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From the Publisher

This issue of Ophthalmology Business opens with part one of a series of articles based on a retirement seminar led by I. Howard Fine, M.D., titled, “Retirement done right.” The first article of the series is, “Building your practice before you leave it.” Whether it’s 1, 5, or even 15 years away, you need to build your practice with your retirement in mind—don’t retire without a plan for the future!

Great leadership is important, but what do you do when the responsibility rests on your shoulders? In an excerpt from his new book, Ophthalmic Leadership: A Practical Guide for Physicians, Administrators and Teams, John B. Pinto shares his insight into the thermodynamics of practice leadership.

“Every practice and every business is defined by its people.” From smart hiring to relevant training, learn how to make your people your best asset in the current economic climate in “The value of people in this economy.”

If you build it, they will come. You’ve hired and trained the best staff, now you need to build your patient base. “New marketing trends for your practice” shows you how. This article provides you with the latest trends in marketing technology and the ways in which they can benefit your practice.

Want to keep the patient base that you build? “Eye apps: Patient education enters the 21st century” details how a growing number of digital patient education tools provide basic information about a range of conditions and aim to improve the quality of patient/clinician encounters. And find more pearls on keeping your patients in “How to keep from being fired by your patient.”

Thanks for reading.

Donald R. Long
Publisher, Ophthalmology Business
From the Publisher

I. Howard Fine, M.D.’s Retirement done right series: Build your practice before you leave it
The how and why behind pre-retirement practice building
by Jena Passut

The thermodynamics of practice leadership
Keeping your practice’s positive “chemical reaction” going
by John B. Pinto

Second Sight: Views from an eye doctor’s odyssey
Review of David Paton, M.D.’s book reviewed by Michelle Dalton

The value of people in this economy
Navigating the rough waters of today’s economy without cutting corners when it comes to your people
by Brad McCorkle

New marketing trends for your practice
The latest trends in marketing technology and how they can benefit your practice.
by Paul M. Stubenbordt

Eye apps: Patient education enters the 21st century
Overview of some of the hottest digital patient education tools that aim to improve the quality of patient/clinician encounters
by Rich Daly

How to keep from being fired by your patient
Reasons why patients might “fire” their physician and how you can proactively address each of these areas
by Brad Ruden, M.B.A.

Anxious patient types, responses vary
Surgeons offer a wide array of suggestions for spotting and addressing anxiety in patients
by Rich Daly

Navigating corrective action
When and how to approach an unethical colleague
by Faith Hayden

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It may sound backward—build your practice and bring on associates before you retire—but that’s one of the crucial first steps in the long retirement process, according to recent retiree I. Howard Fine, M.D., Oregon Eye Specialists, Eugene, Ore.

Besides the obvious pride that comes with success, practice building can help ensure the legacy of the practice, Dr. Fine said. “It’s important because people have to have a vision of what they want their practice to be, and they have to have a plan to do it,” Dr. Fine said. “Practice building is an important asset for everyone. At the time of retirement, it can add value to the transaction. If a physician builds a big practice, a successful practice, then it has value. Someone
is more likely to buy it. A ho-hum practice with a ho-hum profile is not very saleable."

In almost all instances, Dr. Fine said, practice building means bringing on new associates, mentoring them, and promoting their career.

Dr. Fine and his partners Richard S. Hoffman, M.D., and Mark Packer, M.D., took part in a panel discussion on retirement that will be the focus of a series of articles in Ophthalmology Business. Clinic administrator Laurie Brown, C.O.M.T., C.O.E., O.C.S., psychologist Tom Fauria, Ph.D., and medical consultant Bruce Maller also participated in the panel discussion, which began with a talk about building a practice before leaving it.

Dr. Fine: People frequently don’t make the decisions that are necessary or the choices that are best in practice building and bringing on associates. A strong practice can be a marketable asset that facilitates retirement. In practice building, you need a vision of what you want from your practice and what you want your practice to be. If you don’t have a vision of where you want to go, you are never going to get there. You also have to understand that you are going to need others to help you. We aren’t prima donnas who can function because of divine right. We rely heavily on our team of fellow workers.

I think our practice is recognized as a successful practice, but you don’t have to have a practice like ours, and you don’t have to have the type of visibility that we do because you have a unique marketplace, and you have a visibility and a posture within that marketplace, and it should be what you want it to be. My practice is what it is because I always knew that I wanted a practice that would be a blend of patient care, teaching, clinical research, and working with organizations that support physicians. I wanted a practice environment that would allow unlimited growth for all of our employees.

A part of my exit strategy, which I started to develop mid-career, was that I wanted the practice that I had established and the infrastructure for it to continue on after I was no longer practicing. When you bring on an associate, you have to appreciate that he or she has had a lot of training and spent a lot on education. You are a shepherd for the early years in his or her career. You’ve got to be helpful, give good advice and constructive criticism. You’ve got to allow his or her personality and the stamp of his or her views on all aspects of medical practice. I specifically recruited Rich Hoffman because he was uniquely talented as a surgeon. I needed someone who could take the difficult and challenging cases that had been referred to me back to the OR if they needed surgical intervention while I was out of town.

Mark Packer was very interested in participating in research and was willing to travel. Rich Hoffman had four very young children, and there was no way his wife was going to let him escape the experience of toilet training to travel to exotic places in the world, so we needed someone who would be able to travel.

I went to Bruce Maller and said, “Bruce, you understand how these things work. I would like to bring this associate on and he wants to come. We’re both going to hire you. I’m not paying your fee and he’s not paying your fee. We’re going to split your fee, and your job is to make the deal happen.” He arbitrated all of the issues that came up, resulting in a smooth and comfortable coming together.

One of the things you have to do when you bring on an associate is promote his or her career. What I did was bring [Drs. Hoffman and Packer] immediately into all of my research so their names could go on the papers, and I could lend my credibility to them early in the course of their careers. Early on, they would write the papers. It was all my data, but they wrote them. We had them become senior authors quickly. They were included on all FDA-monitored studies. I would turn down a study that wouldn’t include them as investigators. I gave up one of my columns in the medical press. They took that over. They got on the scientific advisory boards for the investigational studies we were doing. I made sure they got consulting agreements and speaking and teaching opportunities. I did the best I could to create opportunities for them to meet other ophthalmology leaders in the same way that you may make an opportunity for your new associate to meet business leaders in your community or other members of the medical or academic establishment.

The name of the game is you’ve got to create opportunities for them. They start out as employees with additional funds available if they reach certain levels of productivity. At the time that I sold the first half of the practice to them, I put them in a position to earn from all of our associated business entities—the surgery center, the optical shop, and the diagnostic lab. Even though the buying price was high, as they were buying in, they were taking home more money than they were taking home when they were employees. I gave them these opportunities, and we all won.

If you promote your new associate’s practice and he or she gets busier, it doesn’t take anything away from you. It makes your overhead lower. You end up with a net gain. If you don’t grow your associate’s practice while you are there, he or she

continued on page 8
may never grow into the position you would like after you leave. You have to start early on giving up certain things so that he emerges as a leader because he may not emerge as well as he could if you try and maintain the spotlight on yourself until after you leave the practice. My aim was to have them eclipse me by the time I retired.

Very frequently you have to recognize your own ego urges and avoid so-called “wrong and unfair issues.” Tom Fauria has helped me with this a great deal. At first, I took my associates with me to as many scientific advisory boards as I could every time we went to ASCRS, ESCRS, or AAO. There was a multitude of these meetings, and I always took them so they could meet the industry leaders. What happened after awhile is that I had too many scientific advisory board meetings, so I would bring Mark or Rich along and then I would leave 10 minutes later and they would stay. The companies would start to get the message that these guys are easier to work with than Dr. Fine, and they’re going to be around a lot longer anyway. When it came time to give the consulting contract out, [the companies] gave it to them. I thought to myself, “That’s unfair.” But as Tom has taught me, that’s what we were aiming for. As soon as I was able to recognize that it’s a goal, it’s not unfair, then I wasn’t bothered by it. The issue is that you’re going to have to give up something to achieve what you want.

I loved the fact that Laurie had the practice’s interest uppermost in mind, and she helped me avoid becoming a pampered senior physician. I let her make most of the decisions because I knew that her interest was in the benefit of the practice. She was looking out for what was good for the practice and what would ultimately best serve my goal.

Once again, just as with bringing an associate on, we hired Bruce to arrange for the sale of the practice and to establish a practice value. I did have one stipulation for my partners, and this is something you may or may not be concerned about. It was my hope that I would help them establish international relationships for clinical research, teaching, and working in medical organizations. One of the concerns when you do that is suddenly they’re a major presence and someone can offer them another job. At the stage of 6 months before you’re about to retire, you don’t want to have one of your partners leave and not want to buy your practice because then you don’t have time left to seek another partner. The stipulation I gave is, “This is what I am going to do for you, but if you buy the first half of the practice, you are obligated to buy the second half.” I sold them each 24% of the practice, and in signing that agreement they were obligated to purchase the second 26% at the time I was going to leave. That stipulation was included in the initial buy/sell agreement.

We had to talk about allocations of operating expenses and overhead sharing, and we accomplished that within an hour. We were in total agreement. One of the stipulations I made was that when one of us was away consulting and earning honoraria, that money didn’t go into our pockets; it went into the practice as productivity. That helped pay the overhead for the others who were at home working.

I had seen many senior surgeons delay departing so long that their junior associates were ready to retire themselves before they owned the practice. I told my partners that 7 years from their purchase of 48% of the practice, they have the option of buying me out. I may not want to go, but they can tell me to go. I stipulated the time after which they would be running the program because I didn’t think they would mature in their own careers under someone else’s drawn-out leadership. They had to be the leaders themselves.

The name of the game when bringing an associate on and nurturing his/her career is you have to make a win-win. “Hooray for me” doesn’t do it.

Ms. Brown: Dr. Fine was interested in keeping the focus on practice building and continuing into the future. We are all there—career technicians, business office personnel, managers—because it’s an exciting place to be. We have so much that makes our practice different, such as clinical research, teaching, everything that Dr. Fine loves about the way our practice is designed is why we’re there, too. It’s very encouraging that he wanted to keep the practice going, so we never slowed down. Three to 4 years in advance, when he knew retirement was in his near future, we adopted electronic medical records.

Many of you might think, “I’m not going to do EMR within 3 years of retiring. Forget it. It’s for the practice. It’s a goal for the future.” But EMR is where the practice needed to be—for the future. We kept marketing. We kept looking for more lines of business even when Dr. Fine was preparing for retirement. We knew Dr. Fine would be slowing down and the other doctors’ schedules would be picking up. We communicated this vision to our staff throughout the process, reassuring them, and communicating that we were committed to the practice and going forward, maintaining the infrastructure and growing it. That type of communication was essential to retain the vision with the staff on board.

Dr. Hoffman: In regard to buying in or selling to your associate, it was helpful to have an independent person like Bruce Maller value the practice. One thing that is overwhelming for a young surgeon when he or she is looking at buying a practice is the total value. For instance,
with our practice, we are buying into a practice, a surgery center, and an optical shop. There was the building, the land, and if you look at the overall price of that entity, it's overwhelming for someone to come in and think, "I'm going to buy this for a million or two million dollars." What was helpful for me, and what might be helpful to you if you are selling to an associate, is breaking it down in a way so he or she can look at what the yearly income is to buy in over a certain amount of time, as opposed to what he or she is going to be paying overall for the entire practice.

As Howard said, when I bought into the practice, my income went up. It was very easy for me to not look at how much money I was putting in overall and just concentrate on what my yearly income was as I was buying in over 7 years. It is kind of like buying a 600,000 or $1 million house as opposed to "this is what my monthly mortgage is." When you look at it in terms of a monthly mortgage, it is easier to accept. That is what made it a no-brainer for me. Basically, my income went up by a certain amount while I was buying in. After 7 years, I own 24% and then do the same thing for the second 7 years. My income goes up even more. That was very helpful in dealing with the overall price of buying into the practice.

Mr. Maller: I think one of the things that many practices struggle with is trying to figure out what the practice is worth. I would like to share a situation I'm working on now. There is a solo practitioner, which is fairly common in ophthalmology, who has a young associate who has been with the practice for a couple of years. In the original letter of intent and employment or work agreement, there was a provision to become a partner in the practice; however there wasn't a lot of detail around a potential buy-in, which is very common.

What we're doing now is developing a model to illustrate the financial arrangement once that person becomes a partner. In this case we already had an established compensation method for how they were dividing money, but in the end what someone wants to be able to see is, "How am I going to be able to afford to pay for this?"

The exercise required us to forecast the potential revenue, overhead expenses, and net income. We then evaluated how the profits would be split. Once this process is complete, it's easier to address the issue of value.

There are two aspects of a typical buy-in. The first is the buy-in to the hard assets of the business. Normally, it is not too difficult to agree on the value of these assets. What's more challenging is reaching an agreement on the goodwill or intangible assets of the practice. In my mind, I equate the value of these assets to a practice opportunity being afforded the new associate.

As Howard articulated, if we can demonstrate that the young physician, once he or she becomes a partner, has a practice opportunity to make more money than was made as an associate, you have at least the basis for determining some type of value for the practice opportunity. Again, I find the term goodwill almost meaningless. What's meaningful is, "When I become a partner, do I make more money? If I can see the opportunity to make more money as a partner then perhaps I'm willing to pay for that."

That's where the issue of adjusting income on a pre-tax basis is most common in buy-in arrangements. From the younger partner's income share we're going to deflect a portion of that and reallocate it to the senior physician(s) who created that practice opportunity.

Practice building is a struggle for many folks who are transitioning out of practice. You have to think about the practice first. What I liked about what Laurie said is you have to keep investing in and building your infrastructure. You can't think of this as, "It's just about me." It's not about you. It's about making investments to ensure the practice can perpetuate.

Dr. Fauria: There are psychological factors that influence sharing and dealing with money. In the area of practice building and selecting associates, it is important to recognize that there will be trade-offs on personal style and personality differences. There will likely be philosophical differences and practice differences that will emerge. These differences create the need for a psychological reorientation about how the practice operates on a day-to-day basis. Because the future of the practice is at stake, it's understandable that a physician would be hesitant or tentative about these transitions. It is important to recognize that feelings of loss are normal, predictable, and natural components of retirement planning. There can be anxiety about unknown landmines that may surface in the future. This is distressing and normal. It's critically important to recognize that a sense of trepidation or fear is part of the process.

Editors' note: Ms. Brown and Mr. Maller have no financial interests related to their comments. Drs. Fauria, Fine, Hoffman, and Packer have no financial interests related to their comments.

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The thermodynamics of practice leadership

by John B. Pinto

Editors’ note: This article is an excerpt from a new book written and edited by John Pinto. Ophthalmic Leadership: A Practical Guide for Physicians, Administrators and Teams, which will be available from ASCRS•ASOA in Spring 2012.

"The thermodynamics is built on the study of energy transfers that can be strictly resolved into two distinct components, heat and work, specified by macroscopic variables." — P.W. Bridgman

The Nature of Thermodynamics
Harvard University Press

Despite the title, you’ll be relieved to know we’re not going to discuss a lot of higher-order math here, but rather the central, applicable, take-home lessons from what might have been one of your least favorite pre-med courses in college.

Getting your practice’s positive “chemical reaction” going takes loads of human energy. Keeping the resulting, inherently unstable “business compound” from flying apart at the seams takes even more energy and careful handling.

Your practice is a complex, day-by-day laboratory experiment. Although you may not think of your business in these terms, you are adding energy (in this case, human time, financial capital, and expertise) to grow something unique, profitable, and enduring. Along the way, you have to overcome operational entropy and friction and sustain an economically favorable chain reaction. Business, chemistry, they’re all the same, with a bit of physics thrown in for good measure.

Conducting a business chemistry experiment successfully always starts at the top. Just one or two alpha leaders in every practice are the critical source of energy.

Here’s a thermodynamic metaphor: a summertime campfire. If you were a Boy or Girl Scout who won your camping merit badge, you’ll recall that you can’t light a big log with a little match. You have to nurture a campfire by degrees: first the kindling, then twigs, branches next, and finally the log.

Until that first log is burning, you have to sit right next to the new fire and keep feeding it. After you have a blaze started, you have to keep it going by adding more logs hour after hour. If you neglect the fire, it runs out of sufficient heat to ignite the fuel and goes out.

Your practice is just like that campfire. It once started small, most likely with a single doctor and a couple of staff. In the early years, the founder’s long hours, daily attentions, and highly directive leadership were essential. In a few years, less energy and attention was needed. The work days shortened a bit. The practice had finally “caught fire,” and there could be fewer meetings. With time and mastery, operational details perpetuated with little oversight from the top.

But like the fire, even the most modest practice needs a critical continued energy input. When that energy is withheld, the fire dims and eventually goes out.

Here’s a case in point. I’ve just returned home to San Diego from a visit with a middle-aged ophthalmologist with a slowly dimming practice. Let’s call him Dr. Brown. The light is going out and his practice is faltering for one clear reason: Dr. Brown himself is faltering.

Dr. Brown was once on fire to succeed. He would arrive an hour before the first patient to tidy up paperwork and rally the troops. Dr. Brown would take lunch with his staff weekly. At night, he’d go over the books and the next day tweak revenue and expenses. He would stoke the fire, both his own personal one and that of the practice.

But that was more than 20 years ago. Today, Dr. Brown is in his early 60s. The fires don’t burn as hot as they once did. Dr. Brown commonly arrives an hour after his first patient arrives. He rarely meets with staff anymore. Evenings are spent watching sports instead of the bottom line. A once-energized staff and doctor cohort has now settled into a much more relaxed pace. “If Dr. Brown doesn’t seem to care or exert any extra energy, why should we?”

I’ve seen this “energy withdrawal disorder” play out in numerous

continued on page 12
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settings, most commonly in larger, closely held practices owned by just one or two older providers who have delayed the admission of partners. “EWD” is compounded when both the owners and the key staff members are at a stage of life and practice where energy levels decline. EWD is less often seen in widely held group practices with a healthy age distribution of doctors and lay leaders.

For the doctor and manager, energy contributions take several forms. Raw, observable intensity prominently frames the gulf between great and mediocre practice leaders. A lot of this intensity is innate. Intense doctors and managers can’t help themselves; that’s just who they are inside.

Those who are not naturally intense—but who have leadership roles obliging at least the appearance of energy and enthusiasm—need to summon the inner equivalent of a high school pep rally. This can be personally engineered in a number of practical ways:

• Listening to recordings of motivational speakers such as Tony Robbins. Some leaders I know who would not be very motivating on their own have gathered a large library of these recordings and start each day on the commute to work with a pep talk.

• Selecting an administrative assistant or similar aid with a cheerleader personality, or at the very least, NOT working with a dispiriting sourpuss.

• Reading the biographies or watching the video documentaries of great leaders or inspiring narratives from those who have overcome adversity. You can’t read Between a Rock and a Hard Place or watch the derivative movie 127 Hours, about Aron Lee Ralston, the hiker who calling five random patients per provider per month and reporting the results to all hands.

For the last few decades, leading a private ophthalmology clinic has been a pretty low-energy enterprise—nothing more than pumping up the troops from time to time to keep the fires burning brightly. In the decades ahead this will not be the case. Shovelfuls of regulatory complexity are poised to bury you. Fee reform and institutional competition are ready with a splash of cold water. Keeping the fires burning brightly is your prime duty as a practice leader.
More than just an autobiography, Second Sight details how one man relentlessly held true to his dream of bettering vision in the developing world even though many of his contemporary colleagues were naysayers.

David Paton, M.D., whose father is known for establishing the first eye bank in 1944, was “Establishment” all the way in his upbringing—from world travel with his father as record keeper on various medical missions, to his private school years at The Hill School in Pottstown, Pa., where he roomed with the future Secretary of State James A. Baker, III, to his college years at Princeton, medical school at Johns Hopkins, and medical internships at New York Hospital. After a stint as a full-time faculty member of Johns Hopkins and a few years at the National Institutes of Health, he was recruited as chairman of the ophthalmology department at Baylor College of Medicine in Texas at 39 years of age.

Dr. Paton is an enthusiastic storyteller, peppering most of his anecdotes with photos of Middle Eastern dignitaries or Washington elite. He is quick to credit his upbringing and its influences—as well as the obstacles he had to overcome on his own, such as dyslexia—as a vital part of why he chose academia in lieu of private practice.

But Dr. Paton will be best remembered for his conceptualization of Project ORBIS (now ORBIS International), which he oversaw from concept phase in the 1960s to reality in 1982. He served as its medical leader during that time and for an additional 5 years. During ORBIS’ conceptualization phase, the reader gets the sense that Dr. Paton fully understood the ridicule and hesitancy to accept a novel idea in the way that ophthalmology at first belittled both Kelman and Ridley for their beliefs. Yet he would not be dissuaded from pursuing his goal of converting a used DC-10 into a veritable mobile ophthalm learning hospital. Dr. Paton is quick to share credit where he believes it is due—especially the efforts of his Establishment friends in financing his vision. For reasons that remain unexplained, however, the corporate board members did not believe a medical doctor deserved to have a voice on the board. Decades later, the reader can tell Dr. Paton is still befuddled by that decision.

Once the plane was up and running, Dr. Paton became convinced the project needed to become more land-based and supportive of “sustainable eye care units in the poorest of nations with the help of American volunteers.” When the board demanded his resignation, the reader can sense—even two decades later—how much the board’s decision affected Dr. Paton and made him question his place in ophthalmology. It feels as though he was particularly bewildered by the request, as the people demanding the resignation were fellow Establishment (his terms) acquaintances and so-called friends.

He wrote with sorrow about how his confidence was shaken after being asked to resign from ORBIS, but how those same friends and their ability to bestow worldly accolades upon him brought him out of his self-described funk. Dr. Paton eventually had to give up surgery in 1987 for physical reasons.

Lest the reader think his memoirs are filled with self-accolades, Dr. Paton is quick to talk about some of his failures as well, including taking a good amount of blame for the failure of his first marriage to Jane (mother of his children). The reader gets the sense that Dr. Paton is, perhaps, most heartfelt when speaking about his sister Pamela, who died as a teenager on a family vacation, and the resultant difficulty his father had coping with the death. His remaining sister, Joan, named her third child after their deceased sibling, and again, Dr. Paton is overtly heartfelt when talking lovingly about his niece Pam mie, who died a few short months before his memories were published, one of the longest survivors of cystic fibrosis on record.

The reader is also made privy to the behind-the-scenes goings-on at ORBIS. Dr. Paton himself believes, in retrospect, that leaving the day-to-day operations to a board with no medical oversight was a mistake. Dr. Paton became convinced the project needed to become more land-based and supportive of “sustainable eye care units in the poorest of nations with the help of American volunteers.” When the board demanded his resignation, the reader can sense—even two decades later—how much the board’s decision affected Dr. Paton and made him question his place in ophthalmology. It feels as though he was particularly bewildered by the request, as the people demanding the resignation were fellow Establishment (his terms) acquaintances and so-called friends.

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The reader is also made privy to the behind-the-scenes goings-on at ORBIS. Dr. Paton himself believes, in retrospect, that leaving the day-to-day operations to a board with no medical oversight was a mistake. Dr. Paton became convinced the project needed to become more land-based and supportive of “sustainable eye care units in the poorest of nations with the help of American volunteers.” When the board demanded his resignation, the reader can sense—even two decades later—how much the board’s decision affected Dr. Paton and made him question his place in ophthalmology. It feels as though he was particularly bewildered by the request, as the people demanding the resignation were fellow Establishment (his terms) acquaintances and so-called friends.

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As I write this, our economy continues to limp along at a snail’s pace. It seems every time we read some good news, it’s just a matter of days before corresponding bad data rains on our parade. Whether it’s the U.S. employment figures, the debt crisis at home and abroad, the U.S. trade deficit, or healthcare reform that’s got you down, the result is that our confidence in the economy remains shaky.

Fortunately, we work in healthcare, one of the few bright spots in today’s economy. The boomers are getting older, people are living longer (not healthier), and we expect more to be insured, so demand for our services is growing at a pace exceeding our ability to provide the necessary care. According to the U.S. Bureau of Labor Statistics, healthcare has added an average of 24,000 jobs per month over the 12 months prior to June 2011. Compare that to employment statistics in construction or manufacturing and you’ll understand how remarkable that number is.

It’s not all roses in healthcare, however. Eyecare professionals have real concerns about the near term. The healthcare reform debate, Medicare reimbursement rates, and the impact of the economy on discretionary spending have limited the upside and tempered the mood, even in healthcare. The mood of today’s ophthalmologists would be best described as one of cautiousness.

The delicate balance that ophthalmologists face (as does any small business owner) is the fine line between appropriately fueling your practice to maximize its revenue potential, without taking unnecessary risks and spending out of proportion with today’s economic environment. Ophthalmic practices are looking to cap or cut expenses without impacting their lifeblood, patients.

As a small business owner, I relate to the feelings of uncertainty that creep in when making decisions impacting overhead, and none of those are more impactful than decisions affecting staffing. Keeping overhead manageable is important, and because there are a lot of things out of our control, is it better to play it safe and do more with less? That’s good to a degree, but in my estimation, when it comes to staff there is a shallow point of diminishing returns.

Nothing is more important than people. The most significant decisions we have ever made at Local Eye Site have all revolved around human
resources. Bad hires can seriously derail a business, and good hires can get it on track. Every practice and every business is defined by its people. People define its culture and turn the service it provides and the feelings of its customers.

Let’s get back to doing more with less. Prudence is good; maximizing productivity of the resources you have is good. Making staffing decisions based purely on the short-term bottom line is bad for business in the long run. Making a long-term investment in highly trained and experienced people of good character to a large measure defines your business and enables you to separate yourself from your competition.

Let’s consider the technician as a position that greatly impacts the experience and level of care that your patients (customers) have and what they tell their friends. Do you hire experienced, highly trained, and certified technicians? What does certification say to you about the level of commitment to career (and care) of the technician versus the noncertified technician? Perhaps you hire “good people” that you will train? I would suggest that hiring good people is in fact very important, but those good people should also be experienced, well-trained, and committed to their careers and our industry.

Tara McAllister, manager of staff development at Charlotte Eye, Ear, Nose & Throat in Charlotte, N.C., had this to say:

“Ophthalmic medical office productivity has become increasingly more important over the last several years with reductions in Medicare reimbursements and impending changes in healthcare. The most efficient way to control costs is to ensure that each task is performed accurately by personnel who are well qualified and trained in the latest techniques in ophthalmic diseases and conditions.”

Ms. McAllister knows that, especially in this economic environment, it pays dividends to invest in people who are highly trained and qualified. If you are going to maximize the productivity and quality of care from your human resources, it’s best to start with quality resources.

A study published in Contact Lens Association of Ophthalmologists in 2008 by Woodworth Jr., C.O.M.T., C.O.E., et al set out to “compare ophthalmic practice productivity and performance attributes, as rated by employing ophthalmologists, of noncertified and three levels of certified ophthalmic medical personnel [OMPs].” Three hundred eighty-five American and Canadian ophthalmologists assessed 14 desirable professional attributes and 10 practice productivity measures. OMPs were rated on attributes such as patient care, satisfaction and reduced patient complaints, doctor productivity, ability to work independently and be trained to perform multiple roles, good judgment, initiative, drive, and revenue per patient.

Results showed that a statistically significant number of ophthalmologists believed that certified personnel showed more of all 14 of the personal attributes considered desirable compared to noncertified OMPs. The study concluded that “compared to noncertified personnel, the employment of certified ophthalmic personnel enhances the quality and productivity of an ophthalmic practice. Overall practice productivity is increased with certified ophthalmic personnel.” Finally, Woodworth et al stated, “The most efficient way to control costs is to ensure that each task is performed accurately by personnel who are neither under- nor over-trained for the given task.”

William Ehlers, M.D., president, The Joint Commission on Allied Health Personnel in Ophthalmology, agreed: “A key to increasing ophthalmologist productivity and efficiency is delegating eye exam tasks to the eyecare team, especially to certified ophthalmic medical personnel.”

Dr. Ehlers continued, “Canadian and U.S. studies have shown that certified personnel made the greatest contributions to productivity in key areas such as triage screening, trouble-shooting rapport, doctor productivity, and number of patients seen per hour. There is a growing recognition that certified personnel bring added value and a competitive advantage to their employers that increases their bottom line.”

As you consider how to best navigate the rough waters of this economy, be a good steward of your resources, but don’t cut corners on your people. Making an investment in quality human resources will ultimately increase your practice’s productivity, reputation, competitiveness, and profitability. Happy hiring!
New marketing trends for your practice

by Paul M. Stubenbordt

Introduction
The way consumers react to marketing is constantly evolving. For instance, a 35-year-old looking for a new car in 1940 might have looked at a newspaper ad. In 1970, a TV ad was likely the most effective way to reach that consumer. In 2011, it might be an ad the consumer sees while surfing the web or on a social media site.

Because consumers are changing the way they shop, we must change the way we market. Falling behind on the current advertising trends can give your competitor a leg up, and you could lose that “state-of-the-art” image along with it. So without further ado, let’s take a look at the latest trends in marketing technology and see how they can benefit your practice.

QR code: Making print interactive
One innovative marketing tool that was created over 15 years ago in Japan is only now gaining popularity in the United States. Quick Response codes, generally shortened to QR codes, are similar to the Universal Product Codes or barcodes found on goods in grocery stores. QR codes have their information organized into matrix barcode so they look like a pixilated black and white square. The important thing about QR codes is that they can be read with a camera phone with the use of a free downloaded QR reader app. A scanned QR code can reveal a website, a patient testimonial video, a coupon, a commercial—you name it. From a marketing perspective, QR codes can be used on billboards, print ads, direct mail pieces, business cards, websites, etc., and consumers can use their phone to read the code which can then link them to your website, offer them a discount, or provide literature or testimonials about your services. This technology has already been popularized greatly in Japan and South Korea, but did not gain a foothold in the United States until 2009. Another example of how this technology is being used is in air travel. Instead of printing out your boarding pass, you can simply check in for your flight, download a unique QR code directly to your smart phone, and use it as a boarding pass when going through security.

With prominent endorsements from Target, Best Buy, and other large corporations, you can expect to see QR codes gaining popularity in the near future, and best of all, QR codes are easy to generate. If you Google “QR code generator,” you will find several legitimate websites that can make a QR code for a URL, phone number, or text.
Social media: What’s the hype all about?

Social media recently set a new milestone for all-time traffic highs in May 2011. Social media continues to influence search engine optimization and general awareness of businesses, but there are some surprising changes. For one thing, Facebook is no longer the primary social medium for businesses. Make way for LinkedIn. LinkedIn surprised Wall Street in May 2011 by doubling the value of its shares on its trading debut. Since then, LinkedIn has been deemed the number one social media site for businesses. Twitter, Facebook, and YouTube still remain useful for social media and search engine optimization purposes, but LinkedIn provides benefits beyond that, such as interactive blogging. LinkedIn is all business. That is the beauty of it—you will not find anyone on LinkedIn who is simply being social.

LinkedIn page setup

To set up a business LinkedIn account, you will need to log in to your LinkedIn account and navigate to the “Companies” tab. At this point you can search for your company name. If your company isn’t currently on LinkedIn you will receive a notice that gives you the option to “Add a company profile.” Only current employees of a company can set up a Company Page on LinkedIn, so you will need to use an email address associated with your practice. After registering you will receive a confirmation email that will allow you to continue setting up the LinkedIn company profile. You’ll be able to add your logo, locations, website, and a feed for your blog. After you’ve set up the general information, LinkedIn will grab data from around its website and post it on your company website. Statistics and networking information like new hires, promotions, other companies that your employees are associated with, top schools that your company hires from, the median age of your company, etc. will be listed.

Additionally, premium features are available including video, polls, and recruiting and hiring packages. These are ideal for larger practices.

Google Places

Lastly, let’s not forget Google. Upon seeing that the majority of search queries were geographically targeted (e.g., Houston ophthalmologist or Denver LASIK), Google decided to make Google Places, a more useful form of the retired Google Local. It’s remarkably simple. Each business is able to claim their Place Page, and then you’re free to update it, add videos, pictures, a description of your practice, and categories you’d like to be listed under. Google Places is also available on mobile devices. Practices can post real-time updates to their Place Page, making promotion marketing extremely simple. Additionally, Google Places listings appear above natural search engine results (when relevant), giving you a boost over any competitors who haven’t yet claimed their Place Page. If you haven’t done this already, do it. It’s free. Most people prefer local businesses for goods and services, and there’s a good chance they’ll find you via your Place Page if they’re searching on Google.

To learn more about Google Places, scan this QR code using your smartphone or visit www.youtube.com/user/stubentube.

Conclusion

Keeping up with the competition today can be very difficult. It’s important to know the latest trends in marketing so you can remain competitive in your market area. With a little bit of knowledge and time, your marketing can be as advanced as your practice.

Mr. Stubenbordt is the president and founder of Stubenbordt Consulting, Roanoke, Texas. With more than a decade of experience, his firm specializes in business development for ophthalmologists, with a focus on marketing and advertising. He can be reached at 682-831-0900 or paul@stubenbordt.com.
Eye apps: Patient education enters the 21st century

by Rich Daly Contributing Editor

A growing number of digital patient education tools provide basic information about a range of conditions and aim to improve the quality of patient/clinician encounters

Patient education in some physicians’ offices may remain mired in the 1980s standard of glossy brochures, wall-mounted clinical illustrations, and heavy reference books.

But in the waiting room of the Center For Sight in Venice, Fla., patients are handed an iPad (Apple Inc., Cupertino, Calif.) loaded with explanatory videos illustrating the visual impact of cataracts, as well as the post-op visual differences possible between standard and premium intraocular lenses. Patients can select from among the subjects and proce-
dure in which they are most interested and which most impact their particular case.

James D. Dawes, M.H.A., C.M.P.E., C.O.E., chief administrative officer, Center For Sight, said the practice moved to the digital patient education system in late 2010 to address the challenges inherent in patient education, especially in terms of conveying what patients could realistically expect from surgery.

“The Site Selector allows us to do this in a matter of minutes,” Dawes said. “A picture is worth a thousand words. The Site Selector is worth a million words.”

Site Selector (Patient Education Concepts Inc., Houston, Texas), one of a growing number of digital patient education tools in ophthalmology, covers 52 ophthalmic topics through either narrated videos or a series of still images that physicians can describe to their patients. Topics include anatomy, laser vision correction, and eye diseases.

The same videos are available as apps through the iPhone (Apple) smartphone system, however the company said there are no plans to create apps for other manufacturers’ mobile devices at this time.

Such mobile education applications that patients can view on their phone or computer whenever it is convenient for them are not only in demand by younger elective surgery patients, according to Daniel S. Durrie, M.D., clinical professor of ophthalmology, University of Kansas, Overland Park. Dr. Durrie has found a growing number of his standard cataract patients are hungry for more information about the procedure and are actively searching for it.

“At least once or twice a week someone will tell me that he or she has researched it or me on the internet,” he said.

Other illustrated products that have emerged include the Ocutouch (Stephen Gordon Inc., North Street, Mich.) system, which is a combined patient self-education tool and physician-teaching aide that uses hundreds of computer-animated videos. Similarly, patients can access these on waiting room monitors or with the physician in an exam room.

David F. Chang, M.D., clinical professor of ophthalmology, University of California, San Francisco, and in private practice, Los Altos, Calif., said the need for quality patient education has increased in recent years as the treatment options available to ophthalmic patients have grown.

“Especially with the option of selecting premium IOLs, the need for effective education and communication has never been greater for our cataract patients,” Dr. Chang said.

In recent years, Dr. Chang has helped another healthcare media company develop similar pre- and post-op patient education videos (Eyemaginations Inc., Baltimore) that describe various clinical aspects and patient options within cataract surgery.

The narrated videos are interspersed with animation sequences, closed captions, and are available on exam room monitors or iPads.

“From the waiting room to the exam room, it is designed to help patients visualize doctors’ explanations and better understand treatment options,” according to the Eyemaginations website.

The manufacturer plans an upgrade that will allow physicians to email to their patients video links relevant to each patient’s diagnosis and situation.

“This is particularly nice for the post-op video, which reduces chair time and allows patients to forward the video of cataract surgery to family and friends,” Dr. Chang said.

“Besides being educational, this becomes a form of internal practice marketing where happy patients can brag about and show off this remarkable operation.”

The Eyemaginations videos differ from IOL company videos in that they provide a “neutral discussion” of the procedures and aim to create conservative expectations. No specific IOL brand names are used.

Beyond general clinical information and details on surgical treatment, the videos also provide information to improve outcomes, such as educating patients on proper eye drop installation.

A side benefit of the videos is that they are designed to improve patient satisfaction by explaining and illustrating the cataract operation.

“Patients are surprised and fascinated to learn how much skill is involved,” Dr. Chang said. “I have found that this really increases patients’ admiration and appreciation of the entire process.”

In May, the company expanded its offerings by forming a partnership with Carl Zeiss Vision (San Diego, Calif.) to offer customized software for U.S. physicians in Zeiss practices to better communicate with their patients about their conditions, treatment options, and the benefits of specific Zeiss products.

Editors’ note: Dr. Chang’s royalties from the Eyemaginations videos are donated to the Himalayan Cataract Project and Project Vision. Dr. Durrie and Mr. Dawes have no financial interests related to their comments.

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How to keep from being fired by your patient

by Brad Ruden, M.B.A.

In a recent article on the U.S. News website, Angela Haupt wrote an article titled “9 Signs You Should Fire Your Doctor.” In the article she listed the following reasons for a person to “fire” his or her doctor:

• You don’t mesh.
• The doctor doesn’t respect your time.
• The doctor keeps you in the dark.
• The doctor doesn’t listen.
• The office staff is unprofessional.
• You don’t feel comfortable with your doctor or worry about his/her competence.
• Your doctor doesn’t coordinate with other doctors.
• The doctor is unreachable.
• The doctor is rude or condescending.

In this article I will address the above points and outline how one can proactively address each of those areas in order to retain patients.

You don’t mesh. As Ms. Haupt mentioned in her article, not every doctor and patient will see eye-to-eye. In most cases, this is simply a communication breakdown between the parties. Often doctors are pressed for time with a full schedule and patient load. No matter how rushed you may be, always ask if the patient has questions or concerns and do your best to be thorough in your response.

The doctor doesn’t respect your time. We all know patients get irritated waiting too long past their appointment time; the issue is whether or not such delays are unique or chronic. I used to have a dentist who routinely saw patients 30-40 minutes past their appointment time. That is why she is my former dentist. Occasional delays will crop up; these should be apologized for and explained to the patient. A patient who understands the unique reason for a delay is more likely to understand and not take offense. If a patient can’t wait, offer to see him/her as soon as possible. If delays are chronic in your practice, you need to take a long look at how you schedule and how you process patients through the practice.

The doctor keeps you in the dark. With the information and misinformation available on the inter-
net, it behooves a doctor to keep a patient fully informed as to why you are performing certain tests or why you are suggesting a treatment plan or course of action. An informed patient is more likely to be a loyal patient.

**The doctor doesn’t listen.** Sometimes doctors are pressed for time with a full schedule and patient load. Other times patients may be rambling in their questions or conversation. Or it may be a case where the doctor has heard the question so many times that he/she stops listening in anticipation of giving an answer. That patient may be your 20th, 35th, or 50th of the day—but you are likely the only doctor he/she will see that day. Don’t just hear a patient, but actively listen without interruption and respond accordingly.

While interrupting is normally considered rude, there are two tricks to keep someone from talking too much. The first is to interrupt with a question—but it shouldn’t be an open-ended question allowing a rambling answer, it should be a question that requires a specific answer, such as yes/no. Once the patient answers you can take back control of the conversation.

The other interruption is along the lines of, “You have touched on an interesting point that I would like to address before we move on.” Again, this allows you to stop the long conversation, take control, and lead the talk to an end point.

**The office staff is unprofessional.** The office staff—good or bad—is a reflection on the practice and doctor. Unprofessionalism can be in the form of appearance, bad habits, or demeanor. A patient will often have more contact with the support staff than time interacting with the doctor. As such, be sure your staff is a positive reflection of you.

You don’t feel comfortable with your doctor or worry about his/her competence. A patient’s lack of comfort with a doctor—or worry about his/her competence—can usually be traced to a lack of trust, which most often stems from a lack of communication. A patient who is uneasy about a doctor’s recommendations may be a patient who doesn’t understand why a treatment or course of action is being recommended. Clear and open lines of communication will go a long way toward establishing trust and creating a strong comfort zone for the patient.

**Your doctor doesn’t coordinate with other doctors.** While this is more prevalent among primary care doctors such as family practitioners, in ophthalmology it is typically a lack of coordination between doctors who referred the patient to you (such as an OD) or doctors to whom you have referred a patient (any subspecialist). Your staff can be one of your greatest assets in maintaining proper coordination between you and other providers treating a patient. When you see a patient with whom you are co-treating with another provider, ask that patient if there is anything the other provider has done or said about which the patient has questions. This will ensure the patient you are staying on top of matters as well as keep you informed if there is anything another provider has done that the patient is unsure about or uncomfortable with.

**The doctor is unreachable.** We all enjoy our free time and hate work interfering with it. However, from a liability standpoint, a doctor that is completely unreachable is possibly setting himself up for trouble. With today’s technology, one can enjoy free time while still being available via email or text. One simply needs to use his or her best discretion as to which patients get such personal contact information.

**The doctor is rude or condescending.** The great majority of physicians with whom I have worked have all been caring and responsible individuals. They chose the profession because they care about their patients. However, we all have our bad days or moments. Most often, patients perceive a doctor as rude or condescending when they feel the doctor is not listening to them. Perhaps the doctor has personal issues weighing on them, perhaps the doctor is too busy—it doesn’t matter. What matters is the patient’s perception. Again, that patient may be your 20th, 35th, or 50th of the day—but you are likely the only doctor the patient will be seeing and the most important appointment of the day. Treat the patient the same. Don’t just hear a patient, but actively listen without interruption and respond accordingly.

**Summary**

Ms. Haupt’s article provided some general points on when a patient should “fire” a doctor. Never forget, patients talk, and unsatisfied patients talk more. One patient lost can easily turn into two, then four, then more. Doctors shouldn’t be quick to dismiss the article but instead take a proactive approach to comparing their conduct and reviewing their practice in the context of each issue she raises. Doing so may help them make the necessary corrections to keep from losing a patient.
Anxious patient types, responses vary

by Rich Daly Contributing Editor

Surgeons offer a wide array of suggestions for spotting and addressing anxiety in patients and highlight cases where it is best to walk away

A little fear is a good thing.

In fact, Daniel S. Durrie, M.D., clinical professor of ophthalmology, University of Kansas, Overland Park, has found that the patients who come right out and tell him that they are nervous about an impending surgical procedure usually present the fewest anxiety-related problems. The indicator even works among the less talkative patients.

“If they’re not saying anything I crack a dumb joke and if they react to show me it wasn’t funny then at least I know they’re just distracted and not too anxious,” Dr. Durrie said.

Dr. Durrie’s counterintuitive experience with patient anxiety is an example of the sometimes complex reality of addressing patient anxiety.
toward procedures that are routine but potentially terrifying for some patients.


The most important tool Dr. Kim has found in assessing and addressing patient anxiety is the pre-op exam. He uses it to identify visual clues of anxiety-related problems, such as patients who involuntarily squeeze their eyes shut when examined, display Bell’s phenomenon, or have tremors.

John D. Sheppard, M.D., president, Virginia Eye Consultants, first checks the patient history for diagnoses of previous neurosis, anxiety, or psychosis and noted surgical angst. Fibromyalgia is one anxiety-related diagnosis that leads Dr. Sheppard to avoid surgery, especially elective procedures.

The screening process for serious anxiety among patients of Donald N. Serafano, M.D., associate clinical professor, University of Southern California, Los Angeles, includes noting how cooperative patients are when their intraocular pressure is taken and during their A-scan.

Clive Novis M.D., Benoni, South Africa, has a similar approach.

“If they are scared of the Tonometer [Reichert, Depew, N.Y.] approaching, it is a sign that they may be scared during surgery,” Dr. Novis said.

Reponses to common anxiety

Surgeons have found a variety of responses are effective in allowing them to treat anxious patients.

Dr. Sheppard uses a combination of environmental tools that aim to calm his patients, including educating them about the procedure, holding hands, and utilizing a large lecture window in the ambulatory surgery center so patients know their relatives are within a few feet.

“This is extremely effective and available to all of our patients,” Dr. Sheppard said about the window.

Dr. Serafano has found regular patient updates or “vocal anesthesia” are effective.

“If I talk with patients and tell them how they are doing, they appreciate the updates,” Dr. Serafano said.

Sometimes the patient’s anxiety can become more serious. When a patient’s anxiety appears likely to increase shortly before or even during a procedure, Dr. Sheppard carefully titrates intravenous medications (midazolam in most, propofol, and fentanyl in older patients) as needed, such as at the beginning of a case when relaxation and cooperation are required for speculum insertion.

“This provides an excellent opportunity to determine the patient’s level of sedation,” Dr. Sheppard said.

Uday Devgan, M.D., chief of ophthalmology, Olive View-UCLA Medical Center, Sylmar, Calif., agreed on the use of a propofol drip for fast surgeries. Lengthier procedures, he noted, can require laryngeal mask anesthesia as an alternative general endotracheal anesthesia.

“Almost all cases of anxiety in adults can be controlled with IV anesthesia, without the need for general anesthesia,” Dr. Devgan said.

Serious response

Patients whose anxiety is related to more serious conditions require more aggressive anesthesia.

“The patient has to be able to cooperate and understand directions and requests,” Dr. Serafano said. “If this is not possible, then sedation and peribulbar block or general anesthesia is necessary.”

Dr. Devgan has found general anesthesia is best for children younger than 12 years old, while those between 12 and 16 years old fall into a “grey area” based on the circumstances.

Anxiety also may affect patients with severe developmental disorders, dementia, or serious mental illnesses. Dr. Kim prefers general anesthesia in most of these patients, but other surgeons have found some of those patients require very little medication because they are calm.

Paradoxically, medications may induce greater agitation in a small number of patients. In such cases, Dr. Kim has found propofol an effective response.

Problems may arise from anxiety in the midst of surgery. In cases where sudden eye movement requires it, Dr. Kim uses a retrobulbar block without breaking the sterile field. A side benefit of such blocks is that they remove the “visual cues” that sometimes induce panic, he said.

Other types of patients who can present surprising anxiety-related challenges are those with claustrophobia and deaf patients. Visually impaired patients may move in unpredictable ways on the operating table because they are used to following visual directives, noted Dr. Kim.

“Typically, claustrophobics are difficult because you don’t have any idea until they are lying down on the table,” Dr. Durrie said.

Editors’ note: Drs. Devgan, Durrie, Kim, Novis, Serafano, and Sheppard have no financial interests related to their comments.

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Navigating

by Faith A. Hayden Staff Writer
corrective action

When and how to approach an unethical colleague

No one enjoys being a snitch, a whistleblower, or a tattletale. It’s human nature to want to be liked and to run from confrontation, and doctors are no different. But certain situations will appear during a doctor’s career where speaking up and stepping in is not just the right response, it’s the only response.

Ethical discussions can be uncomfortable, complicated conversations for even the most skilled surgeon.

“Docs are notorious for not addressing the problem upfront,” said John Banja, Ph.D., professor, Department of Rehabilitation Medicine, and medical ethicist, Center of Ethics, Emory University, Atlanta. “Many physicians don’t have the skill set to approach and manage these situations. They don’t know what to do. It’s personally easier not to get involved. But if you don’t get involved, Dr. Schmo might end up hurting someone.”

How to respond to an ethical concern is largely situational, and as Dr. Banja pointed out, every case is different. But there is a common thread woven into all discussions about ethics: Physicians have a responsibility to their practice, their patients, and the medical community to intervene when there’s reason to believe another physician is deviating from the professionally accepted standard of care.

“You have an ethical responsibility to act,” said George L. Spaeth, M.D., Louis J. Esposito Research Professor, Wills Eye Institute, Philadelphia. “The medical profession is supposed to be acting in the best interests of the patients. If you’re going to maintain the integrity of your profession, you have to police yourselves.”

Regrettfully, these situations are rarely black and white. Ophthalmology Business spoke to a few physicians who gave some scenarios where action is absolutely necessary. For example, let’s say two days out of cataract surgery a patient calls the operating surgeon complaining of pain and blurred vision in the eye in question. Instead of seeing that patient immediately, the doctor puts it off until the next day. As a result, the patient develops endophthalmitis and loses the eye.

“This is a situation where the doctor should have taken action that day,” explained George Bohigian, M.D., professor of clinical ophthalmology, Washington University School of Medicine, St. Louis. “Failure to diagnose and failure to treat early has caused this patient to lose vision. If the offending doctor refers that patient to me, the first thing I do is take a careful history of the patient. Then I get the patient’s records from the referring doctor because that’s the key. What the patient tells you and what actually happened can be two different things.”

Patients can misrepresent facts and details, either intentionally or unintentionally, so it’s important not to overreact.

“You don’t know what the doctor did,” said Dr. Spaeth. “Never jump to conclusions before you get all the facts.”

The offending doctor “might have a very good reason for doing what he did,” said Dr. Banja. “Or there may be variables you have no clue about. You’ve got to do your fact-finding.”

Another example: A patient with pseudophakic corneal edema is referred to you for a corneal transplant. You discover that the patient has a posterior chamber intraocular lens positioned in the anterior chamber angle.

“That’s clearly one of the few times you can say that is standard care,” said Anthony J. Aldave, M.D., American Academy of Ophthalmology Ethics Committee member, associate professor of ophthalmology, Jules Stein Eye Institute, Los Angeles. “You don’t need any records, you don’t need to talk to somebody. That lens should not be placed in that position because of the potential for corneal decompensation to occur.”

The appropriate response in either case is to call the referring physician and discuss the matter, either to get the surgeon’s side of the story or to explain why the actions were inappropriate. The trick is tact.

“My psychologist friend said to me some time ago, ‘You know, you can say almost anything to anybody if you say it in the right tone of voice and if you frame it in just the right way,’” Dr. Banja explained. “It can’t sound accusatory. It’s very difficult to get angry at someone who is genuinely concerned about you.”

“If the physician is approached in a way that is genuinely designed to help him or her, then the physi-
cian will generally appreciate that
and respond appropriately,” said Dr.
Spaeth. “There are people who
couldn’t care less about what you say
and believe they are totally ethical
and that everyone else is unethical.
You can’t expect them to hear you
because they can’t hear anyone
except themselves.”

If the offending surgeon is hos-
tile, say he drops the F-bomb and
hangs up on you, it’s time to go up
the chain of command. If the doctor
is associated with an institution, you
can go to the head of the ophthal-
mology department. If your com-
plaint still falls upon deaf ears, you
can report the infraction to the
American Academy of
Ophthalmology (AAO) Ethics
Committee or your state medical
board.

“Pattern of behavior is key
here,” said Dr. Aldave. “If it’s a
repeated pattern, and the doctor has
spoken to the offending physician
and has not gotten anywhere, I
think it’s your obligation to go a step
beyond and report that behavior to
the medical board or the AAO Ethics
Committee.”

But the Ethics Committee can’t
proceed with an anonymous submis-
sion in a case involving information
not in the public domain. The sub-
mitter must agree to have themselves
identified as the person bringing the
challenge, provide objective evidence
to support their challenge, and agree
to present themselves as a witness in
the unlikely event that the challenge
proceeds to an administrative hear-
ing for resolution.

“They have to read the Code of
Ethics, gather the materials, put it all
together, and then this information
goes to the challenged person with
the name of the submitter identi-
fied,” said Dr. Aldave.

Naturally, attaching your name
to such challenges can be intimidat-
ing, causing many doctors to shy
away from contacting AAO. Over the
past 10 years, approximately 60 chal-
 lenges have been withdrawn once
the submitter understood the full
extent of their necessary involve-
ment in the investigative process.
That number is roughly 7% of the
total submissions over the same time
period, but is close to 50% of the
number of submissions submitted by
ophthalmologists in cases where seri-
ous concerns about a colleague’s
medical practice are raised.

Fear of reprisal can also cause
a doctor to not get involved.

“No one wants to be a snitch,”
explained Dr. Aldave. “No one wants
to get involved in something that’s
going to come back to bite him or
could lead to being sued or accused
of slander.”

“Whistleblowers get punished,”
said Dr. Spaeth. “They might get a
letter from a lawyer saying you’ve
been harassing my client and we’ve
issued a suit against you. Even if it’s
a nonsense suit, it’s very threatening,
it’s very scary.”

Despite the fear and uncertainty
of reporting a colleague, doctors
must put the needs of the patient
first and foremost, which at times
means making difficult decisions. It
means telling patients the care they
received was below standard. It
means making an awkward phone
call to a colleague. And in extreme
cases, it might mean passing onto a
patient the name of a malpractice
lawyer.

Doctors interviewed maintain
that they do not encourage lawsuits,
but they wouldn’t lie to a patient
either.

“Someone has to be forthright
with the patient, but you have to be
careful,” said Dr. Bohigian. “The rule
I follow is do onto others as you’d
have them do onto you. If you were
in the doctor’s shoes, how would
you want to be treated? If you were
in the patient’s shoes, how would
you want to be treated?”

“The initial temptation for doc-
tors may be to say something dis-
paraging about another physician,
either to make themselves look bet-
ter or because that’s the first thing
that comes into their head,” said Dr.
Aldave. “But that has to be resisted.
If a patient asks me directly, ‘Do you
think there was a problem during
surgery that could have been avoid-
ed?’ then I have to say, ‘Yes.’”

Dr. Aldave is quick to point out
that maloccurrence does not equal
malpractice. Just because something
undesirable happens during surgery
does not mean it was surgery error.

“I can think of two cases where I
have said to patients, ‘I would advise
you to speak to a lawyer. I’m not
sure you have a case, but you proba-
bly do. I think that not only is it in
your best interest, but it’s in the best
interest of the medical profession
and the public,’” said Dr. Spaeth.

“You have a responsibility to be
a representative for your profession,”
he continued. “If it’s clear doctors
aren’t acting in the best interest of
the patients, then why should they
get the sort of privileged trust they
have from the public? They won’t. It
will disappear.”

Editors’ note: The physicians inter-
viewed have no financial interests
related to their comments.

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