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From the Publisher

Welcome to the second ezine issue of Ophthalmology Business (OB). It is our hope that the OB ezine will bridge the gap between our quarterly publications and provide you with a quick read to keep you abreast of topics relevant to growing your practice.

Considering marketing tools for your practice? Our feature story offers you an overview of some of the latest apps available that can make marketing your ophthalmology practice more efficient, effective, and maybe be fun for staff and prospective patients alike.

This issue of OB also returns to the matter of ethics and the law we touched on in the last issue. We review some of the more common ethical dilemmas in clinical practice and compare the value of traditional approaches to avoiding legal liabilities with patient practice guidelines.

Whether you are directly involved in recruitment or not, your small practice will inevitably find itself in need of new physicians. How can you attract (and keep) the good candidates? Check out the ideas we offer in our story on the challenges of recruitment.

Finally, while the clinic and surgery center may be home for many ophthalmologists, there are those who eventually choose different paths. From working as a chief medical officer for a large medical company to serving as a physician informaticist, there are alternative career paths out there for the trained and experienced ophthalmologist, if you’re willing to strike out in a new direction.

Thanks for reading.

Sincerely,

Donald R. Long
Publisher, Ophthalmology Business
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The ethical ophthalmologist:
Common ethical dilemmas
in clinical practice

by Tony Realini, M.D.

As long as the physician is providing high-quality patient care, the number of patients being seen should not be an issue

We all strive to make the best decisions we can for the benefit of our patients. Yet nearly every day we are challenged by an ever-increasing patient volume, an evolving array of new surgical procedures to evaluate and master, and emerging paradigm shifts in therapy to incorporate into our practice patterns. These issues present ethical dilemmas that we must navigate with great care. At the annual meeting of the American Glaucoma Society in Dana Point, Calif., in March, a series of common ethical issues frequently encountered in clinical practice was posed and discussed. (It should be noted that the positions espoused by panelists were assigned by the event’s program committee to ensure comprehensive coverage of the topic and did not necessarily reflect their own personal opinions.)

Increasing clinical load

In an environment of decreasing reimbursements and increasing practice expenses, the pressure to increase clinical volume continues to mount. Is there a point at which a busy clinician becomes too busy? At what point does increasing the number of patients seen threaten to compromise a physician’s ethical obligations to his or her patients?

“As long as the physician is pro-
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viding high-quality patient care, the number of patients being seen should not be an issue,” said Christopher Girkin, M.D., professor of ophthalmology, ophthalmology department, University of Alabama, Birmingham. He added that physicians are individually responsible for ensuring that their clinical volumes do not interfere with the delivery of quality care.

Thomas S. Harbin Jr., M.D., M.B.A., Eye Consultants of Atlanta, said that clinical volume can reach a point that precludes good care. He agreed that the burden for policing this volume falls squarely on the shoulders of each individual physician.

“I have several criteria for assessing the balance between volume and quality of care,” he said. “First and foremost, are my decisions always made with the patients’ best interests in mind? Also, do my patients have a full understanding of their condition and their treatment plan?”

His other criteria focus on administrative issues. “Does my charting reflect the standard of care that I provided, and is my billing justified by my charting?”

If these criteria are met, he said, a physician has not exceeded his or her ability to handle the current clinical load. “As the practice size increases, however, this must be re-evaluated on an ongoing basis.”

Personal surgical success rates

There are several compelling reasons for physicians to track and share their surgical success rates with their patients, according to Yara Catoira-Boyle, M.D., assistant professor of clinical ophthalmology, ophthalmology department, Indiana University, Bloomington.

“Keeping statistics on our personal surgical numbers would make us better surgeons,” she said. She pointed out that quoting success rates from surgical studies published in the literature is inadequate.

“The American Academy of Ophthalmology mandates that ophthalmologists must not misinterpret their credentials, training, experience, ability, or results,” she said. “If you can’t tell a patient the likely result of a surgical procedure performed by you, you have not obtained adequate informed consent.”

She added a cautionary note: “In this era of quality, cost-effective medical practice, if we don’t develop a means of tracking our surgical results, payers will do it for us.”

Shan Lin, M.D., professor of clinical ophthalmology, ophthalmology department, University of California, San Francisco, offered a different perspective.

“There is no evidence in the medical literature that knowing our personal surgical success rates in ophthalmic surgery improves future outcomes,” he said. The issue of tracking outcomes was a major factor driving the current movement toward electronic medical records (EMR). In healthcare systems that adopted EMR, he said, there has been no documented improvement in clinical safety or better outcomes.

“Being compelled to tell our patients about our experience with a given procedure, both in terms of volume and outcomes, could be problematic for young surgeons,” he said. “In addition, academic practitioners or those with largely referral practices generally deal with more difficult cases, and their outcomes may reflect this, to their detriment.”

“Additionally, what endpoint should we track?” he asked. “Should our retina colleagues report the percent of retinas that were successfully reattached, or is visual outcome the better endpoint? For glaucoma surgery, is success an intraocular pressure below 21 mm Hg, 18 mm Hg, or 15 mm Hg? Is this with or without medications? Without standards, individual results have little meaning.”

New surgical procedures

The surgical practice of ophthalmology is in constant evolution. How does the ethical ophthalmologist incorporate new surgical techniques into clinical practice?

“There are two key issues involved,” said Martha M. Wright, M.D., professor of ophthalmology, ophthalmology department, University of Minnesota, Minneapolis. “The first involves training: Are we adequately trained to perform the new procedure? The second involves the patient: What are the necessary elements of the informed consent process when discussing a new technique with a prospective surgical candidate?”

Minimal variations on our current techniques are often easily incorporated into our surgical practice, she said, “but if new techniques or equipment are involved, the patient might be interested in knowing that.”

“Just because something is new doesn’t mean it’s better,” she said, pointing out that with new procedures, short-term risks and benefits may be established but long-term risks and benefits may not be. “For a lifelong disease such as glaucoma, this can be a huge issue.”

Editors’ note: The physicians mentioned have no financial interests related to their comments.

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Some surgeons suggest legal liabilities are better avoided with traditional steps rather than through patient practice guidelines

Does following evidence-based guidelines, such as formal practice guidelines established by physician associations, protect you and your practice from malpractice claims? Don’t bet on it.

Physician advocates have long urged state and national measures to provide legal protection for physicians who follow established preferred practice guidelines. For instance, James Rohack, M.D., former president of the American Medical Association, suggested such protective laws in 2009 as a way to spur the development of national physician practice guidelines.

Although these protective national laws never emerged, various ophthalmic societies in the United States and overseas have developed and distributed practice guidelines. In 2009, the American Academy of Ophthalmology established the H. Dunbar Hoskins Jr., M.D. Center for Quality Eye Care to develop practice guidelines and assessments based on clinical evidence and expert consensus. The stated purpose of these guidelines, according to the website, is to assist clinicians “in decision-making about treating specific diseases. The goal of the Hoskins

continued on page 12
Center’s and Academy-approved guidelines and assessments is to improve quality of care.”

Surgeons may benefit from the clinical support of such guidelines, but even that benefit is limited, according to some surgeons.

William Trattler, M.D., director of cornea, Center for Excellence in Eye Care, Miami, emphasized that the various preferred practice guidelines are only meant to serve as tools, which are limited in their scope. For example, they are snapshots in time and not updated as regularly as the clinical expertise of a surgeon who attends medical meetings, reviews research literature, and consults with colleagues.

“I believe that preferred practice guidelines can be very valuable to clinicians,” Dr. Trattler said. “But one of the key issues is that science continues to move forward after the preferred practice guidelines are written, and new information may become available that warrants a change in practice patterns prior to the next update of the guidelines.”

Because they are only guidelines, Dr. Trattler said physicians have the right to decide what is in the best interest of their patients, even if it differs from the guidelines.

That is a view of preferred practice guidelines echoed by other ophthalmic surgeons, including Douglas Rhee, M.D., associate professor, Massachusetts Eye and Ear Infirmary, Harvard Medical School, Boston. He pointed out that even when surgeons choose to closely follow such guidelines, they still need to decide which of several available guidelines from various physician organizations—some of which overlap—they will follow.

The fundamental challenge of the competing guidelines, Dr. Rhee said, is that they suggest courses of action for the average patient while not accounting for the differing approaches needed for statistical outlier patients.

“The challenge is trying to learn whether those patient will behave like the majority in the studies on which the guidelines are based or whether they are outliers,” Dr. Rhee said. “If they respond to treatment like they are supposed to then they fit the majority.”

An instance where the guidelines fall short is the suggestion of some for annual visual field tests for patients; that requirement falls short in patients whose degenerative condition is progressing quickly. Additionally, a clinician can’t meet that standard for some types of patients, such as those with dementia or children, through no fault of their own.

John D. Sheppard, M.D., professor of ophthalmology, microbiology, and immunology, Eastern Virginia Medical School, Norfolk, Va., agreed that such guidelines are useful tools, but that ophthalmologists need to approach their patients as individuals whose needs could differ in unexpected ways from the average patient.

“The bottom line is that patients need to be treated as individuals,” Dr. Sheppard said. “Every situation is different and there are so many different permutations.”

Pearls: Consult with colleagues, improve communication with patients

Adherence to any preferred practice guidelines is generally viewed as only one element of the “standard of care” and not as important as meeting the more general goal of providing the typical treatment for a given condition in a specific area of the country. That standard is notoriously vague and may vary even between malpractice trials in the same community.

Although determining such community standards is not simple or obvious, according to clinicians, one of the ways of figuring it out is through frequent consultations and discussions with colleagues.

Additionally, surgeons can avoid many legal entanglements through improved patient interactions.

For example, Dr. Rhee aims to ensure that every patient is fully involved in the informed consent process.

“Some patients don’t want to decide anything; they say, ‘That’s why I came to you, Doctor,’” Dr. Rhee said. “But they have to decide.”

That process allows surgeons to educate patients about the risks of the procedure or treatment. If an unintended outcome occurs, then clinicians need to follow up and remind patients that the result was one of the possibilities discussed earlier.

Additional helpful steps, Dr. Trattler said, include documenting those discussions with patients and discussing challenging cases with colleagues to help deliver the best care.

Editors’ note: Drs. Rhee, Sheppard, and Trattler have no financial interests related to their comments.
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Marketing your ophthalmology practice

by Matt Young Contributing Editor

Reason No. 237 for why apps are cool
Once you get past virtual fishing and stapling, put apps to use marketing your clinic

If you think Twitter sounds like a waste of time, never try certain App Store apps, like SimStapler, a virtual stapler with a finger above it to ... staple.

“This app is incredible,” according to one reviewer. “The cutting edge graphics and interface really bring to life the fascinating world of stapling. It also saved my marriage, curtailed poverty in my area, slowed down global warming, won the election for Obama, lowered the price of gas, and has a decent chance of bringing peace to the Middle East.”

Now that, admittedly, you’ve tried a staple (or two thousand), realize that not all apps rival the productivity of loitering.

Some are downright helpful when it comes to, say, marketing your ophthalmology practice.

Taking your marketing slideshow to the next level with Animoto

Take Animoto (New York), the most brilliant thing that happened to the slideshow in recent memory. Animoto, which is free, allows users to create a slideshow from their own pictures and it does the rest. Using the latest post-production technology, it whips photos up into a suave, professional, animated video set to music. LASIK clinics across the United States have started making Animoto slideshows for their patients as a way to enhance their experience.

“We started making Animoto videos over a year ago,” said Francis W. Price Jr., M.D., Price Vision Group, Indianapolis. “It’s a great way to spread the word that it’s fun to get LASIK. Some people come in to hear about LASIK and immediately ask if they will get a video like their friend got.”

Here’s where the Animoto app comes into play: For a busy practitioner, you don’t even have to wait until you get back to your office to do this. You can create the video on your iPhone or iPad between cases.

“We’ve also made Animoto videos of staff events, Christmas parties, and a video tour of our facilities,” said Tony Sterrett, practice administrator, Price Vision Group. “We post those videos on our fan page to help our fans feel like they are a part of our family, and it’s working. We’re up to 3,560 fans on Facebook. That’s more than any other ophthalmology practice.”

Don’t make one slideshow and feel like you’re done. Price Vision Group has made just under 1,000 LASIK videos to date, with some videos being viewed a handful of times while others have gone viral, logging hundreds of hits. It’s hard to tell which videos will be all the rage, so keep making them. With the quick and easy-to-use mobile app, it’s difficult to use the excuse that you’re in surgery all day.

iContact: Empowering your email marketing platform

Another way to keep in touch with your client base is iContact (Morrisville, N.C.), an email marketing platform available for the iPhone.

When you ask for contact information from patients and business associates, ask for permission to send them things like an email newsletter and promotional information. As you begin to grow your email database, iContact helps you empower it. With the iContact app on iPhone or Android, you can track your monthly newsletter list, your special promotions list, and your general database side by side on your mobile device. Even monitor “list health” to know how well your list is growing and performing over time.

Ann Ross, massage therapist and owner, Urban Healing Arts Studio, Seattle, uses iContact to send an email newsletter every quarter to her clients.

“In the massage therapy world, I don’t want to overwhelm people with constant information,” Ms. Ross said. But an email newsletter can provide educational information at appropriate time intervals, she said. Not to sound too spooky, but with iContact, she can also gather intelligence on how her enewsletter is being mentally received.

“I can see people opening it and who has clicked on a link,” Ms. Ross said. “There’s a lot of back-end information.”

Knowing what she now knows, Ms. Ross thinks it’s a must for any business—including eyecare clinics—

continued on page 16
to collect emails and put them to use to distribute engaging content on a monthly or quarterly basis.

Avoid email clutter: Publish an ezine or ebook

Meanwhile, if you think your message is going to get lost in all the email clutter, consider publishing your own ezine or ebook. If you have a newsletter in PDF format, you’ve got to check out Issuu.com, the indie rock of self-publishing sites.

Here you can upload your PDF for free and within minutes, get an elegant publication that flips like a real magazine. There’s an app for that, too. Patients and other stakeholders can enjoy reading your clinic’s publications with Issuu on their Android phones.

For serious app clinicians, they can develop their own.

“We have a Skyvision app that’s a free download,” said Darrell White, M.D., president and CEO, Skyvision Centers of Westlake, Ohio.

The app, created by Cloud Nine Development, is like a mobile website and gives the user a particularly high-tech experience. For instance, on your iPhone or Android, you could request medication refills, test results, or medical records.

“We’re having fun with it,” Dr. White said. “We’re on the bleeding edge—not the leading edge—because we’re ahead of the market.”

Mixing old-school marketing with new technology

Meanwhile, some ophthalmologists are testing new technology while still relying on old-school marketing methods.

John D. Sheppard, M.D., professor of ophthalmology, microbiology, and immunology, Eastern Virginia Medical School, Norfolk, Va., said his practice keeps “a database of email addresses for everyone we possibly can,” which he thinks is particularly useful to keep in touch with the LASIK population, although not necessarily the cataract population.

“We do get the message out, but it’s not a significant part of our referral base,” Dr. Sheppard said. What he has found most useful is an automated call from an 800 number that tells patients they have a visit scheduled for tomorrow or the next day.

“It reminds patients to show up for an appointment,” Dr. Sheppard said.

There’s nothing app about it, and yet, “When the system broke, I had a 20% no-show rate,” Dr. Sheppard said. “That’s huge.”

Nonetheless, the apps of today hold special significance for the business-savvy ophthalmologist interested in spearheading practice growth and monitoring progress. Combined with good content, they can help engage and educate clinician communities and soft-sell ways to greater growth.

Editors’ note: The physicians, Ms. Ross, and Mr. Sterrett have no financial interests related to their comments.
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How small practices can compete for good candidates

With training slots down and demand sharply up, practices large and small are finding recruitment challenging, according to John B. Pinto, president, J. Pinto & Associates, San Diego.

These challenges have risen only in the past decade, he said. As a result, practices are ramping up recruitment tactics once used only by practices in adverse markets. These include the avid use of headhunters, payment of signing bonuses, and escalating base salaries, Mr. Pinto said.

In addition, many practices are, and many more should be, substituting OD labor for MD/DO labor, he said.

“ODs are still readily recruitable, even in the most disadvantaged markets and settings,” he said. Practices large and small in major coastal and urban hubs are still finding recruitment of ODs relatively easy, he said.

While large and small practices have different offerings, large practices have distinct advantages over small ones, Mr. Pinto pointed out. These include a deeper bench of management staff to pursue recruitment, more dollars to offer candidates who are on the fence, and more risk tolerance in the event of a failed hire. In addition, larger practices are better at hiring because they do more of it and are more practiced at getting it right, he explained.

The most common recruitment strategies
The online job search sites of ASCRS and AAO are probably the most common way of finding new doctors, according to Derek Preece, M.B.A., BSM Consulting, Incline Village, Nev.

However, personal networking is often the best way to find new doctors, especially through training programs that the practice has a connection with, for example, if one of the doctors in the practice was trained there, he said.

Direct contact with residents, fellows, or employed physicians who have personal ties to the area is sometimes effective, he added.

It’s all in the pitch
“Small practices generally use the same recruitment channels as larger ones,” Mr. Preece said. “The key difference is in the ‘pitch’ that a small practice makes during recruitment as opposed to a larger practice.”

In practices with multiple doctors, each physician has a smaller influence over the direction of the company than he or she would have in a practice with only one or two doctors, he said.

Therefore, the message from a small practice is that the new doctor won’t get swallowed up by a large entity, but that he or she will be a significant part of the enterprise from the very beginning and in some cases may end up as the sole owner upon the retirement of the existing partner, he explained.

“Small practices should seek doctors who are more entrepreneurial, who want to have a greater influence on the direction of the practice, and who don’t want to be just another doctor in a big practice,” Mr. Preece said.

Those physicians who prefer the perceived safety of a larger organization will generally not be excited...
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Click here to watch and listen to Richard L. Lindstrom, M.D.'s 2011 Charles D. Kelman Innovators Lecture: Thoughts on the ophthalmologist's role in education and innovation.
The pros of patient reported outcomes

by Maxine Lipner Senior Contributing Editor

Bringing the patient’s perspective to ophthalmology labeling

Imagine leaving some of your refractive findings up to the patient rather than relying on the Snellen chart alone. Or asking patients to rate the latest age-related macular degeneration or glaucoma medication. An article in the December 2010 issue of Investigative Ophthalmology & Visual Science considered how patient reported outcomes could be incorporated into ophthalmology. The report, led by Rohit Varma, M.D.,

about a small practice, he added. Small practices can also offer more personal attention from staff, more customization of processes to their needs, and more input on questions about equipment and policies, he said.

In addition, according to Mr. Pinto, a small practice is more likely to want comprehensive or generalist physicians, which can be attractive to some providers.

Small but mighty

Small practices can also position themselves to be great at recruiting good candidates by building up weak features and setting standards at a level that is realistically in line with the practice’s prospects, Mr. Pinto said.

“If your practice is a 5, you’re not going to hire many 10s,” he said.

An important attribute small practices can leverage on is having a great location. This can be attractive not only to the candidate but also to his or her spouse, Mr. Pinto said.

A favorable local population to provider ratio (in excess of 20,000 people per ophthalmologist) is also helpful. In addition, putting together practice financials, which tell a great story about future prospects, allow candidates to have a good projection of their careers at a particular practice, he said.

Good immediate chemistry between the interviewer and the candidate is important as well, according to Mr. Pinto. Having someone on the practice side who “owns” recruitment as a job function could encourage this.

Practices should send a clear message to the final candidate that says, “We want YOU,” he said. Also, having a history of successful prior placements and not a revolving door is a good signal to candidates that the practice is a place in which staff members are happy to stay, Mr. Pinto said.

Finally, practices should articulate a fair and transparent track to partnership at the front end and have a draft employment agreement ready to go, he said.

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

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professor of ophthalmology and preventive medicine, Keck School of Medicine, University of Southern California, Los Angeles, summarized ideas brought to light at a 1-day symposium in October 2009 co-sponsored by the National Eye Institute and the FDA.

The thinking behind including patient reported outcomes in the mix is to add to the level of understanding of clinical outcomes and product effectiveness. “In addition to a standard clinical measure that in many ways has meaning only to physicians, patient reported measures have direct relevance to how the patients perceive they’re performing, and ultimately that is what’s important,” Dr. Varma said. “It is how the patients feel that they are doing and whether or not they’re able to function in the way they want and in the things that they want to be doing.”

**Speaking the patient’s language**

Dr. Varma pointed out that, from a layman’s perspective, it can be difficult to interpret typical ophthalmic outcomes. “It may be fine to say, ‘Drug X improves your vision by two lines,’ but what does that mean?” he said. “Does it mean that patients can begin to read or drive when they weren’t able to, or do they have fewer problems doing various tasks?”

Patient reported outcomes strive to bridge the gap between clinical and day-to-day outcomes. “Ultimately, the translational aspect from the clinical measure to what is really important to the patient is what patient reported outcomes are about,” Dr. Varma said. Patient reported outcomes are the norm in many areas such as insomnia research, urinary incontinence management, and pain improvement. In fact, when it comes to pain, patient reported outcomes are the only measure. “There’s no clinical measure of pain,” Dr. Varma said. “The patient says, ‘My pain is at level six out of 10, and now it’s two out of 10.’”

In addition, in ophthalmology, there has been a smattering of patient reported outcomes available. “There have been a few related to improvement of allergies with eye drops,” Dr. Varma said. “But there are not many others.”

Dr. Varma saw the point of the joint symposium as trying to improve the understanding of both the industry and academia, as well as getting input from the FDA on its expectations. “There’s a whole process that the FDA has in place,” he said. “What came across very clearly is that it is willing to have a discussion about this before industry begins trying to do something in this area. The FDA wants to guide industry on what would be appropriate and what would not be.”

**Real world applications**

Ultimately, Dr. Varma thinks that patient reported outcomes could prove useful for clinical trials. “If we could get a validated measure, then we could show what the patient reported before a drug or device was used and then ask the patient after how he or she is able to perform,” he said. “Then we can assess whether or not the change is meaningful.” In cases where a significant change is reported in a large number of people after they have been given a particular drug or device compared to placebo, it will be possible to show the value of the drug or device from a patient reported outcome standpoint.

Dr. Varma sees patient reported outcomes as potentially dovetailing nicely with traditional outcomes. “There are certain primary endpoints that are mainly based on visual acuity,” he said. “In addition to those, there would be secondary endpoints to deal with patient reported outcomes.” As a result, at the end of a trial, in addition to spelling out improvements in acuity, results would also include the patient perspective. These would potentially bolster one another. “We could always anchor someone’s improvement in the patient reported outcome to improvement in clinical measures,” Dr. Varma said. “They would go hand in hand and validate each other.”

Overall, he envisions patient reported outcomes as becoming the norm in the not too distant future. “In the next 5 years I think that these measures should be out there,” Dr. Varma said. “But it’s a two-way street—industry can help and develop it, but the FDA needs to be willing to accept it.”

*Editors’ note: Dr. Varma has no financial interests related to his comments.*

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Ophthalmologists are medical doctors specializing in the diagnosis and treatment of diseases of the eye, or are they? Calvin W. Roberts, M.D., is an ophthalmologist who has taken up post as the chief medical officer of Bausch & Lomb (Rochester, New York). His new life shows that ophthalmology, at its core, can be a business endeavor.

John H. Varga, M.D., is an ophthalmologist-turned-physician informaticist. He’s an ophthalmologist who believes administrative policies help more patients than surgery ever could.

These aren’t the usual ophthalmologists. By their standards, Charles Kelman, M.D., was a typical eye doctor.

If you’re looking for an outstanding career without ever having to operate on another eye, listen up.

**Practicing to give up practice**

After high school, you probably spent a decade or more studying to be an ophthalmologist. At some point, one person called you “Doctor.” And then a lot more did. Your social and financial status grew exquisitely.

Did you walk away from it?

If you continued to grow as an ophthalmologist for 30 years and became an internationally recognized authority, would you walk away from all that?

You would—and you did—if you’re Dr. Roberts. As chief medical officer of Bausch & Lomb, he’s hardly flipping burgers. But he is way out there on a corporate limb when he doesn’t have to be.

Bausch & Lomb credited Dr. Roberts for being the “father” of ophthalmic non-steroidals in its press release announcing his new position as chief medical officer in March. Given his prolific scholarly work in the field, it’s perhaps a deserved reputation, but also one that now teeters despite continuing to be a clinical professor of ophthalmology at Weill Medical College of Cornell University, New York.

There will be no tenure at Bausch & Lomb. If things go wrong under his leadership, suturing an IOL won’t get him anywhere.

“I invested so much time to get to that [medical] level, why give it up?” said Dr. Roberts.

The answer lies somewhere between having a solid 5-year plan
and having abided by the “10,000-Hour Rule,” a notion spearheaded by Malcolm Gladwell in the book Outliers, which claims that success comes after practicing a task for somewhere around 10,000 hours.

“When I was a boy, my father told me that you always have to have a plan in life, and it should be a series of 5-year plans,” Dr. Roberts said. “Not that plans don’t change. Plans always change. But you have to have a plan and follow that plan.”

Dr. Roberts started his first 5-year plan in college. How many does he have in his archives?

“With revisions, at least 10,” Dr. Roberts said. “I have [a current] one now. Just because you’re further along in your career doesn’t mean that you need it any less.”

Somewhere among his 10,000 hours, Dr. Roberts began swapping a clinical life for a business one, consulting for a series of companies that by the year 2000, took up 50% of his time. In 2003, he became a board member of Alimera Sciences (Alpharetta, Ga.), whose products sold to Bausch & Lomb in 2007. The next year was his last in clinical practice, committing to full-time consultations with pharmaceutical companies, private equity companies, and venture capital firms—that is, until Bausch & Lomb came knocking.

 “[Bausch & Lomb is] one of the iconic brands in eyecare,” Dr. Roberts said. “They wanted me to bring the voice of the customer to the highest decision level within the company. I report directly to the CEO and bring clinical experience to the executive leadership team.”

Is Dr. Roberts comfortable about giving up his reputation as a doctor?

“That’s an emotional thing you have to get past,” Dr. Roberts said. “Once I got past that, for me it was the excitement of recreating myself, of learning something totally new, starting at the lowest level and working my way up in terms of knowledge and position, and enjoying the climb.”

But he sees pros and cons of doing so. Professionally and financially, he was doing very well in clinical practice. It was uncertain whether his business acumen would be as good as his ophthalmic proficiency.

“There are very few opportunities in business that are as financially lucrative and professionally rewarding as being a doctor,” Dr. Roberts said. “[If things didn’t work out], could I live with that level of disappointment when I had for a number of years been successful as a doctor?”

He was willing to take the risk, and so far, seems content with his current success.

An administrative anomaly

Dr. Varga has experienced a different kind of success: doing what he loves on a national level instead of being a small-town doctor.

“I did my clinical career in active duty [in the Navy],” said Dr. Varga. “When it was time to leave the military after 20 years … there weren’t that many jobs out there for ophthalmologists. The ones that were available were in rural or small metropolitan areas.”

Dr. Varga wasn’t content with that and realized he had other options beyond the medical profession.

“It started gradually, but I had some administrative roles fairly early in my career,” Dr. Varga said. His involvement was in patient safety quality improvement, and he decided to take that—along with skills in information technology—to another level.

“The senior military command asked me to take a Pentagon-level job,” Dr. Varga said.

It was perfect except that when he started, his clinical responsibilities seemed like they wouldn’t take no for an answer. Despite his new administrative life, he continued to serve as a Red Cross volunteer.

“Curiously, one of the days I was at the Pentagon clinic was two days after 9/11,” Dr. Varga said. “You can imagine what that was like.”

Despite the reminder of his importance as a doctor, Dr. Varga did not reverse his new career choice.

“A lot of people ask, ‘Don’t you miss taking care of patients?’” Dr. Varga said. “If I see 30 to 40 patients a day, I can do good things for 30 to 40 patients. When I am in an administrative role, I can influence policy that helps tens of thousands, hundreds of thousands, or millions of patients a day.”

Benefits of not being a practicing ophthalmologist include a normal “40ish” hour workweek and not having to deal with malpractice issues.

“I have to say, I don’t miss taking care of patients,” Dr. Varga said.

Today, Dr. Varga is president of Falls Church, Va.-based JHV Consulting, doing jobs mostly for the U.S. Department of Veterans Affairs. He has, for instance, worked with the Department to implement electronic medical records (EMR) technology specific to ophthalmology.

“I don’t run into too many ophthalmologists in information technology,” Dr. Varga conceded. “My guess is you might be able to count them on one hand.”

Editors’ note: D rs. Roberts and Varga have no financial interests related to their comments.

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