10 tips to streamline your cataract surgery instructions

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Whether they’re Baby Boomers in the early stages, or Seniors with more advanced cataracts, cloudy vision can seriously impact your patient’s quality of life. These patients will be searching for help correcting the issue so they can enjoy all the benefits of clear vision for years to come. Patty Casebolt, OSC Member and Clinical Director, Medical Eye Center, shares tips to engage patients about cataracts and the premium options available to help them see every moment clearly.

1. **Send a pre-consultation letter.**

   For some patients, it can be overwhelming to learn they have cataracts, and that they need surgery to correct them. Casebolt recommends sending a letter before their consultation that details what to expect and explains the difference between a premium and standard lens. It’s a simple step that can help patients be prepared to accept your best recommendation for cataract surgery while they’re in your office.

   “Giving them information before they come in has completely changed the process,” Casebolt said.

2. **Walk patients through every step.**

   When a patient comes for their consultation, connect them with a dedicated counselor who guides them through the entire process. Counselors that specialize in premium lenses can educate patients about the benefits, costs and financing options to help them move forward with cataract surgery.

   “Our counselors also educate patients on expectations after surgery, and it’s hugely improved satisfaction,” Casebolt said.

3. **Focus on customer care training.**

   Patients who choose premium lenses may have higher out-of-pocket costs – and higher expectations for customer service. Take time to train your team on what patients expect from cataract surgery, and how the entire practice can work together to meet those expectations.

   “Our program is designed around customer service culture in premium lens and eye care services… We’ve always had training, but we wanted it to be more comprehensive,” Casebolt said.

4. **Offer a convenient financing option.**

   For patients with cataracts who want a premium lens, cost can keep them from moving forward. With the CareCredit credit card, your patients have a convenient way to pay for the cataract surgery they need.

   “CareCredit is easy to use and has great promotional financing options, especially longer payment options,” Casebolt said. “We try to make it as affordable as we can.”

5. **Always keep learning and improving.**

   From mystery shopping to patient feedback, there are many ways to identify areas for improvement. Use what you learn to help your team get better at converting patients to premium cataract surgery.

   “Our CareCredit Practice Development Manager regularly visits to train the entire staff on being comfortable talking about CareCredit,” Casebolt said. “I think it’s vital to use people who are familiar with the industry to give us feedback.”

To learn how to engage effectively with every age group, call the CareCredit Practice Development Team at 800-859-9975, option 1, then 6 to request Generational Insights Series Quick Guides.
P

atient compliance is an evergreen issue, but if you’re really hoping to improve compliance, at least pre- and post-cat-
aract surgery, this month’s feature provides some concrete ideas. Several physicians in “10 tips to streamline your cat-
aract surgery instructions” share their thoughts on how to improve patient compliance, including writing instructions down, verbal repetition and reviewing the information with patients and their families regularly, providing online tools, and considering a dropless regimen or having patients bring drops to their clinical visits.

Speaking of evergreen issues, physician burnout is addressed in “A hard look at burnout.” Amy Windover, PhD, explains in the article the results of a survey at the Cleveland Clinic that found 35% of physicians across medical specialties are burned out. Dr. Windover also discusses some steps the Cleveland Clinic has taken to try and improve factors that might lead to physician burnout.

With patients perhaps more willing to shop around for a doctor who best suits their needs and personality, how to create and maintain patient loyalty is an important topic. Fortunately, a nationally representative survey found that patient loyalty in ophthalmology is at a “remarkable level.” That said, there is always room for improvement. Learn more in “What drives patient loyalty in ophthalmology and how to increase it in your practice.”

John Banja, PhD, shares the current status and possible future of artificial intelligence in ophthalmology, both from clinical aspects as well as business, in “Artificial intelligence in ophthalmology: Clinical prac-
tices and business implications.” From a business standpoint, artificial intelligence technologies could reduce costs and/or could take some time burden off of busy clinicians. “Perhaps more than anything, though, these technologies will open up business opportunities for image-reliant practic-

es throughout the world,” Dr. Banja noted in the article before concluding that “it behooves everyone with a stake in the outcome to learn and estimate the quality and scope of AI’s clinical applications so as to plan their business futures wisely.”

Finally, as this is the last issue of Ophthalmology Business, the team would like to sincerely thank readers for their support over the last 9 years. We will continue to bring ophthalmologists highly relevant arti-

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Coming soon to Chicago: EyeWorld Educational Events

Watch for email announcements and join your friends and colleagues for some great breakfast and dinner events. www.EyeWorld.org/meetings
A hard look at burnout

by Liz Hillman, Ophthalmology Business Senior Staff Writer

In addition to finding that about 35% of their physicians would be considered burned out according to the Maslach Burnout Inventory (33% of ophthalmologists at Cleveland Clinic who completed the inventory experienced overall burnout), they found that depersonalization was associated with more ombudsman complaints from patients, emotional exhaustion was associated with a greater likelihood of the physician leaving the organization, and physicians with more clinical time were more likely to be emotionally exhausted.

“What concerns me is that at the end of the day 35 out of every 100 physicians in our group are going home mentally and physically exhausted, feeling like they have nothing left to give, and yet, they’re going home to their families,” Dr. Windover said.

Thirty-five percent is also significant when you look at some of the outcomes of burnout, Dr. Windover said, noting other research that has shown burnout being associated with more surgical errors, medication errors, hospital-acquired infections, standardized mortality rates, and costs to the health system.

Much of the burnout experienced at the Cleveland Clinic, according to Dr. Windover, was related to inefficiencies in practice.

“We don’t think providers get exhausted working with patients, per se ... quite the opposite. There is other data that has come out that has shown that as one’s clinical time increases, the amount of time necessary to document a 15-minute visit is exponentially greater. It’s the
administrative tasks and pressures to document more,” Dr. Windover said.

In light of that, she said they implemented things like “tap and go” badge login for the electronic medical record (EMR). It might sound like a small thing—the amount of time it takes to log in to an EMR—but Dr. Windover said it’s a specific way to shave off time that adds up. They also added IT personnel to be more available to doctors when using the EMR and to improve efficiencies in using the record when possible. Cleveland Clinic added support staff to answer questions from patients, so that task is not entirely on the physician.

In addition to efforts to improve efficiencies, Dr. Windover said Cleveland Clinic has engaged all physicians in relationship-centered communication skills training with an 8-hour experiential course. They measured burnout before and 3 months after that course and found that it resulted in higher levels of empathy and less burnout.

“My last word would be one of hope because there are organizations that have been able to implement changes and demonstrate improvements. It’s going to be a learning process, but it’s one that we finally have national attention being paid to it. … As people start to shift their focus, they’re going to be able to provide more effective and comprehensive interventions,” Dr. Windover said. OB

References

Editors’ note: Dr. Windover has no financial interests related to her comments.

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Sylvie Stacy, MD, owner, Iatric Edge, Birmingham, Alabama, recognized while in medical school that the traditional path of full-time clinical work and being on call would not be for her. She knew she would feel burned out with that lifestyle.

“I found myself looking forward to lectures and didactics much more than clinical sessions,” Dr. Stacy said, adding that she loved the science of medicine. “Medical school and residency are long and in-depth enough that I think you can gain an adequate understanding of what types of positions you’ll be happy with in the long run.”

In Dr. Stacy’s opinion, too many medical students and residents go through training thinking their feelings of burnout will get better over time.

“There is this common, false understanding that young doctors need to ‘put in their time’ of overworked, underpaid misery in order to earn the coveted, prestigious, and well-compensated doctor lifestyle. It doesn’t work this way,” said Dr. Stacy, who maintains the blog “Look for Zebras,” which focuses on helping physicians find career fulfillment in medical and non-medical positions, as well as other areas of their lives.

“If you’re truly unhappy during training or your first few years of real-world work, it’s not just because you’re still in training or on a learning curve. It’s something more than that, and it’s important to be honest with yourself about what it is that makes you unsatisfied or exhausted.

“If it’s dealing with insurance companies, you could look into a cash-only practice, for example,” Dr. Stacy continued. “If your list is long, you need to start looking outside of traditional positions in medicine. Consider something in telemedicine or correctional health if you want to do clinical work, or look into pharmaceutical company opportunities, management consulting, medical writing, or starting your own business if non-clinical work is better suited for you.”

For those who have the drive to be in traditional medicine, Dr. Stacy said selectivity in the job is key.

“The first step is to spend ample time researching an organization and use the interview process to interview them and talk to current employees,” she said. “Choose a culture that you feel at home in. Then negotiate for a position and job description that meets your specific needs [in terms of] the responsibilities, the hours, the administrative load, the PTO, the on-call schedule, etc. Make sure it’s something that will work for your needs. … If the company is not willing to negotiate with you, keep looking. A company that truly values you and your happiness will work with you on these things.” OB

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When asked about her view on the impact of digital life today, one professor at the Boston College School of Social Work responded: “Do you remember when you used to have to wonder things?”

The internet has made finding answers to many questions as simple as typing a query into the search bar. With so much information at our fingertips, it is only natural that many of those queries would relate to one of our top concerns: health. As the number of internet users has increased year after year—now totaling more than 3 billion—more people than ever before are going online to search for and purchase health products and services, including eye care. According to dotHealth’s 2017 nationwide survey of American online health activity, 57% reported that they go to the internet first when researching information about a specific health condition or question. For ophthalmic businesses, this means it is essential to be present where potential patients are looking. One of the best ways to do this, whether it is for a practice or ambulatory surgery center, is to promote the brand through a variety of digital media.

Developing and managing a strong digital marketing strategy is a complex job, but it is made easier by a variety of available tools. These tools help a business create, organize, distribute, and monitor responses to its marketing messages as the business attempts to target the right audiences on the right platforms, while maintaining brand consistency. Think of these tools as the muscles making up the body of a digital marketing campaign. When all are used

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together properly and flexed regularly, they are most effective, attracting more patients and contributing to a business’s financial stability.

There are four essential digital marketing tools:
• Website
• Google Ads
• Social media
• Reputation management

Many ophthalmic businesses choose to focus only on a website, maybe a few social media channels, and leave the other tools entirely untapped or insufficiently utilized. Depending on a business’s economic needs and strategic objectives, this selective usage may be adequate. However, a business that decides not to “flex” all four digital muscles forfeits the full benefit of these tools. When used together, each plays a part in the effectiveness of the others. Most ophthalmic businesses will see the greatest ROI when they invest in a comprehensive digital marketing strategy.

To better understand how these four digital marketing tools strengthen each other and a business, examine the unique benefits of each individually.

Website
A website is the tool at the core of a business’s digital marketing strategy. It is where the other digital marketing tools point to and is the professional destination that persuades visitors they have found the most qualified business to meet their needs. Of the four tools discussed here, a website is the nonnegotiable must-have for an ophthalmic business. While some businesses may be able to get away with a digital marketing strategy driven only by a casual Facebook page, medical providers do not have this luxury. In addition to the fact that the internet has significantly increased competition among all businesses, potential patients expect a higher level of professionalism from a medical provider. If a potential patient cannot find a provider on the web, where even the smallest of businesses is expected to build a website, it casts doubt on a provider’s credibility. For this reason, a website should be priority number one.

A website also allows a business to position itself as a trustworthy medical authority. Persuading site visitors of this authority involves providing the answers to the questions potential patients are going online to find. The previously mentioned dotHealth survey revealed that the most common health-related activity online was researching a specific disease or medical condition, followed closely by researching symptoms, specific treatments, procedures, or drugs. For an ophthalmic business, this means incorporating educational information about the eye conditions it treats within the pages of its website. It should be sure to include keywords related to its services that patients are searching in order to attract the most web traffic. Google Ads can help advertisers select these keywords and much more.
Google Ads
Digital ads are an effective way to attract website visitors. When businesses think of digital ads, they are often thinking only of those that appear on Google search engine results pages (SERPs). However, Google’s advertising service helps marketers connect with people at every step of the consumer journey. Today this service, which was recently rebranded from Google AdWords to Google Ads, is designed to help businesses pay to place ads on SERPs as well as videos, websites, and apps. To aid those placing ads on websites and apps, Google works with a network of 2 million websites and 650,000 apps. All of these ad types work to attract leads, grow online sales, encourage calls from potential patients, and increase brand awareness. With so much relying on ad effectiveness, Google Ads includes resources that allow advertisers to fine-tune campaigns. One of the most helpful is the Keyword Planner, which helps advertisers identify popular keywords.

For those already using Google AdWords who may be worried about how the brand shift could affect campaigns, Google assures that its new Google Ads platform will have the same features and network of AdWords, with a few additions. It will not impact current campaign performance, navigation, or reporting. Instead, Google says it “will help advertisers and publishers of all sizes choose the right solutions for their businesses, making it even easier for them to deliver valuable, trustworthy ads and the right experiences for consumers across devices and channels.”

This update could prove useful to new and veteran advertisers alike, but it will hold little benefit for an ophthalmic business without online venues to direct potential patients to where they can engage with the business. A website’s role in this has already been established, but social media’s massive and connective influence cannot be overlooked.

Social media
In an age that celebrates “self expression,” social media is a crowd favorite. Websites are perfect for putting a business’s best professional face forward, but they are especially useful for inspiring visitors to engage with the people behind the business on social media. Facebook, Twitter, LinkedIn, and Instagram are some of the most commonly used digital conversation starters. They are especially useful for ophthalmic businesses as they allow a practice or ASC to share its personality and interact directly with potential patients while maintaining control of those digital conversations. One of the best ways to maintain that control, outside of careful social media account oversight, is through reputation management software.

Reputation management
Reputation management is becoming increasingly important, as health providers continue to build their overall web presence. After a patient’s experience, for better or worse, the business never knows what they might say about it on a review site. Furthermore, there are so many review sites on the internet that it is hard to keep track of every review. That is where reputation management comes in. Sophisticated software allows businesses to track reviews across all review sites on the internet and receive notifications via email as soon as someone writes a review about the business. This is important because the sooner a business can respond to a negative review, the more likely the individual is to forgive, or even remove the review. Even responding to a positive review is beneficial as it shows initiative and acknowledgment.

Some reputation management software specializes in health providers, collecting data from all known medical review sites (Yelp, Web MD, Healthgrades, etc.), Google reviews, and social media platforms. It combines the reviews into one overall grade/score for the business. Furthermore, those scores can be broken down into scores for individual doctors or locations. A perfect online presence is not realistic, but with reputation management, businesses can proactively protect themselves and respond when needed.

Conclusion
It is important to remember that setting up a website, Google Ads account, Facebook page, or reputation management is only 10% of the job. An effective comprehensive digital management strategy is always active and adjusted based on analytics. Visitors to a stagnant website can sense the lack of effort, whether it is from an old design or outdated copy, and they will not stay long. Google Ads must be managed and watched to ensure budgets are kept and keywords are still drawing click-throughs. A Facebook page or other social media account that has not been posted on in months is presumed inactive and unengaging. Reputation management sites will not do much to protect a business’s reputation if it is not managed. Before investing in these tools, a business must commit to a strategy and be prepared to follow through with the required work. Whether this requires approaching a third-party specialist or hiring someone in-house, be prepared to regularly flex all four digital marketing muscles to achieve maximum ROI.

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What drives patient loyalty in ophthalmology and how to increase it in your practice

by Liz Hillman, Ophthalmology Business Senior Staff Writer

Nationally representative survey finds level of patient loyalty in ophthalmology is high; physician-patient relationship is key

It is six to 10 times costlier to attract a new patient than to retain an existing one, according to Kristin Baird, president and CEO of the Baird Group, a consulting firm based in Fort Atkinson, Wisconsin, that specializes in customer service for healthcare organizations. Thus, maintaining patient loyalty in the hope of retaining them—and perhaps even getting referrals through positive recommendations from them—is important for the health of a practice.

Troy Cole, founder of Fort Worth, Texas-based LogiCole Consulting, works with medical practices to improve their marketing, sales, and patient satisfaction. Mr. Cole said patient loyalty, now more than ever, is harder to achieve for reasons such as growing competition and availability of information online (whether good or bad).

A nationally representative survey that measured patient loyalty in ophthalmology, however, found there is a “remarkable level of patient satisfaction” in the specialty. According to the paper published by Ramsey et al., the survey included more than 140,000 respondents from 566 sites (1,109 providers) over a 1-year period and found that overall, 96% reported a good or very good likelihood that they would recommend their ophthalmic care provider.

Analysis of the survey further drilled down into the factors that might lead a patient to recommend an ophthalmology practice to someone else, a metric, which David J. Ramsey, MD, PhD, assistant professor of ophthalmology, Tufts University School of Medicine, and Lahey Hospital and Medical Center, Burlington, Massachusetts, said shows that the patient has a certain level of trust in and loyalty to the practice.

The biggest factors associated with survey respondents’ likelihood to recommend a practice revolved around that patient-provider relationship: “Likelihood of your recommending this care provider to others,” “How well the staff worked together to care for you,” and “Your confidence in this care provider.”

Other factors, such as ease of scheduling, getting through to the clinic by phone, office hours, and wait room times, were not as correlated with recommending a practice, but Dr. Ramsey said this doesn’t mean these factors should be ignored.

“All factors were important ... all had a statistically significant correlation with outcome,” he said. “Some were far more correlated than others, but you shouldn’t be dismissive of things that are at the bottom of the list.”

Analysis of the survey results found that patients who might have negatively rated “How well the staff worked to care for you” increased the importance they placed on things like “Cleanliness of practice.”

“Of the areas queried, cleanliness of the practice may be an area to concentrate on for improvement and may remediate overall satisfaction for some patients,” Ramsey et al. wrote.

Things at the bottom of the list, such as the structural elements like office hours and cleanliness, are some of the easiest factors to adjust in a practice setting.

“Interpersonal things are far harder to retrain, but that doesn’t
mean you shouldn’t try,” Dr. Ramsey said, noting that ways to boost this could include taking a seminar on active listening.

While the survey doesn’t give specific action items for physicians or practices to try to improve patient loyalty, Dr. Ramsey said its takeaways “allow you to think further into professional development.”

The first thing to do is survey your patient population, if you haven’t done so already. The importance of patient feedback in care is increasing, and Dr. Ramsey suspects it may someday be tied to reimbursement.

“These metrics are imperfect if you’re looking at clinical quality … but in terms of other things that go into providing trust, that goes into providing longitudinal care, which is no doubt related to outcomes and quality,” he said. “Whether it affects reimbursement or not, it doesn’t mean we shouldn’t do it. It’s important to the patient and therefore is important to us.”

While the results of this survey showed that the doctor-patient relationship is paramount to other patient satisfaction factors, Ms. Baird said doctors should make an effort to avoid “initial negative encounters [that] will place the physician encounter at a disadvantage.”

“… patients who have difficulty scheduling or encounter unhelpful or insensitive staff or long wait times will be irritated and unhappy long before they come into contact with the doctor,” Ms. Baird said.

“Make sure every touch point is consistent with the doctor’s standards,” she continued. “Know what happens on the phone when a patient tries to schedule. Know what goes on in the waiting room. Monitor how your team members interact.”

Mr. Cole agreed, saying that while patients might not think at the time of taking a survey that staff interaction, phone experience, and wait times are important, “When there are issues with those, they are important,” he said.

“When you have a 5-minute hold time on the phone, that jumps to the top of a patient’s this-is-causing-me-dissatisfaction list. When they’re waiting an hour in the office every visit, that becomes important to the patient very quickly,” Mr. Cole continued. “It’s an area where we spend time determining every team member’s role with the patient—what that needs to look like and how each person can contribute to the overall patient experience. Every person in the office who touches the patient can either help move them a step closer toward booking a procedure, or they can detract from it.”

Ms. Baird encouraged doctors to focus on four best practice areas:

- Engagement: Engage with patients at the outset of the encounter to forge a relationship and establish trust.
- Empathy: Demonstrate empathy in both verbal and non-verbal communication. Remember that people don’t care how much you know until they know how much you care.
- Communication: Speak clearly and use words that the patient will understand. Validate understanding using a teach-back method. Summarize the key elements of the visit and discuss next steps with the patient prior to wrapping up. Provide a printed summary to take home.
- Gestures of respect: Many of the patients in ophthalmology practices are elderly and older than the doctor, so use a formal name until invited to use a first name. Ask permission to enter the patient’s personal space before performing an exam or test.

Mr. Cole provided a short list as well:

- Look to see what your bottlenecks are. Where are wait times happening? Get phone hold times down and reduce office wait times. Figure out who internally is going to help champion this change.
- Get an outside perspective. A third-party consultant or advisor can provide an objective view of changes that might need to be made.
- Over communicate with your patients. If you know you’re running behind schedule, call patients to tell them they can come in later, or go up to them in the waiting room and explain what’s going on. Patients will give you permission to use more of their time if you ask them for it and communicate respectfully.

Reference

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

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Artificial intelligence in ophthalmology: Clinical practice and business implications

by John D. Banja, PhD

A safe bet is that artificial intelligence (AI) will continue to improve its various functionalities and, as the years go on, will alter the landscape of human productivity, quality of life, and global business practices in ways that are presently unimaginable. IBM’s Watson, which beat the best Jeopardy players in history in 2011, can analyze 200 million pages of text in 3 seconds, illustrating the jaw-dropping computational power of these devices at storing, comprehending, analyzing and retrieving facts and knowledge from very large databases. That capacity has direct applications to healthcare, as “big data” storage and analysis—for example, the immense amounts of data that can be gleaned from millions of medical records and images—will enable diagnostic, prognostic, and treatment models that will increasingly become the norm and, indeed, the standard of care, over the next 2 decades.

AI is already amazingly good and probably will become astonishingly good at image recognition and classification—so much so that it has sparked considerable worry over the future of image-reliant specialties like radiology and pathology. I wondered about the applications of these technologies in ophthalmology, specifically with a view to how they might change ophthalmology workflow and certain aspects of its business model.

I came across two fairly recent studies that illustrate the promise of AI in ophthalmology but that also raise interesting marketplace questions. In 2016 Varun Gulshan and his colleagues published a study in JAMA that used AI to screen persons for diabetic retinopathy using retinal fundus photographs. The researchers trained an algorithm from 128,175 previously rated images for referable diabetic retinopathy, diabetic macular edema, and overall image quality. The algorithm was then tested on 9,963 images from 4,997 patients that had been graded by at least seven U.S. board-certified ophthalmologists. The software exhibited an area under the curve for detecting referable diabetic retinopathy of 0.99. Commenting on the study, Andrew Beam and Isaac Kohane noted that this technology, which relies on a special type of computer chip, can easily be implemented into existing computer systems at a cost of around $1,000. The technology is able to process about 3,000 images per second, which translates to 260 million images per day (because the device can work non-stop). In yet another commentary on Gulshan’s work, Tien Yin Wong and Neil Bressler speculated that this kind of technology would greatly expand ophthalmology workflow and certain aspects of its business model.

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These kinds of technologies and their benefits will only continue to improve. Some of these benefits will include developing large disease or illness registries whereby epidemiologic trends can be followed; detecting new disease etiologies or correlations; identifying beneficial therapies custom-tailored for particular patients; tracking differential outcomes; developing new standards of care; comparing and evaluating existing treatment modalities; and tracking treatment trends and their outcomes. But given the two studies mentioned, how might the clinical and business practices of ophthalmology change?

Considering the Gulshan study on screening for diabetic retinopathy, we should immediately note that the training data set was specialized for that disease and not for glaucoma or age-related macular degeneration—which diabetic retinopathy screening programs would normally include. Consequently, it remains to be seen how such an AI application would be integrated with the other diagnostic tests that a clinician would normally perform. And as Gulshan et al. admit, “this algorithm is not a replacement for a comprehensive eye examination, which has many components such as visual acuity, refraction, slitlamp examinations, and eye pressure measurements.” Another problem is the degree to which such a technology, once incorporated into a retinal camera, would simply be relied on by the ophthalmologist whose trust might become so great that he or she no longer reviews the AI’s image interpretation. Many think that such a degree of explicit reliance on the technology with little if any human oversight will almost certainly happen over time, as physicians and office staff scramble to meet their productivity targets. If so and the AI system errs, however, how will liability be apportioned in the event of an adverse occurrence and a lawsuit?

A third issue that speaks to both of the studies mentioned involves how the business of ophthalmology and other image-dependent practices might just send their images off to centralized reading sites that will interpret the images for a very low cost. Doing so might significantly reduce costs for an ophthalmology practice or, alternatively, free up clinicians and staff to perform more revenue-enhancing tasks. Such “reading centers” may well become commonplace for image interpretation in the years to come, as their access to massive registries, high output delivery that operates 24 hours a day, and associated high levels of accuracy and reliability will enhance their marketplace appeal.

Regardless of whether we are talking about screening and treatment recommendations for common or rare eye conditions, however, any ophthalmology practice is obviously going to scrutinize the quality of AI technologies before buying and using them. An important starting point for these algorithms is the extent to which their data training sets are adequate given the disease variations that patients will present. A training set may require hundreds of thousands if not millions of images or patient records to ensure an acceptable level of reliability and accuracy. In turn, that need will likely result in new, entrepreneurially based business models that will negotiate with clinics and hospitals to acquire and test AI training materials so as to ensure product quality. Additionally, note that Gulshan’s study relied on the interpretations of practicing ophthalmologists to build and inform his training set of images, which means that the quality of the AI’s ultimate outputs is only as good as the quality of their inputs. As Gulshan and his colleagues admitted, “This means the algorithm may not perform as well as images with subtle findings that a majority of ophthalmologists would not identify.”

Perhaps more than anything, though, these technologies will open up business opportunities for image-reliant practices throughout the world. When we think of the business of ophthalmology, radiology, or pathology, AI will almost certainly create a global marketplace that will facilitate access to quality care from which perhaps half the world’s population is deprived. The extent to which that global marketplace might disrupt local practices in industrially advanced countries remains to be seen. But with AI technologies advancing at a rapid rate such that their proceeding to FDA clearance in the U.S. will not be far off, it behooves everyone with a stake in the outcome to learn and estimate the quality and scope of AI’s clinical applications so as to plan their business futures wisely.

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or better compliance with pre- or postop cataract surgery instructions, keeping it simple may be best.

“I simplify the regimen as much as possible to ensure compliance,” said Inna Ozerov, MD, Miami Eye Institute, Hollywood, Florida.

Leaders at eye care practices follow solid teaching principles to ensure that cataract surgery patients understand and comply with their surgical instructions.

The process can take some trial and error. At Eye Centers of Tennessee in Crossville, the instructions for patients could potentially “fill a book,” as Larry Patterson, MD, said, but staff have worked diligently to boil down the instructions to one page. That, in addition to a recent switch to an intracameral injection of medications instead of a patient-led drops regimen, has simplified instructions for his patients.

What are some other specific strategies to ensure that patients understand and follow your cataract surgery pre- and postop instructions? Here are some pearls shared by seasoned surgeons.

1. Write it down—then repeat it orally several times. “The verbal instructions are mentioned by the doctor, emphasized by the technicians, and reiterated by the surgical schedulers, but the real key to the communication is that we write everything down for the patient,” said Jack Parker, MD, PhD, Parker Cornea, Birmingham, Alabama. “That usually means typed sheets with explicit instructions but frequently also includes handwritten additional
information.” Having your instructions in writing and repeated verbally can help reach different learning styles.

The staff at Dr. Patterson’s practice will also print out fresh custom-made instructions for each patient versus using copies of copies. The latter start to fade, making them harder to read, he said.

2. Build in verbal reviews at specific time points. “We find that verbal reviews at different times by different professionals as well as the printed instructions are extremely effective,” Dr. Ozerov said. Specifically, instructions are covered when patients meet with Dr. Ozerov, when they are with the surgical scheduler, and with a technician when patients return for their postop visit. Reviewing postop instructions with a family member is also helpful, Dr. Patterson said.

3. Consider adding informational videos about cataract surgery to your website. Many surgeons said they do not provide cataract surgery instructions on their website because instructions must be tailored for each patient. However, your website could have supplemental information, such as educational videos on what to expect with surgery and general information about eye drop use, said Paul Casey, MD, NVISION, Las Vegas.

4. Encourage patients to call your office with questions they have. This may seem obvious, but Dr. Casey has found that too many information sources, including the internet and well-meaning family members and friends, can confuse patients. He has even seen patients receive conflicting information from per-diem postop nurses at ASCs who work with a variety of specialists. Their instructions may reflect general recommendations given by other physicians and not what cataract surgeons want, he said. To help patients avoid confusion, make it clear that patients should turn to your office for any questions.

5. Provide a check-off chart. Some practices make a chart that shows which specific drops patients should use each day and add a check-off area each time that drop is used. Additionally, patients can bring the chart with them to postop appointments so you can check compliance. “This extra measure ensures compliance and best patient results,” Dr. Casey said.

6. Anticipate common questions and address them accordingly. For example, because patients often will ask what time of day to use the drops, Lama Al-Aswad, MD, MPH, associate professor of ophthalmology, Columbia University Medical Center, New York, will connect the drops instructions to specific daily activities, such as breakfast, lunch, dinner, and before going to bed.

7. Consider eliminating drops. Because drop use is often the most confusing topic for cataract surgery instructions, a number of surgeons now use intraoperative injections instead. Dr. Casey uses a transzonal injection of antibiotic and steroid medications at the end of surgery, so postop medication compliance is a non-issue for him. He explains this to patients by framing it as an evolution of cataract surgery that now includes advanced technology IOLs, femtosecond laser-assisted surgery, and intraoperative aberrometry.

“Others in my practice use a ‘less drops’ approach where combination antibiotic/steroid drops are formulated at a compounding pharmacy. This is more convenient and often more cost effective than name-brand eye drops,” Dr. Casey said.

Dr. Patterson also recently switched to injections versus drops and has found it extremely helpful.

“Simplifying the drops as much as possible is paramount,” said Maria Scott, MD, medical director, Chesapeake Eye Care and Laser Center, and LASIK surgeon, TLC Laser Eye Centers, Annapolis, Maryland.

“Ideally, the drops will eventually be eliminated as we move to a lacrimal depot of drops or longer activity intracameral injections.”

8. Monitor compliance so you can analyze where you might need to update your instruction process. When patients read and listen to the instructions given, as the vast majority of patients do, Dr. Ozerov finds they are compliant. “Issues arise when a patient does not pay attention to the information provided and gets confused about dosing, frequency, and how long they need to stay on the drops,” she said.

One patient group that may need additional support for drop use is older patients who live alone and do not have help, Dr. Scott said. This can be a challenging group in terms of following their instructions and their drop regimen.

9. Encourage patients to bring their drops to the office. “No one remembers what drops they’re using or what the names of those drops are,” Dr. Parker said. “That’s why it’s critical to have the patient bring all eye drops with them to every visit, so that we can verify that they’re using the correct one in the correct amount.” This alone has helped practice staff address compliance issues more than all other efforts combined.

10. Occasionally update your instructions to reflect changes in your practice or surgical approach. For example, Dr. Al-Aswad no longer stops anticoagulants for cataract surgery and most glaucoma procedures. She also has patients resume daily activities earlier than previously, including showering. She will give instructions for patients with special health conditions (such as diabetes or glaucoma) based on disease severity and surgical procedure versus a blanket plan for everyone.

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

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Four MDs on why they choose to practice small and how they do it

by Liz Hillman, Ophthalmology Business Senior Staff Writer

The pros and cons of a small or solo practice

“Can small practices survive?” That’s the question Khullar et al. ask in an article published in JAMA. The authors cite statistics of declining numbers of small practices, possible reasons for the decline, and how physicians at small and solo practices can make it work.

Ophthalmology Business spoke with four ophthalmologists who operate in small or solo practices to get their perspectives on bucking the trend of larger practice models, their insights on how they remain competitive, and their advice for others who think small or solo might be for them.

Reena Patel, MD
Wichita Vision Institute, Wichita, Kansas
Solo practice for 14 years

When Dr. Patel first moved to Wichita, she wasn’t necessarily intent upon opening her own practice, but when she started looking at the options, she couldn’t find a practice that held her same values in patient care.

“When I first started, I knew nothing about practice management. I went straight from training to having my own practice,” Dr. Patel said. “The financial aspect of the practice was overwhelming at first as I had no idea what to expect … but I learned that if you can make your practice efficient and you know your style of practice, then as a solo practitioner you can shine. I know that I enjoy my patients and I love getting to meet people every day. What is exciting to me is the challenge involved in the entire patient visit starting from why the patient is coming in to learning their history and finding a solution.

“It’s a privilege to be able to do it. I truly enjoy patient care, which is why I became a physician, and this allows me to focus on that and balance a home life as well,” she said of the joy of running her own practice, which she started in 2004.

Dr. Patel said she thinks small practices offer different types of care compared to larger groups.

“A patient I saw this morning said, ‘No matter how many times I’ve come in here’—and I’ve seen him for a decade—’you’re always smiling, you never rush me, and you always take the time to hear what’s on my mind,’” Dr. Patel recalled. “[Another patient] was complaining that this was not a 15-minute appointment; they didn’t read their new patient
You have to be ready to roll up your sleeves.

—Jennifer Loh, MD

paperwork where we say this may take 2–3 hours. They’re coming in for a potential surgery, so we’re going to take the time to take care of them. Our care is a niche care.”

Dr. Patel said she learned what she needed to know about starting a practice and its management from resources offered by ASCRS and other ophthalmology organizations. She also said relevant listservs can be helpful sounding boards for ideas and advice.

“I found that in the ophthalmology community … people are more than willing to share,” she said.

While she doesn’t like the government regulations that are impacting practices—Dr. Patel said it distracts from patient care—it keeps things from getting old. “There is always something new and different,” she said, noting that she spends at least 25% of her time on aspects of practice management.

Starting your own practice out of training can be daunting, Dr. Patel said. She recommended that those interested in going down this road look into their EMR software early and take coding and billing classes.

“Most doctors have no idea about billing and coding,” she said, explaining that those in small practices might “need to know that information because you’re ultimately responsible for that.”

She also said those interested in starting their own practice should be prepared for the time it takes to get the doors open. Finding and building out a space can take longer than you think, and you need to have a detailed business plan ready for the loan process, Dr. Patel said.

“You have to be self-motivated,” Dr. Patel said. “If you’re not, I think this is a difficult path. It’s not right for everyone, just like group practice is not right for everyone.”

Jennifer Loh, MD
Loh Ophthalmology Associates, Miami
Solo practice for 2 years

When Dr. Loh told people she was starting her own solo practice 2 years ago, after working as an employee doctor in another solo practice for 2 years followed by a larger practice for 3 years, she said she would often get a look, an ‘Are you crazy?’ look. There are a lot of naysayers to going out on your own, she said, and maybe not wrongly so.

“I probably should have been more cautious than I was. It was one of those situations where you don’t know what you don’t know,” Dr. Loh said.

But in her years as an employee doctor, she always felt that she wanted to be “the creator of a practice.”

“Whenever you join a practice, my experience was I learned a lot, but I didn’t have as much control over the way the practice was managed as I wanted,” Dr. Loh said. “I thought maybe I could make my own practice culture, create the environment that I wanted to practice in and create the patient base, eye diseases I wanted to treat and take care of. … You can become a partner in a practice, but what I did find in my limited experience was that sometimes finding the right fit can be tough. I realized that I could go out on my own, take a chance, and create the practice that I knew I wanted.”

In addition to the expected nerves about all the unknowns of starting a practice, Dr. Loh said she soon realized one of the biggest hurdles would be getting on the insurance panel.

“If you are by yourself and you open your practice, to get on an insurance plan, it’s much harder. If you join a practice, you’re automatically added within a month or two,” Dr. Loh said.

That’s when she approached Eye Physicians of Florida, a hybrid group, as Dr. Loh put it, of ophthalmologists who came together to centralize administrative tasks, such as billing, accounting, and IT but maintain their own practices. Joining Eye Physicians of Florida made it easy for Dr. Loh to get on the already-agreed-upon insurance panel, plus she got to take advantage of the economies of scale the group provided.

“I feel like I have the best of both worlds. In terms of branding, the way my practice looks, my logo, office hours, who I hire, who I fire, that’s all up to me. When I take vacations, up to me,” Dr. Loh said. “It’s my own profit and loss center. All of the money I bring in is mine, all of the expenses are mine, too. All the patients are mine; however, that also means I have the sole responsibility of attracting my own patients.

“Legally, I have to have the Eye Physicians of Florida [EPF] logo on all of my paperwork and documentation,” Dr. Loh continued. “What I have to comply with is there is a percentage fee of insurance collections that I have to pay to EPF in order to be part of the group; part of the reason you’re paying is because they are providing the service of doing the billing and the collection. However, even if I hadn’t joined EPF, I would either have to pay an employee to perform these tasks or pay a third-party vendor. So I don’t see it as a negative but as a positive since it is still in-house, and it reduces the need for extra employees. Other than that there are not a lot of restrictions.”

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While the decision to join Eye Physicians of Florida took care of a couple of major hurdles of starting her own practice, Dr. Loh said there was still anxiety. “Prior to opening my practice, I didn’t have a business background, I had never hired an employee. There’s that doubt ‘Am I actually going to get patients?’ Will I be able to pay all my expenses before I’m bringing in revenue? On top of that you have to actually practice medicine still,” she said.

Completing the Physician CEO program at the Kellogg School of Management helped Dr. Loh receive some business acumen. In terms of building her practice, once the doors were opened, she said it’s been a lot of networking. Dr. Loh personally visits optometrists and primary care doctors, passing out business cards, providing her cell phone number should they ever have a question, hosting small gatherings at her expense to get to know possible referring providers. Dr. Loh said she has done a little advertising and social media and encourages her patients to leave her reviews online. When she was just opening, Dr. Loh said she performed all the tasks a tech would usually do as well.

“You have to be ready to roll up your sleeves,” she said.

Dr. Loh feels like she has really built something and that she loves seeing growth on a daily basis. She also likes setting her own schedule and being the doctor patients come to see. Despite being established for a couple of years, there is still stress. “It’s a little like a roller coaster ride. Every day there is something that pops up, business or HR related, … having to deal with all of those things and at the same time wanting to be a good doctor and a good surgeon, some days it can be draining,” she said, adding that the challenge of it, however, can be fun as well.

For those who might be interested in setting out on their own, Dr. Loh’s advice is to do your research, create a business plan, talk to as many people as you can about how to run a practice, and “the last piece of advice I have is just be prepared for anything.”

John Parker, MD, and Jack Parker, MD

Parker Cornea, Birmingham, Alabama
Small practice for 21 years and 1 year, respectively

When Dr. John Parker first entered medicine out of training, he worked for 5.5 years at the institution where he had held his cornea fellowship. When that institution changed ownership, he decided to go out on his own. He said the new owners were accommodating, selling him used equipment, leasing him space, and allowing him to see patients he had accumulated. A technician and receptionist also came with him to his then-solo practice.

Initially, a sticking point was the billing service he had hired. It was a problem from the beginning. Dr. John Parker said, but despite having five young children at home, his wife took on the practice’s billing in the earlier years. Now, Parker Cornea employs 10 full-time, non-physician staff members.

For his part, Dr. John Parker said he’s never been tempted to join another practice since starting his own.

“Being my own boss wasn’t always easy, but it has been very rewarding,” he said. “We’ve been able to treat our patients and employees the way we think they should be treated. We get to go to the meetings and buy the equipment we think would be most helpful.”

Disadvantages of being in a small practice, Dr. John Parker continued, are having to be a jack-of-all-trades and needing to comply with a myriad of changing rules and regulations. When his practice was solo, prior to his son, Dr. Jack Parker, joining, every time Dr. John Parker went to meetings or took vacations, the office had to close.

Dr. Jack Parker said one of the pros is that Parker Cornea is not just a small practice, but a family practice. “My father and I see the patients, and my mother and sisters run the office. It’s an arrangement whose benefits are impossible to overstate,” he said. “The office feels like home and the patients feel like family.”

On the flip side, Dr. Jack Parker said the blending of work and family means “all we talk about is work,” even outside the office. While this is OK with them, “we’re not as fun at parties,” he quipped.

At a time when the pressures of practice management might have smaller and solo practices thinking of joining a larger group, Dr. Jack Parker said they remain competitive by cultivating strong relationships with patients and referring doctors. He also said they have been early adopters of some services, giving them an edge.

“For example, we [were] the first in the state to offer DSEK, DMEK, corneal crosslinking, and Bowman layer transplantation,” he said.

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

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How to manage harassment in your practice

by Lauren Lipuma, Ophthalmology Business Contributing Writer

Workplace sexual harassment is becoming more widely recognized, and when it happens in a medical practice it can lead to potentially devastating lawsuits, destroy staff morale, and tarnish a practice’s reputation, according to an expert who presented at the 2018 ASCRS•ASOA Annual Meeting.

Craig Piso, PhD, president, Piso and Associates, Larksville, Pennsylvania, a licensed psychologist and medical consultant, described the various types of harassment and interpersonal boundary violations that can occur in a medical practice. Dr. Piso also offered pearls of wisdom for becoming more adept at managing such violations, including how to create cultural safeguards that help prevent these violations from occurring.

“We can do a lot of things that make a fun, friendly, warm environment, as long as we know where the boundaries lie and what the consequences are,” Dr. Piso said.

A recent study by the U.S. Equal Employment Opportunity Commission (EEOC) found that 25% to 85% of women report having experienced sexual harassment in the workplace. Dr. Piso noted, however, that anyone can be a perpetrator and anyone can be a victim of sexual harassment—both men and women as well as practice staff, patients, visitors, and vendors.

“The tolls of sexual harassment can be monumental,” Dr. Piso said. “We know that when it’s going on, it erodes staff trust and respect for the practice. If you’re not stopping it, you’re giving tacit approval.”

Any person, whether staff, patient, visitor, or other, who experiences harassment in your practice becomes a negative ambassador to your brand, which can hurt the flow of referrals to your practice and ability to attract and retain the best available talent, he said.

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What constitutes harassment?

Sexual harassment occurs whenever unwelcome conduct on the basis of gender affects a person’s job, Dr. Piso said. Federal EEOC laws protect American workers from abuse, so sexual harassment is a violation of federal law. Dr. Piso focused specifically on gender harassment, but harassment could be based on other personal attributes such as race, ethnicity, sexual orientation, gender identity and expression, disability, physical appearance, body size, or religion.

Dr. Piso defined two basic types of sexual harassment: quid pro quo and hostile environment. Quid pro quo, or “this for that,” encompasses threats and rewards used to coerce someone into sexual activity. Threats include loss of employment, blocking a promotion or salary increases, demotions, and poor performance evaluations. Rewards include promotions, salary increases, continuation of employment, and favorable evaluations.

It’s important to remember the harasser does not have to be the victim’s direct supervisor; anyone in the practice with the power to affect a person’s terms of employment could be guilty of committing quid pro quo harassment, Dr. Piso said.

Hostile environment harassment occurs when anyone in the practice with whom an employee interacts creates an abusive work environment or interferes with the employee’s work performance. This type of harassment is not limited to people who work in the practice, Dr. Piso said. Vendors, visitors, and patients could all be affected by or perpetrators of harassment.

Managing hostile environment harassment requires practice managers to be aware of the various physical, verbal, and non-verbal behaviors that constitute harassment, he said. Physical behaviors include unnecessary touching, kissing, or hugging; grabbing or blocking a person’s path; or any type of coercive physical or sexual action.

Verbal behaviors include using foul or obscene language; propositions, threats and cyber stalking; and comments about gender-specific traits or a person’s physical attributes, sexual activities, orientation, or lifestyle. Nonverbal behaviors could be staring, whistling, catcalling, and performing pranks, or offering gifts, letters, or gestures of a sexual nature.

Hostile environment harassment is more difficult to identify and stop, so it’s more common than quid pro quo, according to Dr. Piso. Most often, these behaviors are subtle and progress from mildly offensive to more abusive over time.

“People engage in limit-testing behavior,” he said. “If you allow them to rub your shoulder and don’t do anything, don’t be surprised if that person, having successfully crossed that line, will see how or if you’ll react to the next deeper level of boundary violation.”

If you’re unsure whether a behavior constitutes harassment, imagine if a stranger committed such an act in public, Dr. Piso said. For example, if a stranger kissed you, grabbed you, or hugged you on the street, you might call the police or accuse that person of sexual assault.

“It’s a helpful barometer for understanding we have a right to expect that when we walk down the halls or interact with each other, we’re not going to be violated in these ways,” he said.

Manage harassment effectively

The first step in managing harassment is to prevent it by creating a culture of safety, Dr. Piso said. Establish clear written policies and procedures regarding harassment and have them vetted by legal experts. Be sure to educate and re-educate staff about these policies as often as needed and encourage reporting of harassment and open communication.

Build a practice culture based on embracing diversity, showing interpersonal respect, and demonstrating empathy, putting ourselves in the place of others to understand how our comments and behaviors make them feel.

“Ask yourself, ‘How would I feel if my spouse, parent, or child saw or heard this behavior?’” Dr. Piso said.

When harassment occurs, it’s best to nip it in the bud and make a statement about your standards of behavior in the workplace, he added.

If an employee feels he or she has been the victim of harassment, Dr. Piso recommended reporting it to the harasser’s supervisor and the practice’s human resources department. Be sure to document and describe all incidents that have occurred, including the date, time, place, quotes, and names of participants and witnesses; these details serve as anecdotal records and evidence.

If someone does report harassment, managers should conduct a timely, appropriate, confidential, and thorough investigation. The practice is responsible for stopping any abuse or harassment and must protect any affected person from further incidents and retaliation, Dr. Piso said.

“The clock starts ticking once a complaint or report is made to any practice manager,” he said.

Dealing with harassment swiftly and effectively is best for the victim but also for the entire practice, according to Dr. Piso. “If someone’s polluting the water, we all suffer,” he said. “But if we have competent managers who work to resolve it, you’ve filtered the water for the rest of us.”

Editors’ note: Dr. Piso has no financial interests related to this article.

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