consciously about how they want to live their lives.”

Inherent balance within the specialty

Some might see ophthalmology as offering more opportunity for work-life balance compared to other medical specialties. Ophthalmologists still encounter being on call and need to attend to emergencies when they arise, but as Dr. Ristvedt put it, “I can do surgery but still be home by 5:30 at night.” This is partly the nature of ophthalmology but also due to the boundaries she and the practice she works for have set.

But did Dr. Ristvedt choose ophthalmology because of its potential to afford more of a home life? Not really.

“Going through medical school, I was most into what do I want to do? OB, that was my backup, and I had talked to an OB/GYN, saying, ‘I know ophthalmology is very difficult to get into. How do you manage call and life [as an OB]?’ He gave me the best advice. He said you find a

continued on page 18
practice that fits how you want to practice. He said, ‘I'm in a practice of 9 physicians so we each take call every ninth night. Sometimes that's hard because you're not delivering all of your patients, but at the same time you're not going in every other night to deliver your patients.’ I thought that was good advice.”

Clara Chan, MD, Toronto, said she knew in residency she wanted to be a surgeon and understood that ophthalmology could afford a better work-life balance than general surgery, for example.

Dr. Christmann said she also took work-life balance into consideration when choosing pediatric ophthalmology as a subspecialty 30 years ago, but it was only a factor.

“I was looking for a surgical specialty where I could have the option to do surgery, but also have a vigorous office practice,” she said.

Karen Spencer, chief executive officer, Virginia Eye Consultants, Norfolk, Virginia, said there are a number of things that can be done to strike a good balance at the practice level, like setting realistic schedules.

“We know our physicians well; we know their patterns well. We make sure that the schedule templating accommodates for a regular arrival and a reasonable departure,” she said.

Ms. Spencer said Virginia Eye Consultants tries to limit after-work meetings to the same day each week. Under this scenario, physicians/leadership and their families know ahead of time not to schedule personal appointments or events on this particular evening each week. “While we don't meet every week, knowing that we could helps to avoid a lot of conflict. We also commit to making efficient use of this meeting time so that it is always time well spent. The win here is that our meetings do not take away from practice productivity, and they are extremely time efficient and productive.”

Other policies that could encourage physicians to take time off and maintain a good work-life balance include not allowing time off to roll over from year to year. “If they don’t take it, they lose it. This provides motivation in and of itself to take that time off. This is so important in the quest to strike a work-life balance,” Ms. Spencer said.

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Tips for striking a good work-life balance

- Look for a practice that shares your work-life balance philosophy
- Prioritize what is important to you
- Be efficient with your time at work and at home
- Schedule after-hours meetings on the same day each week for consistency
- Make daily and surgical schedules realistic time-wise
- Be aware of practice policies and contractual obligations that could affect home life

Taking the reins

There are many steps ophthalmologists can take to lay the foundation and establish a good work-life balance. Being upfront with practice leadership is 1 of the key components to reach this goal and maintain relationships.

“I interviewed a doctor who early in the interview said, ‘I want to let you know that my family is really important to me.’ I appreciate that as an employer. It was a male candidate,” Dr. Christmann said.

When you know big life events are coming down the pike—such as a baby or a family member having surgery in which you’ll need to help out—tell leadership early so they can plan accordingly, Dr. Christmann said.

As a former practice owner herself, Dr. Christmann said practices large and small need to have established leave policies, which should be applied equally among employees. On the flip side, being aware of policies and contractual obligations before you sign onto a team is an important responsibility as well.

Dr. Chan said a physician needs to consider overhead costs of a practice, for example.

“If ophthalmologists are in a practice where no matter whether they work or not, they have to pay a fixed proportion of the overhead costs, that would deter them from taking significant time off,” she said.

Asking for policies during the interview process might feel uncomfortable, but Dr. Christmann said it’s worth it.

“It’s good to know up front what will happen because the last thing you need when you’re in the throes of those other things,” be it an unexpected illness, a maternity or paternity leave, or another situation, “is to try and figure it out and feel like your job is in jeopardy on top of everything else,” Dr. Christmann said.
“If ophthalmologists are in a practice where no matter whether they work or not, they have to pay a fixed proportion of the overhead costs, that would deter them from taking significant time off.”

Clara Chan, MD

Choosing to be involved in academia, research, industry, and/or traveling to meetings or speaking engagements, which can aid in professional development, can cut into home life as well.

Dr. Christmann recommended people think about what they want to achieve outside of work and find a way to make it beneficial to the practice. For example, if you want to exercise in the morning, Dr. Christmann said taking on later evening hours or Saturday morning hours could be mutually beneficial.

“Structure in your own mind how it can be a win-win,” she said.

Many think there is currently more of an emphasis on work-life balance in the field than in years past.

“I think several years ago, it was quite common to see docs putting in what I would consider today to be unnecessarily burdensome work hours—sometimes 60- to 70-hour weeks—and you just don’t see that anymore,” said Ms. Spencer, who has worked for more than 20 years as a medical practice CEO. “I think there has been a lot of positive emphasis in recent years on work-life balance. Striking this critical balance enhances physician career satisfaction, which increases longevity in the profession. The benefits, however, go beyond that. The patient experience is greatly improved when the physician is well-rested, less stressed, and less rushed. The leadership and staff are also happier, healthier, and more loyal to the practice long term when they are afforded the opportunity to strike this same balance.”

“I think more and more, physicians plan their work and personal lives to achieve some balance,” Dr. Chan said. “Having access to technology we have now also helps. For example, we can answer emails while playing golf. It’s important to prioritize having a good work-life balance, otherwise one can easily be consumed by work. Scheduling a personal day to go to the spa or meet your spouse for lunch can help to energize you and reset your mental status for the next work day.”

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When the market plays

by Roger Balser
One of the most frequent questions I’m asked in the course of my business is, “Why does the market behave the way it does?”

There is an old saying on Wall Street that the market climbs up the stairs but comes down on the elevator.

That’s really a true picture. I have found in more than 28 years as an investment advisor that the market, in its same old boorish way, slowly and steadily grinds up until ... BAM! Five percent down in a couple of days or 10 percent down in a week. It happens. Maybe you’ve experienced this phenomenon yourself if you follow the markets on a regular basis.

The market tends to move up like it is climbing a staircase. Up a little, down a tick, up a little more, down a tick. But when it wants to really come down, it takes the express elevator to the ground floor.

Let’s take a quick look at the elevator side of this story.

There are times when the market has a quick pullback, say 5% to 10%. These times in retrospect have turned out to be great buying opportunities (remember the 1990s?).

Other times we’ve had swift pullbacks in the market, which signifies a growth-to-recession mode. In the past few years, we haven’t had any growth in the economy, so can we really have a recession? It doesn’t make any sense.

Some of these times we simply see a period where the market seems to be very choppy and trendless. I refer to these periods as a “time-out.” The “time-out” period is where we stand now. It’s been more than a decade since we experienced a time-out. Right now, a lot of factors are casting a shadow over the market with no clear consensus.

Here’s an example: For the number of folks who are concerned about disinflation, an equal amount will point out that inflation has almost doubled in the past 12 months, from 0.7% to 1.3%. Could this be why the market is in time-out?

Truthfully, I don’t know.

For the number of folks who are concerned that the Federal Reserve is way behind the curve and needs to immediately raise interest rates, there’s an equal number suggesting that the Federal Reserve follow Japan to negative rates.

Could this be why the market is in time-out?

Truthfully, I don’t know.

Politically, the nation is about to slip into a Trump or Clinton administration. Could this be why the market is in time-out?

Truthfully ...

As an investment advisor (and an investor myself) it’s important not to get caught up in the news (or the noise) of the day. Each and every day you can open the newspaper or turn on the television and take in very different views on why the market is behaving as it is.

Mr. Balser is the managing partner and chief investment officer of Balser Wealth Management in Avon, Ohio. He works with individuals to reduce risk in their investment and retirement portfolios to ensure they will not run out of income in retirement. He can be contacted at roger@balserwealth.com.
Buying and hiring trends in ophthalmology today

by Liz Hillman, Staff Writer

Higher starting salaries and trouble selling solo practices characterize the market

The hiring market in ophthalmology within the last 2 to 5 years has changed. Base salaries for physicians just out of residency are higher. Competitive metropolitan markets have more openings. Residents are starting their job search earlier and earlier. And those on the flip side looking to retire or sell their solo practice are having a harder time finding interested buyers as group practices gain more popularity.

There are many factors playing into this change in the ophthalmology hiring atmosphere, according to Lauren Simon, an ophthalmology recruiter with The Eye Group, Boca Raton, Florida.

And it’s a world that Josh Zaffos, MD, who is completing his fellowship in cornea, external disease, and refractive surgery at the Gavin Herbert Eye Institute, University of California, Irvine, said was a “black box” to him when he neared the end of his residency at the Krieger Eye Institute, Sinai Hospital, Baltimore.

“I knew very little about the job search process: how it worked, the process, interviewing, contracts—these were all topics that I heard little about during my training,” he said, explaining that while some information about the process is posted online, most of what he knew he learned from his peers. This led him to work with job search companies like The Eye Group. “In hindsight, this was the best decision I made because I learned that not all employers post their positions online.”

Shortage drives higher salaries

Ms. Simon said the “biggest change” driving the market at the moment is a “serious lack” of ophthalmologists. She said residency programs, which have decreased acceptance rates by a slot of 2, have not adequately prepared for the large generation of baby boomers who need eyecare; they are also leaving ophthalmology practices without a successor.

Although slight, this has made a difference in a market that needed an increase in ophthalmologists, not a decrease. Plus, more and more trainees are women, and balancing families and career can sometimes result in them reducing their workload to part time, which has an impact on a field that already has a shortage, Ms. Simon said. Overall, it is a generation of men and women who have a work-life balance priority.

“The salaries have increased significantly because even in the popular markets … there are a lot of openings,” she said. “The secondary markets and more rural areas are having an even harder time because it’s harder to move doctors outside of major metropolitan areas as they have so many choices.”

As Ms. Simon put it, how is a practice in Springfield, Massachusetts, for example, going to attract a physician who has 5 other opportunities in Boston?

“They’re going to pay $350,000 and attract the candidate based on salary,” she said.

But even practices in the major cities are dishing out unprecedented salaries. It’s a trend Ms. Simon has noticed happening for the last couple of years, but most significantly this year. It’s also a trend that she cautions job seekers to be wary of.

To explain why, Ms. Simon offered this example: Let’s say a practice offered a base salary of $200,000 and agreed to give the physician 30% over 3 times their base. This means that anything they collect over $600,000, they could keep 30% of that while the rest would go to practice overhead, partner compensation, etc. With even higher salaries though, physicians would need to collect up to $1 million to get a bonus.

“More importantly,” Ms. Simon said, “they would have to collect at least double that to cover their own salary. Between overhead and benefits and their own salary, in order for a practice to break even, they have to collect that much money to cover themselves.”

Thus, she offers caution to those attracted to high salaries in primary markets. Those in secondary markets might have an easier time though.

“The good news about that is once you go outside of a larger community, you’re able to produce more. You’re not in such a competitive atmosphere. There is something to be said for that,” she said, noting the additional quality of life benefits in secondary markets, such as not needing to focus on marketing to build a patient base as in metropolitan markets. “The patients are more readily available [in secondary markets.]”

Ms. Simon also tells hirees to consider earning potential over the long term, such as considering bonus...
programs or what the partners are making.

“Someone who is guaranteed $200,000 a year could potentially make $800,000 a year. Someone who is guaranteed $350,000 might only be able to make $350,000,” she said.

**Navigating today’s hiring market**

Dr. Zaffos said he knew he wanted to find a practice that would allow him to perform cornea transplants, complex cataract surgery, anterior segment reconstructions, and refractive surgery. Not only did this limit the pool of choices, but he was afraid to an extent.

“I was afraid of joining a small, private practice where I would potentially be unhappy because the other partners may not hold themselves to the same high standards of patient care I hold. I heard horror stories of people uprooting their families and moving to a new state to join what sounded like a promising career, only to leave begrudgingly after a year due to promises not being kept by the employer. I was looking for a group of like-minded, professional providers that took care of their staff and patients with the utmost integrity and professionalism,” he said.

As such, he’s glad he worked with The Eye Group, which identified his wants and needs to help him find the right fit. Ms. Simon said residents should start looking for jobs up to a year-and-a-half before they finish training. This is a shift from about 4 years ago, she said, when residents would look for just a few months in their last year.

“The credentialing and licensing process has gotten so that it takes 6 months to 9 months. In order for [physicians] to get fully credentialed, which helps the first year in terms of gross collections, they would have to start their licensing and credentialing at least 9 months before,” she said.

While the onboarding process might take awhile, Dr. Zaffos said he was at least surprised by how quickly the hiring process progressed after an initial conversation.

“Often times they would offer to fly me out to visit on site with the practice and their partners,” he said. “Up until the job search process, interviews were always structured: universal applications, set deadlines, and match. The job search process had no deadlines or rules. You pick the locations, you pick the practice type, and you decide whether or not you want to pursue the opportunity further. It was a nice change of pace from medical school residency and fellowship applications and interviews.”

Ms. Simon also reminded those scouting new jobs to look beyond the base salary at the broader earning potential and consider expanding their market search.

“If you look within an hour [of a primary market], you could still have that lifestyle but just a better career, especially the first year out. Some of these physicians don’t get enough volume out of residency, and that takes a toll on their surgical skills,” she said.

Dr. Zaffos recommended talking with as many people as possible about a practice you might be considering.

“Drug reps are a great resource, as are other ophthalmologists—it’s a small world and everyone seems to know everyone,” he said. “The more informed you are, the more informed of a decision you can make.”

**Troubled succession plans**

On the flip side of the coin, there are physicians who hope to sell their practices, and these people might be having a hard time in today’s market as well, according to Ms. Simon.

“A lot of practices are closing and giving their patient base to a local doctor or selling for no good will and just hard assets,” she said.

She described 3 types of buyers: the solo ophthalmologist, the group who buys it as a satellite office, and the independent practice organization. The solo ophthalmologist is increasingly hard to come by.

“There are very few doctors who are, No. 1, willing to go in and take the risk of owning their own practice and, No. 2, they definitely don’t want to be the owners like the previous owners, the weekend workers,” Ms. Simon said.

Being in the ophthalmic recruiting field for 3 decades, Ms. Simon said that she’s seen disinterest in the solo practice go back and forth.

“Over the past 30 years we’ve seen the pendulum swing a few times in terms of companies coming in and buying up practices and then they end up selling back to doctors. This isn’t the first time, and I’m sure it won’t be the last.”

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It’s no surprise that we’re all driven by our different personality types—a fellow surgeon in your office may always focus on the bottom line, while 1 of the technicians may always try to find a way to personally connect with patients. Your administrator may be an ace at focusing on the numbers.

Recognizing personality differences—and matching someone else’s personality type during social situations—can make for a smoother practice, among staff and with patient interactions, said Michael Besserman, key account manager, Alcon, Fort Worth, Texas. Mr. Besserman and Michael Hecker, also a key account manager with Alcon, presented 4 different personality types during an ASOA course at the ASCRS•ASOA Symposium & Congress, “Talking Does Not Equal Communicating: Communication That Drives Results.”

Mr. Besserman and Mr. Hecker described to attendees the 4 different personality types as classified by the Social Styles Model, designed by David W. Merrill and Roger H. Reid in the 1980s. The personality types described by Mr. Merrill and Mr. Reid have been used in workplace trainings around the globe to help lead to better communication and productivity. Here is how Mr. Besserman and Mr. Hecker described the 4 personality types.

**Expressive**

**Driving**

**Amiable**

**Analytical**
Driving: “I will”
People with a Driving personality are usually business-oriented, competitive, confident, natural-born leaders, task-oriented, and decisive. They tend to focus on the bottom line, and they like their communication with others to be brief and efficient. “They want the succinct bullet points,” Mr. Hecker said.

People within the Driving classification tend to have a louder voice, intense eye contact, and want to control a conversation. Although they can be described as pushy or dominating, they are also practical and independent. Two professions associated with a Driving personality include ER physicians and attorneys.

Expressive: “I want”
The Expressives in a practice tend to be the most sociable. Verbal, outspoken, emotional, and enthusiastic are a few words used to describe those who are Expressive. They can be loud, animated, and easily distracted as well as open, warm, and talkative. The model from Merrill and Reid says that Expressives can be excitable and undisciplined at times, but they are also known for their friendliness and enthusiasm. Counselors, actors, and salespeople all tend to have Expressive traits.

Amiable: “I feel”
In contrast with the Driving and Expressive personalities, those classified as Amiable are quieter and more slow and steady. They can be friendly, just like an Expressive personality, but they also will focus more on listening to what someone has to say. The Amiables are the patient peace-makers in an office; on the negative side, some can be described as conforming or unsure of themselves.

Analytical: “I think”
As the name implies, those in the Analytical category are the quieter thinkers in an office. Their facial expressions and eye contact are more limited than those in the Expressive

5 tips for interaction with each personality type

Driving
Tell what first
Focus on the present
Be brief and efficient
Get to the bottom line
Allow them to make decisions based on options provided

Expressive
Tell who first
Focus on the future
Relax time constraints
Show personal interest and involvement
Compliment them and recognize accomplishments

Amiable
Tell why first
Focus on tradition
Be easy and informal
Detail how to accomplish objectives, 1 item at a time
Support accomplishments with personal attention

Analytical
Tell how first
Focus on past, present, and future
Stress facts and data
Focus on detail and accuracy
Be quietly patient while they evaluate the data

Source: Alcon; Merrill and Reid

continued on page 26
and Amiable category. The Analytical type is usually logical, detail-focused, organized, and a good planner. Although they can be industrious, they are also sometimes perceived as indecisive or stuffy.

Although someone may see him- or herself in 1 of these categories more than others, people often fall into more than 1 category, Mr. Besserman said. For example, it’s common to find someone with both Driving and Expressive traits; conversely, it’s also common to find someone with Analytical and Amiable traits.

“There are no best or worst styles, and there is no one who is 1 pure style,” Mr. Hecker said.

In the general population, the most common types are Amiable and Expressive, Mr. Hecker said. Driving and Analytical types are a smaller percentage.

**Understanding patients’ personality types**

While your practice can’t offer a personality test to patients, if your staff are familiar with the different personality types, that can help guide their interactions, Mr. Hecker said. By adapting to patients’ personality styles, “they’re more likely to listen and to adhere,” he said.

Mr. Hecker gave the example of diagnosing someone with a chronic condition, such as glaucoma. If you have someone with a Driving personality, tell him or her the diagnosis first, and then you can focus on why the patient may have the condition and any other details. With an Expressive, make sure to let him or her know that many other people have the same condition. For someone who is Amiable, you can address right away why he or she may have the condition. When you have a patient who appears to be an Amiable type, the patient may need a bit more time and hand-holding than others, Mr. Hecker said. The Analytical types usually will want to know how the condition affects them first.

**Finding out more**

If you are interested in using the Social Styles Model in your office, there are several approaches. The classic Merrill and Reid book is *Personal Styles and Effective Performance*, published in 1981. You can find online resources and links to training if you look up “Social Styles Model” online. Alcon also offers workplace trainings on the topic to select practices, Mr. Besserman said.

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Key Features

No Cost DICOM Image Management System, diagnostic machine, & practice management integrations.

Average Implementation Time: 90 days

Server Sync™ increases remote office productivity & eliminates outages caused by unreliable internet connections.

Mobile App securely access your patient records on your mobile device.

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- Digital accuracy without error
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