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From the publisher

This month’s issue of Ophthalmology Business is dedicated to the topic of investing. Whether you’re just starting out or are a seasoned investor, this issue promises to give you some helpful financial pearls for getting your investment portfolio in order.

“Caring for your specialized financial health” shares tips on how to find and select the best financial advisor for your own personal needs and goals (pg. 12). Not sure how or where to begin building your portfolio? Ben Utley outlines the top seven questions physicians should answer before they make that investment (pg. 16).

“Investing in ophthalmology” (pg. 19) discusses the high risks and the potentially high rewards of investing in ophthalmic companies.

Could your practice be seeing more patients? Could you perform more procedures? In the story “Planes, doctors, and medical facilities and their role in patient flow,” Ophthalmology Business offers pearls for determining whether your practice is flying at optimum capacity.

Finally, read about the personal investing experiences of two ophthalmologists for whom investing has become more than just a hobby in “Viewing investing through the slit lamp” (pg. 24).

As always, thanks for reading.
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Planes, doctors, and medical facilities and their role in patient flow

by Larry R. Brooks and Tim Griffin

Medicine is a business, and like all businesses, you have something to sell. In medicine it is the intellect, knowledge, and skill of the doctors. To provide that to patients they need time. In essence doctors are in the business of selling their time, so it is in the best interest of the patients, practice, and doctors to wisely utilize the time they have.

Every minute without a patient to see is lost opportunity that cannot be regained. This is similar to an airplane departing with an empty seat—that airline loses the opportunity to rent that seat and generate revenue. So how do the airlines attempt to maximize their opportunities? They know exactly the capacity of that airplane and market, staff, and book to fill each seat.

You should do the same. But first you must know what your capacity is, and that is not as easy as counting seats. How do you determine your capacity and if you are at it or not currently? First take a step back and look at your practice. It is comprised of many moving parts: information, staff, doctors, patients, equipment, etc. It takes a choreographed effort to organize the logistics of systems, staff, and space to allow you to be as productive as you can be.

For instance, the systems of your office are made up of the flow of patients, staff, and doctors. The appointment template controls the input of patients; communication systems, staff, and space affect the throughput; and the doctor controls the output. When any of the parts upstream from the doctor are out of sync with the doctor’s capacity, the overall process breaks down, either causing
the doctor to not have a patient ready (lost opportunity) or for there to be too many patients (negative patient perception).

To determine if you are reaching your potential, a time assessment needs to be performed to see how your time is consumed now. This time assessment should track the doctors and the staff. The beginning time of each event is noted, what is being done, and by whom. This data is then separated into events/time that have to be done by the doctor and those that do not. See the time assessment example (Figure 1).

This study will identify what events are causing you to lose time and how much time is being lost. From that data determine the average amount of time effectively spent per patient doing things only you can do for the patient. This will identify your capacity or potential patient volume. See the time assessment summary (Figure 2). Could you go from being a regional jet to a jumbo jet in capacity?

If so, the medical facility, staff, and systems of your practice need to be re-engineered to support that new potential patient volume.

**Practice re-engineering**

The magnitude of practice re-engineering required will be based on the delta between your current patient volume and the potential. So just like the airline analogy, the capacity of the resource (doctor/plane) determines the need for staff and space. A large jumbo jet will not fit in a gate for a regional Embraer just like a high-volume doctor will not fit into the same number of exam lanes as a low-volume doctor. The high-volume doctor requires more staff, just like the large jumbo jet.

In regard to staff, the time assessment will identify the amount of additional staff time that will be required to perform the tasks to be delegated to them. Once the type and number of staff required is determined, that data along with the patient volume of the doctors is used to project the space need. As with the time assessment, space need projections start with the doctors.

The first space question to answer is how many exam lanes does each doctor need? The second question to answer is how many doctors will be in at the same time? The number of exam lanes a doctor needs is referred to as an exam pod.

This is determined by the average time the doctor spends with a patient and the amount of time the staff need to get that exact exam lane ready with a new patient once the doctor exits the previous patient. The chart in Figure 3 illustrates this.

In this example, the doctor is planned to see eight patients per hour on average, and the turnaround time for the exam lane is 8 minutes. This turnaround time could get longer depending on the tasks being assigned to the staff. For instance, is the staff refracting for you? Do you...
not use a scribe or does the scribe go with you to the next patient and another staff performs follow-up work with the patient? Those things will have an effect on the length of turnaround time and therefore the number of exam lanes you need.

In determining these exam lanes you will also use the hourly patient volume of the doctor multiplied by the average length of time for the staff to work the patient up to determine the number of workup staff and workup rooms/lanes.

In determining the number of doctors to be in at once, be very critical in regard to the large swings in the number in at once. The less variation in the number in at once, the smaller the facility, staff, and overhead the practice will have. Sometimes very minor changes to the weekly schedule can have very significant positive effects on the practice, profit, and patient wait times/satisfaction.

At this point you should know the number of doctors to be in seeing patients at once, the number of exam lanes and work plans required, and the overall patient volume to be planned. This information can then be used to begin projecting space needed. This is the one mistake we typically see practices and general architects make when assessing/planning medical facilities. A complete listing of all rooms, sizes, patient volume, staffing, etc. is not developed to define the target in which to assess or plan space. The design process begins to only consume valuable time and money revising and redesigning. Figure 4 is an example of a portion of a space needs spreadsheet.

The assessment of your current medical facility is based on this spreadsheet. Depending on the outcome of that assessment, this space needs spreadsheet serves as the basis for the design of the changes to that facility or design of a new facility.

Taking this operational approach to assess your current practice flow, medical facility, and your patient volume capacity, you develop the tools to better serve you, your patients, and your practice. OB

Figure 4: Space needs spreadsheet example

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Caring for your specialized financial health

by Enette Ngoei Contributing Editor
The first step in finding the right financial planner and advisor is to make a credible list, Mr. Utley said. Two good places to start your search are the National Association of Personal Financial Advisors (www.napfa.org), the leading professional association of “fee-only” financial advisors, and the Financial Planners Association (www.fpanet.org), the largest membership organization for personal financial advisors in the U.S.

Mr. Utley recommended physicians start with a fee-only advisor. “A fee-only financial advisor, financial planner, investment advisor is compensated with a fee, which means that you pay him with a check, a credit card, or with authorization to deduct money out of an account; all compensation is fully disclosed and invoiced. The same way that you would pay a doctor or attorney, it’s a professional fee.”

Everyone else charges something that is less clear, he said. For example, they may sell a product and receive a commission. Usually when there is a commission involved, Mr. Utley said, there is a potential for conflict of interest because various products give different levels of compensation.

Searching outside one’s community increases the odds of finding the most qualified advice. Many financial advisors work with clients by telephone, fax, and email on a regular basis, so distance is not a problem.

To round out your list of prospective advisors, Mr. Utley recommended contacting friends, coworkers, an accountant, and/or attorney to find financial advisors they might recommend.

Look for certification

“Beware of generic pseudo-credentials like ‘financial advisor,’ ‘financial consultant,’ ‘wealth manager,’ and even ‘vice president,’” Mr. Utley warned. These merely signify that an advisor is in the business and may have a license to operate.

“While most licenses require an advisor to pay a fee and pass an exam, these may be easily acquired with a minimal commitment of time and effort,” he said. “In contrast, certifications usually require a higher level of commitment and dedication. Formal training, rigorous examination, continuing education, years of experience, and oversight by a board or governing body are part of attaining and keeping a certificate, so certification is an outward indicator of the quality of advice you may receive.”

Prospective advisors on your list should at least be certified as a Chartered Financial Analyst (CFA) or Certified Financial Planner (CFP). CFA may delve into matters of personal finance, Mr. Utley said, but most specialize in the management of investment portfolios. He recommended that physicians with large portfolios consider seeking the advice of a CFA.

The CFP mark is the most sought-after credential among advisors who practice financial planning, Mr. Utley said.

“If you need help with more than one issue in your financial life or if you are targeting long-term goals like retirement or college education, make sure a CFP is on your list,” he said.

Do a phone interview

Mr. Utley recommended making a preliminary phone call to ask some key questions that may help narrow your list of possible candidates.

1) Who will you be working for when you serve me?

“If your advisor is a ‘registered representative’ then he owes his first duty to the company that employs him, not you,” Mr. Utley said. However, if your advisor is a fiduciary, he owes his first duty to you by law. A fiduciary will offer you an Investment Advisor Disclosure Brochure before allowing you to hire him. Most fiduciaries also use a contract or engagement letter to form a business relationship with you, he said.

continued on page 14
2) Do you work for people like me?

Find out if he specializes in working with M.D.s by asking what proportion of his clients is M.D.s, Mr. Utley advised. If you’re self-employed, find out how many M.D.s he works with who are also self-employed. The same goes if the physician is part of a larger practice.

3) How long have you been in business?

There’s no substitute for experience. Look for at least 10 years of experience when seeking advice, he said.

After this round of screening, make appointments to visit advisors who remain on your list, Mr. Utley said.

Find a personal match

Resist the temptation to sign up for services at the first meeting, Mr. Utley said. Instead, collect information and get a feel for how you and the advisor might work together in the long term.

He suggested a few important questions to ask:

• What does your ideal client look like in terms of age, employment, and financial situation?
• How does your investment and/or planning process work?
• Who will I work with—you or an assistant?
• What one thing do you do better than all the other financial advisors I might encounter?

“Asking these questions will tell you whether or not the advisor might do a good job of serving you,” he said.

Knowing some personal details about the advisor can also help you determine if he has similar interests, priorities, and philosophies in life. Some questions include:

• Are you married? Do you have family or children?
• What are your interests beyond financial advising?
• What drew you into the profession? Why did you stay?
• What’s been your best experience with a client? Your worst?
• What do you expect from me as your client?
The final decision
After meeting potential advisors face-to-face, asking yourself these questions may help you make your final decision, Mr. Utley said.
1) How well did each financial advisor listen to me?
The hallmark of a good relationship with your financial advisor will be your ability to communicate your needs to him. This means he must do an excellent job of listening to you in order to understand how he can help. Consider the amount of time he spent listening to you versus the time he spent selling his services.
2) How clearly did each financial advisor express himself?
Even if you received the very best financial advice from your new advisor, you might not follow the advice unless you fully understand it. Consider whether or not the advisor “speaks your language.” Make sure you are comfortable with his style of communication.
3) What promises did each financial advisor make?
In addition to reviewing the questions you asked in your first meeting, consider how each advisor attempted to win you as a client. Some advisors may try to dazzle you with their past performance records or wow you with the big clients they’ve handled. The best advisors attempt to set clear, realistic expectations about your work with them during the very first meeting. They know the foundation for a great long-term advisor/client relationship is their ability to make promises and deliver on them. Look for promises that include a clear statement of services and fees, regular contact and availability, and a duty to act in your best interest.

The financial advisor for you
Once you’ve decided which advisor to hire, Mr. Utley said you will realize what good financial advisors already know to be true: The financial advisor you choose may be a lot like you.
“People have a natural tendency to trust others who are much like themselves, so the advisor you choose will likely share your interests, your outlook, your beliefs, and even some of the same financial goals you hold. No matter which financial advisor you choose, make sure the one thing you have in common is an uncompromised interest in your financial health,” he said.

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Utley: 541-463-0899, contact@physicianfamily.com
Get it right and you’ll sail through the stormiest economic seas with your capital intact. Get it wrong and you’ll jump overboard as your hard-earned money crashes into the rocks.
It's easy to make an investment. Just take your money and buy something with the hope it will be worth more tomorrow than it is today. It's just as easy to make an investment mistake, and most people do. According to an annually revised study by Boston-based investor research firm DALBAR Inc., both equity and fixed income investors have underperformed the broad market indices. Over the 20 years ending December 31, 2008, equity investors experienced average annual returns of only +1.9% while the S&P 500 Index of U.S. stocks averaged +8.4%. Fixed income investors experienced average annual returns of +0.8%, while the benchmark Barclays Aggregate Bond Index averaged +7.4% per year.

Why do so many investors fail to garner the returns that can be had by simply buying and holding index-based investments? The answer lies in the way investors behave when they handle their investments, a phenomenon known as “the behavior gap.” Simply put, most investors experience poor investment results because they make investment decisions based on hope or fear, not logic.

To bridge the behavior gap, all you need is a well-reasoned plan and the will to follow it. Here are a few questions you can answer as you develop a plan for your investments.

1) How will this money be used?

When you take the long view, you'll realize that all the money you have today will either be spent or shared. You can't take it with you. So ask yourself, "What do I want this money to do for me?" Sample answers might include:
- Retirement: "I need my money to support me until the day I die."
- College: "I need my money to pay for 4 years of college starting [when the kids enter school]."
- Charity: "I want to see my favorite charity be able to [do good in the world]."
- Legacy: "I want to make sure my kids have enough money to [do something great]."

2) Do I really need to invest it?

If you have a whole bunch of money, it might not be necessary to invest at all. For example, if you're a 60-year-old ophthalmologist who lives on $120,000 per year and you have $12 million in your portfolio, you can stuff your money under the mattress, spend the principal, and never run out of money. Even safe savings vehicles might yield enough interest to support you. Don't take risks if you don't have to.

3) How much should I NOT invest?

The business cycle, or the boom-bust-boom phenomenon that you can see when you watch the economy, typically lasts at least 5 years. During that time, stock and bond prices may gyrate wildly. If you happen to make an investment during the wrong part of the cycle, then you may have a very long wait before you can recoup your capital.

For this reason, you should only invest money if you plan to use it in more than 5 years. Everything else might be better kept where it is undoubtedly safe.

4) How much risk should I bear?

The answer to this question will make or break you as an investor. Get it right and you'll sail through the stormiest economic seas with your capital intact. Get it wrong and you'll jump overboard as your hard-earned money crashes into the rocks.

You can approach the answer from two angles.
- Measure your risk tolerance: To make an objective decision about this emotionally subjective issue, you might take a risk tolerance exam. The best-known exam is produced by FinaMetrica (www.finametrica.com), a company founded in 1972 by psychometric researcher Geoff Davey. An exam like this can help you begin to allocate your investments between high-, medium-, and low-risk options.

You can continue on page 18.
in order to make your financial goals a reality. If you assume that high-risk investments can garner a 10% rate of return while low-risk investments garner a 4% return, then a 50/50 blend of high-risk and low-risk investments might deliver the return you are targeting.

You may find that the amount of risk you need to bear is more than the amount of risk you can actually stand, in which case it would be wise to target the tamer mix. It will be easier to stick to your plan, but it may also mean you need to save more, spend less, or reach your goals at a later date than originally planned.

5) How will I control risk?

In theory, the best way to manage risk is to select the best investments and buy them at the best time. If you do this successfully, you can avoid the losers, protect your profits, and reap the reward with less risk. In practice, stock picking and market timing lead to subpar and even disastrous results because you’re more likely to pick the wrong stock and sell it at the wrong time.

A better way to control risk is to sort potential investments into two categories or “buckets”:
- Your “high-risk” bucket includes anything that looks or acts like a stock. Stock mutual funds and certain bonds also belong in this bucket, like emerging market bonds, junk bonds, and small cap mutual funds.
- Your “low-risk” bucket includes pretty much anything that’s not in your high-risk bucket, like short-term corporate bonds, investment grade bonds, intermediate duration bond funds, and certain municipal bonds (which yield tax-exempt interest).

Each bucket has its role in your portfolio. High-risk investments give you a chance to earn returns that exceed inflation. Low-risk investments reduce the chance that you’ll abandon your investment plan altogether.

Set a target for how much you’ll invest in your high-risk and low-risk buckets, then write it down. This step is what the investment pros call “establishing your target asset allocation,” and the document you’re creating is known as your “investment policy statement” or “investment guidelines.”

6) When should I make a change and why?

From time to time, you may feel the need to exchange an old holding with a new one. For example, if a stock in a taxable account has lost ground, you may decide to sell it and write off the loss against ordinary income. Or you might sell a mutual fund that has had a change of manager. In either case, you would probably turn around and reinvest the proceeds in something with a similar level of risk.

No matter what you do, resist the temptation to tamper with your target asset allocation. If the stock market is going through the roof, don’t plow everything into the high-risk bucket. If the bond market looks like it’s going to collapse, don’t trade all your bonds for cash. While things may look rosy or horrific now, the most important thing you can do is stick to your plan.

Really the only good reason to change your target asset allocation is because something in your life has changed. For example, maybe you had a big family or a big divorce and you have been investing in an aggressive manner over the past several years as you try to catch up to your peers. Recently your Aunt Mabel died of a stroke (you told her to stop smoking, right?), and she’s left you a large estate. So now you may have enough money to retire, and you might be able to reach your goal by taking less risk with your investments. It’s time to reconsider your target asset allocation.

However, if your Aunt Mabel didn’t actually die but she’s been dying to share her stock market secret with you, beware. When she encourages you to sell all your dowdy low-risk investments and pile into the XYZ Opportunity Fund, what will you tell her?

7) Things look bad. Shouldn’t I make a big change?

The answer is “no.” Remember that your investment plan is supposed to guide you through thick and thin. If you’ve done your homework, thought things through carefully, and you’ve put a great plan in place, the odds are against you if you decide to make a big change. The key to success lies not in your ability to make better investments but in your decision to become a better investor by making and following a plan.
Ophthalmology is brimming with successful surgeons who have forever influenced medicine by supporting innovation. Without these pioneers, irreplaceable technologies like the femtosecond laser, foldable IOLs, and micro-invasive glaucoma devices may not exist today.

As essential as investing is, though, it's a bit like gambling in Vegas: With high risk comes high reward, and you can't win if you don't play. *Ophthalmology Business* spoke with three successful investors who shared their best advice on the realities of getting into the game.

**Look before you leap**
Before you consider collaborating with a company, you must have a clear understanding of your own financial picture. It's quite possible an idea won't pan out, and your investment will be lost.

“You have to have the discretionary funds to be able to do this. There’s a certain degree of uncertainty in investing,” said **John D. Hunkeler**, M.D., Hunkeler Eye Institute, Overland Park, Kan. “But if you’re investing in ophthalmology, investing in a field you know something about and have ideas you’d like to see propagated, it’s exciting to watch it happen. But recognize it’s not 100%.”

**Richard L. Lindstrom**, M.D., founder and attending surgeon,
Minnesota Eye Consultants, and adjunct professor emeritus, ophthalmology department, University of Minnesota, Minneapolis, is one of the most successful investors in ophthalmology today. But he didn’t get to that point by accident. He had a financial plan every step of the way.

For example, he made sure he had his practice, a 401k and various retirement plans, and 20% of his annual salary in savings to fall back on.

“I didn’t just throw my whole net worth and life into one of these ideas. You have to have a controlled plan,” he said. “You have to have those conservative investments based on the assumption that every single one of your speculative investments in solving ophthalmology’s unmet needs will fail.”

If you do invest in a company, assume you’ll need to give well over the initial amount required. For example, if you invest $50,000 in a start-up company, plan on making two more $50,000 contributions for the company to make it.

“You need to set aside a reserve because things are always harder than you think they’ll be,” Dr. Lindstrom said. “They’re always longer than you think they’ll be, and the original founders and original investors often have to go back to the well at least twice before [the company] can get outside money.”

Even the best ideas fail, and it may not be a reflection of the concept’s integrity. It can be something as simple as change in company management or a serious lack in judgment from the company’s board of directors.

“In the early days of IOLs, I had some ideas for early generation foldable IOLs,” Dr. Lindstrom explained. “The company I was working with thought that foldable IOLs were a fad, and it didn’t make any difference if you had a 6 mm incision or a 3 mm incision. That’s what the management team decided. Things like that happen. You can have a great idea and it doesn’t make it.”

When to invest

Smart investors don’t take just any offer; they strategically align with people they respect and ideas packed with potential.

“When I collaborate with a company, what I’m looking for is a product that has a significant advantage or resolves an unmet need in the ophthalmic space,” said Eric D. Donnenfeld, M.D., co-chairman, Cornea, Nassau University Medical Center, East Meadow, N.Y. “I look for companies that have good intellectual property, but most of all I’m looking to work with people I admire and trust and feel will help bring their product to market.”

Anyone can have a good idea, but it’s a rare person who has the wherewithal to follow the idea through and mold it into a successful product.

“Without working with the right people, most ideas are going to be unsuccessful,” Dr. Donnenfeld said. “We can always modify an idea, and that happens constantly in the development of business proposals in ophthalmology.”

Dr. Lindstrom also has set criteria he evaluates before collaborating with industry.

“The idea has to resolve an unmet need, and the unmet need has to be large enough to make [the investment] worthwhile,” he said. “We have some unmet needs where if you brought a product to market it would generate $5 million in sales globally. But that doesn’t work. You can’t interest anyone when you get to the second and third levels of capitalization unless it’s a minimum of $100 million.”

Furthermore, the idea must make sense, which means the pathophysiology of the issue has to be well understood by the community. Finally, Dr. Lindstrom evaluates the people involved.

“For me, I do it for fun and work with people I really like as much as possible,” he said. “I want people to have a good set of values consistent with my values, have integrity, and do things the right way. I like people who are in it not just to make money, but also to serve ophthalmology and our patients.”

Of course, part of knowing when to invest is knowing when not to.

“The number one reason I would turn a product down is if I didn’t think it would be successful,” Dr. Donnenfeld said. “If I don’t think a product meets a need or has sufficient improvement in something that’s already available, my personal belief is it’s not worth spending my time to develop. I want to develop unique devices and pharmaceuticals that change the practice of ophthalmology. So I look at the potential. It’s not the idea that’s important, it’s the potential of the idea and where it can go in the future.”

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Smartphone popularity leads to surge in dry eye

by Michelle Dalton Contributing Editor

Once thought to afflict mainly older people, the increased use of smartphone technologies is causing younger patients to seek dry eye relief.

Smartphones, tablet computers, and netbooks have become so pervasive in society that it’s unlikely you can walk a city block without finding someone texting, emailing, or playing games on his or her cell phone. “With the increased number of hours spent utilizing these wondrous devices, there has been an increase in dry eye complaints from people who are typically too young to experience the disorder,” said Barry Schechter, M.D., Florida Eye Microsurgical Institute, Boynton Beach, Fla.

“What we’re seeing is much like computer vision syndrome from the 80s and 90s,” he said. “It’s the same kind of thing, only instead of people working on their computers and then going home, everyone is connected all the time.” Computer vision syndrome results from prolonged computer use; the amount of ocular surface inflammation that leads to discomfort is proportional to the amount of time spent on devices. Common symptoms are eye strain, headaches, blurred vision, dry eyes, and neck and shoulder pain. Screen glare, improper viewing distances, and poor seating posture (or any combination) are all causative factors for the syndrome, Dr. Schechter said, and the same causes are responsible for the issues with smartphones.
Since smartphones have, for some people, essentially replaced the computer with their ability to check email, take photos, and surf the Web, Dr. Schechter said, “People are on their cell phones for an increasing amount of time during the day and well into the evening.” So unlike computer vision syndrome where complaints receded in the evening hours, that’s not happening today. One way of controlling computer vision syndrome is to provide alternate lighting, but smartphone use occurs under all lighting conditions.

As a result, ophthalmologists are noting an increase in the number of younger people complaining about blurry vision, headaches from working on the computer/cell phones, and irritated eyes, he said. “We’ve even seen children in our offices using artificial tears because they’ve been texting friends into the wee hours of the morning,” he said.

Most general practitioners don’t really think about eyelid blink rates, Dr. Schechter added. “A normal blink rate is about 16-20 per minute,” he said, “but when people concentrate on mobile devices or tablets, their blink rate drops to six or eight per minute.” A secondary concern is increased asthenopia, again because the patient is focused on one point for elongated periods of time. Lastly, physicians should be educating patients about the increased possibility of vergence accommodation difficulties as the film and gaming industries bring more 3D products to market.

“Anterior segment surgeons need to get the word out about these disorders, even amongst our peers,” Dr. Schechter said. Other disorders that are much more significantly debilitating may take precedence over complaints of irritated eyes, he said.

“With the elder population booming, an increased number of patients with posterior segment disorders [is] using magnifying glasses—and those patients can equally benefit from medicated drops like topical cyclosporine 0.05%, loteprednol, or by having punctal plugs inserted,” he said. “If an AMD patient is using a reading device, it’s going to take [the patient] longer to read what’s on the screen, which only aggravates the problem.”

Dr. Schechter recommended ophthalmologists advise all patients, especially younger ones, to practice the 10-10-10 rule. “Every 10 minutes, give your eyes a break and look at something that’s 10 feet away for 10 seconds,” he said. “Depending on the amount of time someone spends on his or her cell phone or iPad, decreasing that rule to 5-5-5 may not be a bad idea.”

Typically, he said, younger patients have thicker tear films, “so they’re able to look at the screen for longer periods without noticing any irritation, but the damage is being done.” Once patients start entering middle age, hormonal changes and an increased likelihood of meibomian gland dysfunction mean surface issues and more common complaints.

“If we can get people to start adhering to the 10-10-10 rule now, it may help offset some surface complaints down the road,” he said.

For the most part, younger patients seem to be more amenable to altering their mobile device viewing habits, Dr. Schechter said. “They’ve opted to visit a specialist because their eyes are irritated or because they’re having difficulty focusing. But until they exhibit the symptoms of dry eye directly, most patients won’t comply because they still think they’re invulnerable to disease.”

The upside for ophthalmologists is not only the increased potential patient base—and an increasingly loyal one that has a chronic disorder—but the ability to educate the general public and prevent more serious surface disorders, Dr. Schechter said. “Just go into your waiting area and note how many people are in your office because of irritated eyes, but there they are, on their iPads, tablets, or cell phones,” he said. “Even if the main complaint is not irritation, we should be sensitive to those issues and query the patient about 10-10-10.”

Editors’ note: Dr. Schechter has financial interests with Bausch + Lomb (Rochester, N.Y.) and ISTA Pharmaceuticals (Irvine, Calif.). iPad is a registered trademark of Apple Computer Inc.

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Your surgical touch may be golden, but what about your investment aptitude? While admittedly ophthalmologists aren’t schooled in tackling the stock market, there are those who by virtue of their own time in the trenches have become versed at this. *Ophthalmology Business* asked two such ophthalmologists to share advice on entering into this relatively unfamiliar financial territory.

Robert J. Freedland, M.D., a general ophthalmologist interested in cataract and refractive surgery, Mayo Clinic Health System, La Crosse, Wis., has been an avid investment hobbyist since 1967, when as a child he took $300 in gift money and invested it. Since then it has been in his blood. In recent years he has become an avid blogger and podcaster and is one of a select few picked for his own page on Covestor (covestor.com/robert-freedland), an investment management platform that allows average investors to automatically mirror the real trades made by those with proven aptitude.

**Education first**

He encourages other ophthalmologists who think they may have an interest in investing to educate themselves first. “One of the great things you can do is to join a stock club,” Dr. Freedland said. “We have a stock club at our hospital. It’s an opportunity for people to develop some understanding.”

**Develop a philosophy**

Dr. Freedland also stressed the need to develop some philosophy. He cited the advice of famous investor Peter Lynch who for a period of time outperformed the market tremendously year after year. “The simplified explanation of Peter Lynch is about buying what you know,” Dr. Freedland said. For physicians, however, he has found that there is a need to modify this to pertain more to the world at large. “Just because a medical company has a good product, that doesn’t necessarily mean that the product is significant in the entire picture of the company,” he said. But taking notice of the more basic picture in the world around you can prove lucrative. “One of my best investments recently has been McDonalds,” Dr. Freedland said.
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With the slow economy, this seemed to him to be a natural place where people would spend money. As a rule, he tends to stay away from ophthalmic investing, citing ethical concerns. However, he does try to capitalize on the broader health market. For example, after a recent health scare he decided to invest in robotic surgery with a company called Intuitive Surgical (Sunnyvale, Calif.), which makes the da Vinci Surgical System, for neurologic and gynecologic surgery, as well as another company, Mako Surgical (MAKO, Fort Lauderdale, Fla.), that does robotic orthopedic surgery.

He also suggested looking into companies involved in managed care issues, insurance, and electronic medical records, which he sees as large trends. Even something like generic medication he feels has possibilities. Dr. Freedland pointed to companies like Perrigo (PRGO, Allegan, Mich.) and High-Tech Pharmacal Co. (HTK, Amityville, N.Y.) to get involved there.

He encouraged those who are entering the markets to read voraciously. One classic book he recommended even though it is out of press is The 100 Best Stocks to Own in America, in which author Gene Walden rates stocks with his own system of stars. Dr. Freedland spends a lot of time looking at websites such as MarketWatch, Seeking Alpha, CNN Money, and Yahoo Finance.

**Dissect a stock’s potential**

Dr. Freedland touted famed investor William O’Neil’s CANSLIM system for dissecting a stock’s potential. This takes into account common sense factors such as last quarter results. One of the other things that Mr. O’Neil has preached that Dr. Freedland thinks is very important is to sell your losers. While most people erroneously think that the time to do this is when the stock is on the rise, Dr. Freedland stressed that it is quite the opposite. “If a stock goes down be anxious to sell it and try to keep your hands off the stocks that are doing well,” he said.

Dr. Freedland isn’t the only one who follows Mr. O’Neil’s advice. Louis P. Kartsonis, M.D., San Diego, touts him as a guru. Dr. Kartsonis began investing at the knee of his father and later found renewed enthusiasm like many during the run-up to the tech bubble in 1999.

“The thing that I like about William O’Neil’s system is that he has a number of data points, which you can check for each stock, as well as chart patterns and how to analyze them,” Dr. Kartsonis said. “He will recommend that you look at things like earnings per share and relative price strength and return on equity.” He pointed out that the things that many have been conditioned to look at, such as price earnings ratio and dividends, Mr. O’Neil claims have not shown to affect the performance of the stock.

Dr. Kartsonis routinely gets information from Investor’s Business Daily and its accompanying website Investors.com and listens to CNBC. In sizing up an investment he begins by looking at the earnings per share. “I’ll check the most recent quarterly earnings per share and look for an increase compared with the prior year’s same quarter,” he said. “I’m looking for an 18-20% jump and an increase in earnings per share over the last three quarters—it should be an upward trend.” Dr. Kartsonis also considers the return on equity. “I want it to be at least 17%,” he said. He also looks at the relative price strength of the stock and how it performs against the rest of the market. Then he checks on the sector that the stock performs in to see how this is performing since those that do well generally have the most winners, he finds.

He also looks at the stock’s chart for a potentially winning pattern such as a cup or flat base. A cup has a dip and then a rise, as its name suggests. “When the rise reaches a point that is ten cents above the point at which the cup started, that is a potential buy point if it is accompanied by heavy volume,” Dr. Kartsonis said. Likewise with a flat base if the stock price stays within about 5-10% of the close each week for several weeks and then takes off on high volume, it is an indication to buy. “Similarly if a stock falls on heavy volume, that indicates that institutional investors are probably getting out and you may want to cut your losses,” he said.

Dr. Kartsonis has found that it takes discipline to do this. “It’s counterintuitive to my instincts,” he said. “But in reading some of O’Neil’s analysis, he points out that if you sell a stock when it has fallen 8%, you need to gain only 9% to break even,” Dr. Kartsonis said. “But if you let your stock investment drop say 50%, you’ve got to gain 100% just to get back to even.”

When it comes to ophthalmology, he thinks that the next big development in research from an investment standpoint will be in something like stem cell therapy or treatment for macular degeneration, which is the most common cause of blindness right now in the U.S. “If there is something like that pending that looks like it can get to market and help a lot of people, I think that would benefit [ophthalmologists], and they’re going to know about that before the general public will,” Dr. Kartsonis said. But overall he stressed that this is very limited. “The thinking that is going to help any investor is to focus on fundamental, technical analysis, and good old-fashioned discipline,” he said.

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