Passing the hat to patients
Making adjustments in a lean economy
P. 20
Thank You for 25 Years of Support.

Twenty-five years ago, with the support of the American Academy of Ophthalmology, OMIC opened for business as the nation’s first, and only, professional liability insurance carrier exclusively for ophthalmologists. We extend our gratitude to the 800 ophthalmologists who believed in OMIC in 1987 and to the nearly 4,500 who believe in us in 2012.

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As physicians you live and work by a code of ethics. Ophthalmologists’ principals are tested daily, with questions about finances, unhappy patients, and more.

*Ophthalmology Business* has devoted this issue to some of those tough dilemmas, including a useful primer on ethics vs. morality by ethicist John D. Banja, Ph.D. (“Some fundamental observations about ethics,” page 14).

In our feature story, contributing writer Faith A. Hayden talks to experts about how to ethically deal with angry patients (“The ophthalmologist and the angry patient: Ethical strategies for taming tempers,” page 16).

It’s easy to find yourself in an ethical pickle when dealing with finances. Ophthalmology consultant John B. Pinto discusses this in “Passing the hat to patients: Making adjustments in a lean economy” (page 20), while finance experts John J. Grande, Traudy F. Grande, and John S. Grande teach you how to make the most of your practice’s profits (“Medical professionals: A prescription for your financial health,” page 10).

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Doctors: Why you need your

by Robert F. Melendez, M.D.

I often get the best insights about technology from my children. It’s no surprise that my “aha moment” about having a practice app came from my high school-age son and daughter.

They have a friend whose father is also a physician. My children told him, “Our dad has his own app.” The other student was incredulous, then extremely impressed. My children were quite impressed that he was impressed. This is just about the textbook definition of the “wow factor.”

I know that my reputation isn’t staked on gadgets, gizmos, or being cool. But when it comes to differentiating your practice in the minds of patients and patient prospects, a little “wow” goes a long way.

Besides, a smartphone or tablet isn’t exactly a gadget or gizmo. They are the heartbeat of mobile commerce, and the astounding growth of this market segment indicates how much consumers are using their mobile devices to make decisions, purchase services, and conduct their personal business.

In 2011, Ingenex Digital Marketing reported that mobile commerce increased by 91% over 2010 usage. Mobile Commerce Daily predicts mobile commerce will increase another 71% to reach $11.6 billion in sales.

About a year ago, I downloaded the Eye Handbook App (Cloud Nine Development) and learned firsthand that a smartphone equipped with the right app can be an invaluable practice tool.

Created by three ophthalmologists, the Eye Handbook App provides immediate access to an atlas
of ophthalmic images, ICD-9 codes, a vision symptoms menu and diagnostic images, a treatment menu, ophthalmic medications, and preferred practice patterns and patient education videos.

Once I was hooked on the Eye Handbook App, it only made sense to take a look at the Doctor App, which was developed by the same three ophthalmologists. Here’s what I liked about it:

• The Doctor App appears on the patient’s device as a branded (to your practice) app.

• The patient can use it to schedule appointments, obtain directions to your office, learn about medical services, view educational videos, meet the office staff, refer another patient, ask a question, or request information.

• Push notification is a feature that allows your office to send a text to the patient’s phone announcing openings in your schedule, new services, specials, and new recruits to your practice.

About 6 months ago, I began using the Doctor App, acting as a “guinea pig” among 42 doctors in our practice.

Being a cataract surgeon with older patients, I often get the question, “What’s an app?” from my patients. We are working on educating patients with a desktop sign in the office and some conversations and quick demos.

I believe the Doctor App will take off for LASIK surgeons, pediatric ophthalmologists, and general ophthalmologists who are serving young through middle-aged, all of whom

continued on page 8
use smartphones more frequently. There’s no doubt that having an app improves communication between patients and doctors.

The Doctor App works well with my Facebook page, as one type of media supports the other. As compared to other forms of marketing, the price of an app for the physician is reasonable and creates a significant “wow” among younger patients. The app is free to the patient on the iPhone and Android devices. You can view my app at www.cloudninedevelopment.com under the title “Robert Melendez, MD.”

If you’re looking for a competitive edge against other practices, a practice app sets you apart. OB

Dr. Melendez is a cataract and refractive surgeon and partner with Eye Associates of New Mexico, and clinical assistant professor, Department of Surgery/Division of Ophthalmology, University of New Mexico. He can be contacted at rfmelendez@gmail.com.

Give your app this quiz

If you’re considering acquiring a practice app, ask these questions of each app product you’re evaluating:

1. How long has this app been in use?
2. How does the total cost (upfront cost and monthly charge) compare to similar apps and to other practice marketing tools?
3. Is this app branded to your practice on patients’ devices?
4. Does this app enable you to reach out to patients?
5. Does this app allow you to upload photos and graphics?
6. Is this app easy to set up? (Ask for physician users to contact.)
7. Is this app easy for patients to use? (Ask for demo and ask physician users.)
8. Does the cost include upgrades?
9. If you have a problem, is there live help, and who gives it? (Tech support should come from a high level.)

Gone mobile

Statistics show consumers love their mobile devices:

• It takes 90 minutes for the average person to respond to an email. It takes 90 seconds for the average person to respond to a text message.
• 70% of all mobile searches result in action within 1 hour.
• Mobile coupons get 10 times the redemption rate of traditional coupons.
• There are more mobile phones on the planet than there are TVs.
• 91% of all U.S. citizens have their mobile device within reach 24/7.
• It takes 26 hours for the average person to report a lost wallet. It takes 68 minutes for them to report a lost phone.
• There are 6.8 billion people on the planet. 5.1 billion of them own a cell phone, but only 4.2 billion own a toothbrush.
• In some countries, there are more mobile subscriptions than there are people. (How can this be? It’s because some people own more than one mobile phone.)

Source: Mobile Marketing Association
Missed an EyeWorld event at the 2012 ASCRS•ASOA Symposium & Congress?

Find out what happened here!

EyeWorld rePlay Special Edition offers video wrap-ups and pearls from EyeWorld events at the 2012 ASCRS•ASOA Symposium & Congress in Chicago.

Jump to the site using your smartphone and this QR code, or go to EWrePlay.org
Medical professionals: A prescription for your financial health


Just as patients need periodic checkups, you may need to work with a financial professional to make sure your finances receive the proper care.
More than ever before, the demands on medical practitioners can seem overwhelming. It’s no secret that healthcare delivery is changing, and those changes are reflected in the financial issues that healthcare professionals face every day. As an ophthalmologist you must continually educate yourself about new research in your chosen specialty, stay current on the latest technology that is transforming healthcare, and pay attention to business considerations, including ever-changing state and federal insurance regulations. With reimbursement headed south and office overhead heading north, it is imperative that you focus on your own personal financial security.

Like many, you may have transitioned from medical school and residency to being on your own with little formal preparation for the substantial financial issues you now face. Even the day-to-day concerns that affect most people—paying college tuition bills or student loans, planning for retirement, buying a home, insuring yourself and your business—have become even more complicated by the challenges and rewards of a medical practice. It’s no wonder that many medical practitioners look forward to the day when they can relax and enjoy the fruits of their labors.

Unfortunately, substantial demands on your time can make it difficult for you to accurately evaluate your financial plan or monitor changes that can affect it. That’s especially true given ongoing healthcare reform efforts that will affect the future of the industry as a whole. Just as patients need periodic check-ups, you may need to work with a financial professional to make sure your finances receive the proper care.

**Maximizing your personal assets**

Much like medicine, the field of finance has been the subject of much scientific research and data and should be approached with the same level of discipline and thoughtfulness. Making the most of your earning years requires a plan for addressing the following issues.

**Retirement:** Your years of advanced training in ophthalmology and perhaps the additional costs of launching and building a practice may have put you behind your peers outside the healthcare field by a decade or more in starting to save and invest for retirement. You may have found yourself struggling with debt from years of college, internship, and residency; later, there’s the ongoing juggling act between making mortgage payments, caring for your parents, paying for weddings and tuition for your children, and maybe trying to squeeze in a vacation here and there. Because starting to save early is such a powerful ally when it comes to building a nest egg, you may face a real challenge in assuring your own retirement. A solid financial plan can help.

**Investments:** Getting a late start on saving for retirement can create other problems. For example, you might be tempted to try to make up for lost time by making investment choices that carry an inappropriate level or type of risk for you. Speculating with money you will need in the next year or two could leave you short when you need that money. And once your earnings improve, you may be tempted to overspend on luxuries you were denied during the lean years. One of the benefits of a long-range financial plan is that it can help you protect your assets—and your future—from inappropriate choices.

**Tuition:** Many medical professionals not only must pay off student loans, but also have a strong desire to help their children with college costs, precisely because they began their own careers saddled with large debts.

**Tax considerations:** Once the lean years are behind you, your success means you probably need to pay more attention to tax-aware investing strategies that help you keep more of what you earn.

**Using preventive care**

The nature of your profession requires that you pay special attention to making sure you are protected both personally and professionally from the financial consequences of legal action, a medical emergency of your own, and business difficulties. Having a well-defined protection plan can give you confidence that you can practice your chosen profession without putting your family or future in jeopardy.

*continued on page 12*
Liability insurance: Medical professionals are caught financially between rising premiums for malpractice insurance and fixed reimbursements from managed care programs, and you may find yourself evaluating a variety of approaches to providing that protection. Some physicians also carry insurance that protects them against unintentional billing errors or omissions. Remember that in addition to potential malpractice claims, you face the same potential liabilities as other business owners. You should consider an umbrella policy as well as coverage that protects you against business-related exposures such as fire, theft, employee dishonesty, or business interruption.

Disability insurance: Your income depends on your ability to function, especially if you’re a solo practitioner, and you may have fixed overhead costs that would need to be covered if your ability to work was impaired. One choice you’ll face is how early in your career to purchase disability insurance. Age plays a role in determining premiums, and you may qualify for lower premiums if you are relatively young. When evaluating disability income policies, medical professionals should pay special attention to how the policy defines disability. Look for a liberal definition such as “own occupation,” which can help ensure that you’re covered in case you can’t practice in your chosen specialty. To protect your business if you become disabled, consider business overhead expense insurance that will cover routine expenses such as payroll, utilities, and equipment rental.

**Practice management and business planning**

Is a group practice more advantageous than operating solo, taking in a junior colleague, or working for a managed care network? If you have an independent practice, should you own or rent your office space? What are the pros and cons of taking over an existing practice compared to starting one from scratch? If you’re part of a group practice, is the practice structured financially to accommodate the needs of all partners? Does running a “concierge” or retainer practice appeal to you? If you’re considering expansion, how should you finance it? Questions like these are rarely simple and should be done in the context of an overall financial plan that takes into account both your personal and professional goals.

**Practice valuation**

You may have to make tradeoffs between maximizing current income from your practice and maximizing its value as an asset for eventual sale. Also, timing the sale of a practice and minimizing taxes on its proceeds can be complex. If you’re planning a business succession or considering changing practices or even careers, you might benefit from help with evaluating the financial consequences of those decisions.

**Estate planning**

Estate planning, which can both minimize taxes and further your personal and philanthropic goals, probably will become important to you at some point.

Options you might consider include:
- Life insurance
- Buy-sell agreements for your practice
- Charitable trusts

You’ve spent a long time acquiring and maintaining expertise in your field, and your patients rely on your specialized knowledge. Doesn’t it make sense to treat your finances with the same level of care? 

**Note**

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Some fundamental observations about ethics

by John D. Banja, Ph.D.

Because the feature of this issue of Ophthalmology Business focuses on ethics and because I’ve been calling myself an “ethicist” for 30 years (implying I know something about it), I thought I might make some basic points about ethics itself.

The first point concerns the difference between ethics and morality. Technically, morality refers to the beliefs and values that guide a person’s behavior and that inform him or her about right and wrong and good and evil. Ethics, however, involves reflecting on and analyzing those values and beliefs with a view to whether they best preserve human rights, accomplish the most good or the least amount of harm, and are fair and just. So any “ism”—libertarianism, liberalism, totalitarianism, Protestantism, Catholicism, Judaism, atheism—is characterized by a “morality” or a set of moral beliefs and values. But it’s when we start rigorously examining that belief structure and asking, “Is this the best we can do? Are these beliefs and values of mine the most reasonable and the most conducive to behaving rightly and decently? Do they hold up to rigorous scrutiny?” that we start doing ethics.

Consider this example. In his book Waking Up Blind: Lawsuits Over Eye Surgery (Langdon Street Press, 2009) ophthalmologist Tom Harbin, M.D., relates a story about an Emory ophthalmologist who, 30 years ago, allegedly had a practice of scheduling his well-insured patients early in the day, with underinsured or uninsured patients scheduled much later in the day. Bearing in mind that this latter group of patients were mostly African-American, this meant that they would arrive at Emory early on the day of their surgery but then experience hours and hours of waiting. What would the distinction between morality and ethics say about this?

The primary ethical issue we’re looking at is how benefits and burdens were distributed among this physician’s patients, and the key justification in his length-of-wait distribution scheme was the amount of reimbursement his clinic received. Apparently, he felt it morally fair that better paying patients should experience less discomfort in their awaiting surgery, while lesser paying or uninsured patients could justifiably experience more. The ethical questions are: Is that policy in fact fair? Would it pass ethical muster?

I’ve always thought this to be an interesting case. Some readers might denounce this scheduling practice as discriminatory by saying that benefits and burdens should be distributed evenly among patients because they are all equally deserving human beings. Others might condemn the practice on the grounds that as a surgical day wears on and provider fatigue sets in, patients scheduled later in the day will bear a greater risk of harm from errors or bad judgment calls. Consistently exposing one particular group of patients, i.e., the less well insured, to that aggravated risk of harm is discriminatory. Furthermore, if patients with little or no insurance routinely present with greater disease acuity such that their operations are technically more challenging, then the risk of harm to them from late-in-the-day scheduling is compounded even more.

These seem to be compelling ethical concerns that I’d say should win the argument. But let’s suppose, just hypothetically, that the providers’ fatigue levels in this case never fall below a threshold of unreasonable risk so that the only burden that the patients scheduled
... ethical reasoning becomes frustrating because we frequently can’t find a compelling way to prove that this or that ethical argument is the correct one

later in the day would experience is the discomfort of their wait. Would the policy then be ethical or not?

Why couldn’t someone argue that the marginal profits obtained from better insured patients make it possible, through cost shifting, for the poorly insured or uninsured patients to in fact have their surgeries? This argument would say that it isn’t ethically wrong to make the latter bear more discomfort per their waits because they benefit enormously from those patients whose insurers pay more for the same procedures. Consequently, the inconvenience of their waits is more than justified (because it is offset) by the benefit they receive from the earlier scheduled patients, whose generous reimbursements to the clinic make their surgeries possible.

Nevertheless, others might respond that underinsured or uninsured patients do “pay” their way because they comprise a large fraction of patients on whom medical students and residents have historically practiced on in learning their trade. Although these patients’ insurance reimbursement might not cover costs, many physician training programs would be severely compromised if not become extinct without them.

These arguments and counterarguments bring up a second point about ethical judgment: Where does one go for the ethically “correct” answer? This is where ethical reasoning becomes frustrating because we frequently can’t find a compelling way to prove that this or that ethical argument is the correct one in the way we can consult the periodic chart of the elements to determine the molecular structure of plutonium. Nevertheless, some ethical opinions are better than others so that one way of testing whether this ophthalmologist’s scheduling practice at least met a minimal ethical threshold is to convene a group of his peers and ask them to analyze the policy’s pros and cons. If peer groups of ophthalmologists and other ethically reasonable people would consistently and consensually accept or denounce the policy given their various reasons, then I’d say that’s about as “objective” as we can get in matters of ethical reasoning. This doesn’t say that 50,000 ophthalmologists can’t be wrong, but it does say that if ethically conscientious individuals would consider this case, reason as best they could about it, and ultimately find the policy acceptable or unacceptable, then that’s probably the best we can do. And doing the best you can is very good, indeed.

A third point: Notice that codes of ethics and even legal regulations are often of little help in cases like this. Codes of ethics are nearly always written in too broad a language to be helpful in down-to-earth cases like this one. Legal regulations and case precedents, on the other hand, might be very helpful, especially if they would directly address the issue at hand. But if there are no legal precedents or rules available—and there frequently aren’t—then the law obviously won’t be of much help either. Indeed, our case would be an interesting one to analyze from a discrimination standpoint since the patients aren’t being denied a service but are “merely” being made to wait extra hours to receive their care. Would the courts deem that wait “unreasonably burdensome” or rule that it singles out a particular group of patients and places them at an undue and unfair degree of risk?

A final point is that ethics, as opposed to morality, is ultimately about justification. Whereas moral positions take their correctness for granted, the proof of the ethical pudding is in the quality of the arguments and the reasons we give for our moral positions. Ultimately, if we wonder whether our moral positions are ethically defensible or not, we should put them to our peers and our organizational leadership, such as ASCRS, for debate. We should especially ask ourselves if we could defend our positions publicly or would we be embarrassed by them? I’ve always told physicians that if you can defend your moral practices and beliefs by looking straight into the TV camera and confidently give a thoughtful and coherent account of why you did what you did or believe what you believe, you’re probably ethically OK. It’s when we refuse to be accountable that we start looking ethically suspicious. OB
The ophthalmologist and the angry patient

by Faith A. Hayden Contributing Writer
**Ethical strategies for taming tempers**

Picture this: It’s a busy day at the clinic and you’ve fallen behind schedule. Mr. Jones paces around the waiting room, seething. It’s 45 minutes past his appointment time, and his post-op refraction after cataract surgery doesn’t meet his expectations. Mr. Jones is frustrated, angry, and targets an unsuspecting receptionist to unload on—in front of a waiting room of people.

Sound familiar?

If it doesn’t yet, it will. Ophthalmologists across all specialties are bound to run into a cantankerous, volatile patient eventually, regardless of physician skill or staff professionalism.

“It happens a couple times a year,” said Vonda Syler, C.O.E., McDonald Eye Associates, Fayetteville, Ark. “I can think of one several years ago who got really irate and was taking it out on the staff. He was quite unbearable in the office. It did get to the point where I had to talk to him about his behavior; as in most circumstances, he had other issues in his life that were affecting his behavior and calling [this] to his attention changed his attitude.”

**Physician protocol**

Dealing with an angry patient presents a number of challenges to staff and physicians. Although situations vary, there are best practices an office can invoke regardless of the circumstances. The number one priority for all parties is controlling emotions.

“It’s important the physician never communicates any hostility toward the patient, no matter how much the clinician dislikes the patient or wishes that the patient be treated by someone else,” said John Banja, Ph.D., professor and medical ethicist, Emory University, Atlanta.

Gary Foster, M.D., a Colorado-based cataract and refractive surgeon, agreed. “The natural reaction when someone expresses anger toward you … is to respond with anger,” he said. “But that escalates the tension and decreases the chance that any successful resolution will be accomplished.”

For instance, if a patient is frustrated with his treatment, both Drs. Foster and Banja strongly recommended physicians approach the patient with kindness and compassion.

“The first step is to make sure you give the patient a chance to express clearly what he’s frustrated about,” said Dr. Foster. “The second step is for the doctor to say he is sorry that the patient is frustrated about this issue, which is very different from saying you’re sorry and it’s your fault.”

When having a potentially contentious conversation with a patient, Dr. Foster sits next to the patient, rather than across from him, so they’re on the same team. He also makes sure to show the patient on a chart exactly where they are in treatment and outline on paper how they can partner to move forward. The emphasis is on working together to solve the problem and meet the original goal.

“It’s hard to get and stay angry at someone who tirelessly supports you and obviously wants to help you,” said Dr. Banja.

**Staff strategies**

Staff, though, have to handle angry patients a bit differently than physicians as the issues are dissimilar. Staff tends to receive the brunt of patients’ bad attitude, especially when patients don’t understand their bill or feel their time is being disrespected. Regrettfully, these instances are likely to unfold in the middle of a busy waiting room with a captive audience. In those situations, the most important step is to immediately move the angry patient into an isolated exam room or office so others aren’t unnecessarily alarmed.

The next step is to have either the attending physician or office administrator “inform the patient that his or her upsetting comments to other patients in the waiting room aren’t appropriate and cannot be tolerated,” said Dr. Banja.

An administrator’s job doesn’t end with disciplining the problem patient, however. The administrator has to contend with the patients who witnessed the confrontation who may have questions about the situation. It’s here that the importance of staff training comes into play, as HIPAA laws put a gag order on how much staff can reveal.

“Sometimes you can say a word or two to diffuse things and make everyone smile a bit, but you’re limited with what you can do with that,” said Dr. Foster. Although you

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**Dealing with an angry patient presents a number of challenges to staff and physicians. Although situations vary, there are best practices an office can invoke regardless of the circumstances**

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can’t reveal any personal information, “you can say, ‘Everyone has a bad day sometimes, but no matter what we’re here for folks,’” Dr. Foster continued. “That lets the patients know you’re compassionate about [the situation] but you’ve got it under control, and the sky isn’t falling.”

Ms. Syler takes a more hard-line approach. “I just say anything involving patients is a private matter,” she said.

**Worst-case scenarios**

Occasionally, a physician and staff will come across a patient so irrational and abusive that the above strategies will fail. In those rare instances, “divorcing” the patient from the practice may be the only option.

But “the clinician cannot abandon the patient,” said Dr. Banja. “This means that if the patient has a clear and obvious need for continued treatment but must depend on that clinician and only that clinician for care—because it would be unreasonable to expect the patient to get treatment from another capable care provider— the clinician is professionally obligated to grin and bear it and remain with that patient. Otherwise, he or she would be guilty of abandonment. Then, if the patient’s condition would worsen, the physician would be ethically and legally liable for allowing harm to occur.”

Luckily, there’s typically more than one clinic that can meet a patient’s needs. In those situations, Ms. Syler has a form letter she sends to patients, severing ties with the practice.

[The letter] says we’ve determined our office is not a good fit for them, and although we’ve enjoyed our time with them, we feel another office would better suit their needs,” she said. “We give [patients] a list of other area practices they can go to, tell them we will cover them for any emergencies for 30 days, and wish them well.”

The obvious goal, though, is to never get to this point. Dr. Foster believes firing a patient does more harm than good, on both ends.

“It’s much better if the doctor remains an adult when the patient throws a tantrum and their relationship is maintained because in that process, the relationship strengthens,” he said. “The original treating doctor is generally the one in the best position to help the patient heal. If the relationship breaks down and the patient goes somewhere else, his anger and frustration can hinder him from healing and finding a resolution to the problem. In that initial grievance, the doctor can remain calm and work on a pathway to a solution, and the patient tends to heal much faster and in the long run have a better result.”

**Resources for physicians and administrators**

Managing belligerent patients is challenging, but there are resources physicians and administrators can turn to for extra guidance.

“In order to avoid legal ramifications, physicians can utilize HR Online, an ASOA member service that allows them to confidentially submit questions and receive advice from human resources experts,” said Lisa Marie Romano, ASCRS•ASOA marketing manager. “Patient relations are also frequently discussed in ASOA EyeMail; physicians have the option to compare how other ophthalmic practices have managed similar situations. ASOA EyeMail is an online discussion list/forum that connects participants to consultants, certified ophthalmic executives (C.O.E.s), and ophthalmic colleagues. Receive these services by signing up for an ASOA membership or a 3-month free trial ASOA membership. Contact asoa@asoainfo.org or visit www.asoa.org.”

On the empathy side, Dr. Banja recommended the following books: Jodi Halpern’s *From Detached Concern to Empathy*; Robert Buckman’s *How To Break Bad News*; and Albert Bernstein’s *Emotional Vampires*.

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Editors’ note: The sources have no financial interests related to this article.
Monday, November 12

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The Amazing Race for Improved Outcomes in Customized Laser Refractive and Cataract Surgery

Supported by an educational grant from Abbott Medical Optics Inc.

6:30 – 7:00 AM Registration

7:00 – 8:00 AM Program

Program Chair Eric D. Donnenfeld, MD

Faculty Perry S. Binder, MD
Steven C. Schallhorn, MD
David J. Tanzer, MD

Preliminary Program

7:00 AM Destinations and Challenges — Eric D. Donnenfeld, MD

7:10 AM Defining Success in Laser Vision Correction
— David J. Tanzer, MD

7:27 AM Pit Stop: Assessing the Impact of Customized Arcuate Incisions on Astigmatic Correction Nomograms and Outcomes — Steven C. Schallhorn, MD

7:45 AM Around the World of Femto CCIs: Maximizing Wound Architecture and Integrity — Perry S. Binder, MD

8:00 AM Adjourn

www.EyeWorld.org
"It is pretty hard to tell what does bring happiness; poverty and wealth have both failed"

Kim Hubbard
Passing the hat to patients

“Poverty is the schoolmaster of character”

by John B. Pinto

Mr. Anatoly Brunton, our beloved 9th-grade English teacher, was not a snappy dresser. For the entire year, each day he wore one of two threadbare suits—one brown, one gray. He carried his burden as a still-poor immigrant on his shiny coat sleeves, reminding us—his room of mostly lower-middle class students—how lucky we were to be able to eat every day. Or come to school in safety. Or see a doctor when we were sick.

Mr. Brunton had perpetually sad eyes—the kind that even misbehaving boys like us settled down for, not wanting to make them even sadder. As we came to learn over that year, he had barely survived World War II and came west after it was over.

Each class day, Mr. Brunton would end the class period with a short story from his life. Some funny, some frightening, and all ending with the same appeal: “Appreciate what you have, kids. And if you have a little lunch money left over, please drop it in the jar on the way out. Today is ‘Penny Pinching Day.’”

Hitting one’s students up for their lunch money would probably be prosecuted as a crime today. Mr. Brunton sent the funds, or so he told us, to the people he had left behind in Eastern Europe. Maybe it was true.

Why do I share this? Because everyone reading this—even those of you who grew up lean like me, or who have been more recently personally impacted by the Great Recession—are living a life today of relative abundance, relative to your past, perhaps, but also to your future.

If you’re a practice administrator or a technician—even a front desk clerk—you earn vastly more than Mr. Brunton did as a public school teacher.

And if you’re an ophthalmologist, you’re likely a member of the now-hounded 1%. Enjoy the moment. It may not last. Profound change is coming to eyecare as we all stand at the intersection between our fat, limitless past and the inevitable future limits to healthcare cost escalation.

Here are some of the current signposts that the past will not be prelude.

• Less elaborately, another new iPhone app “Pupil Meter” is now available, allowing your patients to more accurately untether themselves from your care.

• At last check, a Google search for “buy eyeglasses online” generates 9.7 million hits.

• I’ve recently run into a company, one of several likely to emerge, that plans to launch mini-exam booths. Step into a small cubicle and a few minutes later you’ve not only been screened for eye disease (and referred on to a collaborating local provider, maybe someone who owns a stake in the booth), but you have a prescription for glasses in hand.

• In many states the percentage of Medicaid beneficiaries is growing, while enrollment in private insurance plans is shrinking, not only from job loss but from employers hitting the breaking point and having to reduce or withhold health benefits to stay in business.

• For the last 33 years, most of the surgeons I know have enjoyed a year-on-year pay raise. Even in the middle of this last recession, most practices have done well with three kinds of fear: surgeons who feared looming fee cuts and redoubled promotional efforts; commercial patients who feared job loss and came in to use vision care and

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optical benefits that might not always be there; and senior patients who came in for the same reason, many of them fearing that their Medicare benefits were on the line.

- In one client setting, we’re about to acquiesce to a pending reduction in Medicaid fees—not because we want to, but because we have to. Medicaid payments provide just enough marginal revenue to stay afloat in this tough setting.

- In another client’s office, Medicaid fees for pediatric ophthalmology services have just been reset well below historic figures. This doctor could likely be closing the practice and retiring shortly, leaving patients in a 200-mile radius without subspecialty care.

- In numerous large client settings, our 10-year business plan is to take over (through mergers, acquisitions, and new office development forcing out those who won’t join us) a substantial majority of the remaining private practice eyecare in our service area.

- Many of the country’s heretofore “struggling but safe” eye surgeons are one bad vote in Washington away from disaster. I’ve got scores of clients with profit margins below 30% (while norms range from 35-45% and higher). Some of these low-profit surgeons got that way because they chose to practice in costly urban and suburban settings with too many doctors. Others have been painted into a corner with debt from their education or a past business misstep. For the typical general ophthalmologist with a 25% profit margin today, a 5% Medicare fee reduction along with even mild inflation will result in a 25% pay cut. Imagine what would happen if Medicare shaved off 10%.

- Surgeons who once blanched at the idea of seeing more than 25 patients in a day are now obliged to hit more than 40 visits in order to make payroll. In the future, if lower payments arrive, 50+ patients will have to be seen—if they can be found.

- Later this year I’ll be launching a new collaborative study with several clients on opportunities for “frugal innovation.” We’re doing this on the assumption that profit enhancement—once almost entirely dependent on revenue gains—must now simultaneously depend on a material reduction in the cost to serve each patient. On the hit list will be things we never fussed with before, like having regular employees handle routine office cleaning throughout the course of the day (saving the cost of a night janitor), or switching from the sharply creased cotton lab coats the doctors like to polyester ones because the docs can take them home and throw them in the washer instead of paying for dry cleaning. In the future environment, these picayunish savings, when added up, will be meaningful.

Because the economic recover is anemic and our leaders are divided as to a solution, the federal deficit will continue. Because of ongoing deficits, the nation’s debt as a percent of GDP will keep sailing well past the 100% warning line and reach levels that briskly elevate our borrowing costs. As borrowing costs rise, interest payments will edge out funds available for the entitlement spending, which supports 60% or more of the typical ophthalmology practice.

This will compel lawmakers to take emergency steps, and we’ll undertake an obliged phase shift in the way that healthcare is paid for. When the music stops, there won’t be enough chairs for everyone. And the chairs still left will not be quite as overstuffed as in the past.

No matter the pace of events, I’m sure we’ll all learn to make adjustments, just like Mr. Brunton. Maybe he was on to something. And at some breaking point in the future, we will say to every patient, “If you have a little lunch money left over, please drop it in the jar on the way out. Today is ‘Parsimonious Day.’”  

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Apps selected will be published in Ophthalmology Business and their submitters will receive a $50 iTunes card. You may be selected for a brief interview.
Medical practices are seeking ways to cut costs and stay competitive during these challenging times, and many are adding part-time employees (PTEs) to their full-time teams. Because PTEs typically do not receive benefits, such as health or unemployment insurance, using them can cut personnel costs by as much as 30%, a key selling point in today’s fragile economy.

While there are similarities between full-time employees (FTEs) and their part-time counterparts, there are major differences in the roles they play. PTEs often perform a lower level of work, filling minor, day-to-day tasks, such as filing and light data entry, and/or tasks that may seem tedious and repetitious. Generally speaking, PTEs fill jobs that offer little chance for advancement, and job satisfaction is minimal.

For the most part, motivating PTEs is a little harder to accomplish than motivating FTEs because they may feel: 1) left out of the communication loop, 2) alienated from the friendships that form between full-timers, and 3) just plain different. Unless you are content to address your part-timers separately from the rest of your office staff, thus doubling your work and leaving the practice vulnerable to potential time-consuming problems, you must first put in place a strategy to integrate your PTEs into your practice.

Bridge the differences to motivate your PTEs

A manager can embrace the challenges that part-time workers represent and turn them into a potent force. To effectively integrate PTEs into the practice culture, you must bridge the differences between them and discover ways to include them as part of the practice team. The following tips can help you discover what motivates your PTEs:

- **Orient them to the practice.** Take 15 minutes to examine the PTE’s job description or duties in the practice. Review with him/her the employee policy and procedure manual on basic practice policy. Avoid future confusion for both types of employees by clearly identifying who is authorized to assign work and perform specific tasks. Most people will play within the rules if they know what those rules are before the game begins.

- **Assign a mentor.** Assign each part-timer a full-time mentor. This serves two purposes: 1) the mentor feels valued in the practice, and 2) the PTE has someone to go to with relatively minor problems and feels more like part of the team. When choosing a mentor, pick someone who is patient and has the time and ability to answer questions.

- **Mix up the workload.** While it is common to give PTEs the work assignments no one else wants, be careful not to overload them with tedious tasks; it is demoralizing, and the end result could be negative. Be sure to find out what specialized skills each has and capitalize on those strengths when assigning work.

- **Eliminate any hard feelings right from the start.** Make sure your full-timers know why you are hiring part-time help and assure them that their jobs are not in danger.

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Helen J. Harris recounts her struggles with retinitis pigmentosa and the drive that helped her create RP International

Helen J. Harris may well be remembered most for her enthusiastic, positive attitude about retinitis pigmentosa, as well as being the founder of RP International, a non-profit dedicated to finding a cure for the devastating disease. But only by reading her autobiography, peppered with original poems and reproductions of her paintings, does one realize Ms. Harris' embarrassment as a child, her pride in refusing to ask for help until her eyesight was almost completely gone, and her wish to be able to see again. She might have continued suffering from her disease in silence had she not realized she had passed the disease onto two of her three children. Hence, in 1974, RP International was founded.

Ms. Harris began noticing her vision was "not right" in her early childhood years—years marked by skinned knees, a debilitating fear of walking anywhere at night (due to night blindness), and several emergency room visits after falling or tripping in broad daylight—but found solace in being recognized as a talented artist. She allowed others to label her a klutz rather than admit she could not see. Her description of her descent into darkness is particularly poignant, given the accolades she’d received as a painter: "Imagine the horror of being a talented artist, someone whose greatest joy is to pick up paintbrushes and express emotions on canvas, only to have that gift slowly and insidiously extinguished by darkness—a blindness that begins almost imperceptibly in the early years of life, which gradually closes your peripheral vision, making your world smaller and darker with each passing year until only a tiny pinhole of light remains."

With more than 30 million people in the U.S. suffering from some type of retinal disorder, Ms. Harris believes a lack of general awareness of RP is what has hampered patients...
from receiving proper diagnoses earlier as well as researchers finding causes and cures.

Realizing she began suffering from RP at 8 years old, Ms. Harris recalls her family simply calling her clumsy—and every vision test given to her as a child in the 1940s came back as “20/20” vision. Her deteriorating vision altered her from an outgoing child to an almost-recluse as a teenager. (One major goal of RP International is to ensure all children receive peripheral vision screening as well as Snellen acuity to ensure a misdiagnosis of RP does not occur.)

“As founder of RP International, I’ve become aware of many misdiagnosed cases with even worse consequences. Undiagnosed retinal disease sufferers have fallen victim to accidents that could have been prevented, such as being hit by cars, falling, getting lost, and wandering into dangerous situations,” she writes. At the time, physicians were mistakenly diagnosing RP as strokes or brain tumors, she said.

A difficult youth
A good deal of Ms. Harris’ memoirs are dedicated to her struggle to overcome the stereotype of the white cane—a sure sign she was blind, and while she had “vision problems,” she refused for years to accept that she was legally blind and had virtually no ability to function on her own. After all, vision tests continued to prove she was 20/20. When she finally does accept her need for a white cane, she lets readers know it’s not intuitive—users need about 200 hours of “intensive training” before they can safely handle themselves in various situations.

“If this book does nothing else but reach one person who succeeds in learning mobility skills and using them despite the problems, it will have been a success,” she writes.

Ms. Harris is a gifted storyteller, eloquently describing her initial resistance to both the white cane and her mobility specialist (again, these were the days before low vision aids were available). She jokingly refers to her age-related macular degeneration counterparts as her other half—as she lost all peripheral vision due to RP, her AMD friends had lost all their central vision.

Once the reader understands the incredible obstacles Ms. Harris faced—being the first person with absolutely no business acumen or previous fundraising experience to

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create an organization dedicated to abolishing the disease—it becomes heartfelt to read how quickly Charlton and Linda Heston (and many other Hollywood elite) came on board and supported the organization financially and through fundraisers. It’s obvious once RP International got established, Ms. Harris’ memoirs truly come to life. Throughout the book she regales readers with her own poetry, which mostly describes her angst at no longer being able to see, and litters chapter introductions with accolades from the multitude of speakers at RP International’s Vision Awards. Among the noted ophthalmologists and scientists honored at the Vision Awards: Jules Stein, M.D.; Roy H. Steinberg, M.D.; Gholam Peyman, M.D.; Herbert Kaufman, M.D.; Alan Latties, M.D.; Dean Bok, Ph.D.; Thomas S. Tooma, M.D.; Keith Black, M.D.; SriniVas Sadda, M.D.; Kerry Assil, M.D.; Mark Humayun, M.D.; Vincent Chow and Alan Chow, M.D.; Shalesh Kaushal, M.D.; and Gavin Herbert.

Ms. Harris shares stories from her younger days, days when her pride and concern about outward appearances were all-consuming. In essence, Ms. Harris ostracized herself from humanity and from the social life she so clearly enjoyed because she refused to admit she had vision issues. First she stopped going to the movies with her siblings, since she couldn’t see the screen and other patrons were intolerant of the movie being described in detail to her. Next, she became a recluse when her family bought its first TV, as she again could not see the screen.

But because she was unable to enjoy one of her favorite pastimes, as an adult she vowed all blind people would be able to go to the movies and use ear pieces that would describe the onscreen happenings in detail. Forrest Gump became the first film to be described for blind people. One of Ms. Harris’ goals is to have TheatreVision in every theater in the nation so people with severe vision issues can attend movies alongside their sighted friends.

For the reader, Ms. Harris offers 13 steps for “surviving retinal disorders,” among them informing others of personal vision issues, trying to maintain a positive attitude while allowing self pity to occupy only 5 minutes daily, and incorporating healthy diet and exercise into daily routines. Ms. Harris also includes a section on treatments currently being evaluated for RP, including increasing vitamin A intake.

But finally, perhaps the most telling page of her memoirs is the final one—a blank page, “waiting for a cure for RP.”

Sell the FTEs on the concept that this is an attempt to make their jobs easier and more rewarding. Open communication with staff members during staff changes is critical in maintaining trust and loyalty within a practice.

• **Offer flexible hours.** Many employees have situations that may allow them to work only part time. Use this to your advantage. By allowing flexibility for employees with part-time hours, you will retain these employees longer, thus eliminating the costly expense of retraining. If circumstances change for the employee and the practice, and a new position opens up at the same time your PTE would like more hours, you will already have a trained, experienced employee who has become a part of your team.

• **Present financial incentives.** Most practices don’t offer PTEs any bonuses. That may be a mistake. Set up a bonus plan for them based on company revenues, as this may be the spark that ignites their interest and enthusiasm and gets them motivated to excel. Offer your PTEs a raise after a period of review and training. This will keep your competitors from raiding your employee pool, forcing you to rehire and retrain. Many PTEs become full time after a period of time based on proven performance and practice need.

• **Include PTEs in company activities and culture.** Employees who work fewer hours will find that a lot goes on in their absence. Make a point to include your part-timers in company-based activities (holiday parties, planning meetings, etc.). Inclusion strengthens your team and solidifies morale. A successful practice can always find value in a fresh perspective and new talent.

**Treat PTEs like family**

Often overlooked as a valuable asset to the office, PTEs may prove a veritable wealth of talent. Pairing them up with a full-time mentor and including them in staff meetings, bonus programs, interesting work assignments, and company activities will help minimize any sense of isolation and alienation a part-timer might be feeling. Treating part-timers like they are part of the family from the start will result in better work performance from these individuals.
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